STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325038	A. BUILDING _____ B. WING _____	01/29/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASA REAL	1650 GALISTEO STREET SANTA FE, NM 87505

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 0151 **Level of harm -** Actual harm **Residents Affected -** Few	**Honor all of the resident's rights as a resident of the nursing home, free of coercion and reprisal, and as a citizen or resident of the United States.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to honor resident's rights for 1 (R #113) of 1 (R #113) resident reviewed during a complaint investigation by inappropriately placing a wander gurard on R #113 for 76 days without an order preventing him from being able to leave the facility and threatening to discharge R #113 if he didn't comply with the placement of the wander guard. If residents are being intimidated to comply with facility rules, then staff are violating residents' rights to have a choice in how they wish to live their lives which could result in feelings of frustration, fear, humiliation and depression. The findings are: A. Record review of Ombudsman Notes dated 11/25/15 revealed Meeting yesterday (11/24/15) with resident, his daughter, tribal officials, Administrator, DON (Director of Nursing), SSD (Social Services Director) and MDS Coordinator. Resident has not been assessed to lack capacity. Resident leaves facility and usually walks to where his daughter works, several blocks from (Name of facility). Administrator states that they need to discharge him because he does not follow policy by signing out, and therefore they cannot guarantee his safety. Resident states that he cannot always sign out because the sign out book is not always present at the front desk (Ombudsman confirms that book is not always there). Since 11/03/15 resident has been wearing a wander guard on his right leg due for his own safety per Administrator. There was no physician's order for a wander guard and the daughter/POA (Power of attorney) had not been notified that a wander guard was in place until the day of the meeting (11/24/15). B. Record review of Face Sheet dated 11/03/15 for R #113 reveals R #113 is his own responsible party. C. On 01/25/16 at 2:54 pm during interview with Social Services Director (SSD), she stated that regarding R #113, I have know this man (R #113) for about 7 years. He walks all over. That has always been his routine. It is care planned. When the new team (Administration) came, they thought of it as a liability. SSD confirmed that R #113 walks to his daughter's work which is a few blocks away and also goes next door (hotel) to play cards with the housekeepers. One day he went out and it was kind of cold, he was wearing a jacket. They got very concerned and put him on the wander guard. We had a meeting with his daughter and tribe (11/24/15). He stayed with the wander guard until I could get 2 doctors to say he was competent. That he could make his own decisions and was aware of the risk. He has medicaid so it was hard (to find physicians). SSD confirmed that he never had an order for [REDACTED]. D. Record review of the Physician orders revealed during October 2015 and November 2015 revealed there was no order for a wander guard. 1. A Physician order dated 11/24/15 revealed Keep wander guard in place until psych (psychiatric) consult to evaluate need for wander guard related to flight risk and personal safety. 2. A Physician order dated 01/18/16 revealed D/C (discharge) wander guard r/t (related to) results of competency evals (evaluations). E. On 01/26/16 10:47 am during an interview with the Corporate Nurse Specialist she stated. We do not have an order for [REDACTED]. F. On 01/26/16 11:27 am during an interview with Administrator when asked when the wander guard was placed on R #113, he stated that it was after he (Administrator) was hired (10/15/15) and before the Care Plan meeting in November (11/24/15). When asked for the reason the wander guard was placed on R #113, he stated There was concern of him going out in inclement weather and whether or not he was able to make those decisions. Administrator confirmed that at the Care Conference on 11/24/15, there was a request for some evaluations to be done. It was agreed that the wander guard would be removed once the competency assessment was completed and it was decided that he was capable of making his own decisions. When asked if a wander guard could be put on a resident without a physician's order, he stated It should not be. G. On 01/26/16 1:19 am during interview with Clinical Psychologist, she stated. I was asked by the facility if I could perform a competency test on R #113. I tested R #113 with a higher cognitive test and the results indicated he was cognitive and able to make rational decisions. I then submitted the diagnostic evaluation to the facility. H. On 01/27/16 10:24 am during an interview with R #113 he stated They put that thing (wander guard) on me so I wouldn't leave the building. A buzzer would sound when I would want to leave the building, It made me feel bad cause I could not leave the building. It was a nuisance to me every time I walked by the front door the buzzer would sound. It felt like I was in jail. I did not do anything else so they would not punish me any more. I am not such a bad boy. I don't want that thing on me again. I try to obey. I know how to follow instructions. I. On 01/25/16 to 01/29/16 during an interview with Medical Doctor (MD) #1, he confirmed that he never gave an order to put the wander guard on R #113. MD #1 confirmed that he was not informed that R #113 had a wander guard until after the care conference meeting (11/24/15).
F 0154 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Tell the resident completely about his or her health status, care and treatments.** Based on record review and interview, the facility failed to ensure that residents are communicated with in a language that they understand. This deficient practice is likely to result in residents feeling isolated and not being aware of the care and treatment that they are receiving. The findings are: A. Record review of the Employee Handbook dated 12/2012 revealed that The resident has a right to be fully informed in a language that he or she understands of his/her total health status, including but not limited to, his/her medical condition. B. On 01/21/16 at 5:02 PM during interview with Anonymous Staff (AS), S/he stated (Name of CNA #7) was speaking Spanish to the residents and (Name of Director of Nursing and Administrator) got upset and said they didn't want staff speaking in Spanish. C. On 01/22/16 at 10:46 am during interview with Family Member #1, she stated The staff has told me 'We can't speak Spanish and that we're called pigs.' I fear for the care that my brother will receive with agency staff that doesn't know how he functions and what he needs. Staff are walking on pins and needles or have left. What a sad, sad thing. I tell them all, stick to your guns and don't go anywhere. Report it. I have thought about calling the company that manages it. In 9 years, I bet we have had 7 administrators. They don't stay. All they want to do is look at the bottom line. Get rid of the people that have been here and hire people. Please don't let them get rid of the people that know what they are doing. They are bilingual and can speak to the residents that only know Spanish and they have a right to know what's going on daily. If there was another place that would take good care of my brother and I could afford it, I would move him. If they want to

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

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F 0154 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) know what needs to be approved, I can tell them. I have been here for 9 years. I fear for what will happen when you (surveyors) are gone. D. On 01/23/16 at 11:52 am during interview with Family Member (FM) #2, she stated that staff informed her that they were not allowed to speak Spanish to the residents. FM #2 stated that she observed the Director of Nursing and Activity Director being mean to the staff, especially those speaking Spanish by degrading them, talking down to them, yelling at them in public and threatening them with their jobs. FM #2 stated that she observed the Activity Director yelling at an Assistant and accusing him of being on drugs in front of residents and other family members. E. On 01/25/16 at 2:54 pm during interview with another AS, S/he stated the the Director of Nursing told staff that they should not be speaking Spanish to each other and the residents. No Spanish music and no Spanish channels cause she said it wasn't Almost every resident back there (Alzheimer's Unit) speaks Spanish. She asked them not to speak Spanish in front of her. I reported it to (Name of the Administrator) and HR (Human resources). (Name of Administrator) said we shouldn't be speaking any other language here (at the facility). When asked if residents have ever complained, S/he reported I have heard about instances in which they (residents) have Spanish music playing in the dining room and they (Administration) have asked them to turn it off. The CNAs (Certified Nurse Aides) asked me about it. I told them that in front of her (DON), don't (speak Spanish). They were very offended.
F 0157 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the residents' legal representative or interested family member of any significant changes in residents' condition for 3 (R #10,12 and 81) of 3 (R #10, 12 and 81) residents reviewed for notification. This deficient practice is likely to prevent family members from making decisions and advocating on behalf of residents. The findings are: Findings for R #10: A. Record review of R #10's Nursing Notes dated 06/20/15 indicated resident was found lying on the floor and taken to the hospital on [DATE]. Resident returned to facility on 06/22/15. B. On 01/19/16 at 10:59 am during interview with R #10's Power of Attorney, (POA) she stated, Last June we never found out what happened. She had a fall and broke her right femur. They found a raging abdominal infection. They didn't notify me. Findings for R #12: C. Record review of R#12's medical chart indicated that resident was taken to the hospital on [DATE]. Resident returned to facility on 01/12/16. D. Record review of R#12's Face Sheet indicated that her brother is listed as POA and his telephone number is listed on the Face Sheet. E. On 01/15/16 at 12:25 pm during interview with R#12's brother and POA he stated, (Name of R#12) was taken to the hospital last Thursday night. The facility called my ex-wife instead of me even though I am the POA for my sister. Findings for R #81: F. Record review of R #81's Nursing Notes dated 12/29/15 indicated that resident was taken to hospital on [DATE]. G. Record review of R #81's Comprehensive Plan of Care dated 08/14/15 revealed Notify MD/family/hospice of any change in condition. H. On 01/29/16 at 1:28 pm during interview with Family Member (FM) #2, he confirmed that he is R #81's POA. He stated regarding R #81, Mainly he did have about 4-5 falls. The first one they did report to us. The ones after, they never called. FM #2 explained that he arrived at the facility on 12/29/15 at about 1:00 pm to visit R #81 and the Nurse (unidentified) told him, I meant to call you. FM #2 stated the R #81 had been sent to the hospital at 9:00 am for what later turned out to be pneumonia. FM #2 stated that he wasn't notified, and that the Social Services Director (SSD) apologized to him. Per FM #2, The last straw was when they didn't contact us for the pneumonia. FM #2 confirmed that the family chose to not take R #81 back to the facility after that incident. I. On 01/29/16 at 3:17 pm during interview with Social Services Director (SSD) when asked what the protocol is for notification, she stated, The charge nurse is supposed to call the doctor and the family. J. On 01/29/16 at 4:28 pm during interview with Regional Nurse Specialist #1 when asked if families or POAs for R #10, 12 and 81 had been notified, she stated, No, notification was not made to any of the families.
F 0164 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep each resident's personal and medical records private and confidential.** Based on observation, interview and record review the facility failed to safeguard clinical record information by leaving Private Health Information (PHI) where unauthorized persons had access to it for 5 (R #3,142, 171, 174, 175) of 5 (R #3,142, 171, 174, 175) residents reviewed during random observation. If resident's clinical information is not sufficiently safe guarded, resident's PHI is likely to be viewed by unauthorized residents, visitors and staff. The findings are: A. On 01/15/16 at 10:12 am during an observation of the front reception area, the was a clipboard with Hospice participant information face up on the counter. The clipboard was visible upon approach of the desk. The information included about 20 hospice participants' names, addresses and diagnoses. However, upon review none of the participants were current residents of the facility. B. On 01/15/16 at 4:13 during an observation at the nurses station on the south unit, the Activities of Daily Living (ADL) flowsheet book was opened, placed atop the nurses station and oriented toward the common walkway. The ADL flow sheet of R #171 dated 01/13/16 was visible to passersby. C. Record review of the ADL flowsheet for R #171 dated 01/13/16 revealed information regarding the number of bowel movements and instances the resident had urinated during the day and night shifts. D. On 01/15/16 at 4:27 pm, R #2 walked up to the nurse's station and began looking at the record and flipping through pages of resident ADL flowhseet book. E. On 01/20/16 7:53 am during an observation of the south side nurses station a Vital sign sheet for all residents on this unit was observed face up at nurses station visible to passersby. F. On 01/23/16 at 8:30 am during an observation of south side nurses station a 24 hour nurse report was set face up on the nurses station with the PHI regarding R#3, R #142, R #174 and R #175. G. On 01/23/16 at 8:35 am during an interview with Licensed Practical Nurse (LPN) #1 stated. Leaving anything face up where it can be seen is a HIPAA (Health Insurance Portability and Accountability Act) violation and should not be left for others to see. H. On 01/23/16 at 8:40 am during an observation of north side nurses station a stack of 9 shower sheets for R #144, R #160 and R #176 were observed to be set face up. I. On 01/23/16 at 8:45 am during an interview with Registered Nurse (RN) #1 she stated. Nothing with personal resident information should be left sitting out for anyone to see. J. Record review of the Policy and Procedure regarding Confidentiality of Information dated December 2006 revealed, Access to resident medical records will be limited to the staff and consultants providing services to the resident.
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.**

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F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Based on record review and interview, the facility failed to protect residents from abuse and neglect for all 109 residents in the facility, listed on the Resident Census provided by the Administrator on 01/15/16 by 1. Offering temporary employment to a Certified Nurse Aide (CNA) from a sister facility that had been terminated from this facility for abuse making him ineligible for re-hire. 2. Not reporting an accusation of abuse to the state agency within 24 hours and submit a 5 day follow up investigation timely. 3. Not keeping track of resident/resident family member grievances including how they were resolved. If the facility employs individuals that have a history of abuse, neglect, exploitation, mistreatment, and misappropriation of property, doesn't report these incidence to the state agency timely, and doesn't track grievances and how they are resolved, then residents are at risk of being victims of abuse, neglect and exploitation. The findings are: A. Record review of Registered Nurse (RN) #2 statement dated 01/24/15 revealed that CNA #2 stated. (Name of CNA#1) had put several of the resident to bed wet and had not attempted to change them and he (CNA#1) had been very rough with (Name of R #177) when putting him to bed. 'At the early morning change, I observed (Name of CNA #1) being rough with (Name of R #73) while getting him changed.' (Name of CNA #1) displays a brusque manner with many of the residents which can cause some of the more sensitive residents to become hostile or agitated. B. Record review of statement dated 01/26/15 written by Interim Director of Nursing revealed, On the afternoon of 01/25/15 I received a phone call from (Name of Licensed Practical Nurse (LPN) #2) informing of a situation involving (Name of CNA #1). I was here (at facility) before 6 pm to inform (Name of CNA #1) that he was not to work and why he was not being allowed to work. I informed him in Spanish that we had do an investigation related to a complaint about a resident he had cared for on 01/24/15 between the hours of 6a (am) to 6p (pm). I explained to him in Spanish that he was being suspended pending the investigation and he went home. On the morning of 01//26/15, I got this statement from (Name of CNA #2). (Name of R #177) was being put to bed but he was slow in standing up. (Name of CNA #1) grabbled him roughly and threw him onto bed, causing him to yell out. Another observation was that another resident was put to bed wet. This resident can be combative when he is being changed, and (Name of CNA #1) stated that he was not going to deal with it. C. Record review of letter of determination dated 01/26/15 by Acting Manager revealed, In light of the statements by the C.N.A. and two nurses, and after review of (Name of CNA #1)'s file, the determination was made to terminate (Name of CNA #1). D. Record review of the Staff Sign In Sheet dated 01/21/16 revealed that CNA #1 was working at the facility. E. On 01/22/16 at 4:09 pm during an interview with Regional Nurse, when asked how CNA #1 came to work at the facility, she replied They called down to (Name of other facility) to see if any of their staff can come over here. I was told 4 people (CNAs) were going to be off. When asked if the facilities communicate with one another regarding staff prior to hire, she replied Very few (staff) get through the holes. When informed of the numerous accusations against CNA #1 in the file, she confirmed that she had not read his entire employee record and she was unaware of the extent of these abuse accusations. F. On 01/22/16 in the evening, during interview with the Regional Nurse My understanding is that (Name of CNA #1) had been terminated from this facility and was not eligible for re-hire at any of our other facilities. I will call the other facility immediately and have him suspended pending investigation. G. Record review of the Health Facility Licensing and Certification Incident Report revealed that the incident happened on 01/24/15 and facility self reported the incident regarding CNA #1 on 01/27/15. A five day follow up investigation wasn't sent to the state agency until 03/20/15. Findings related to following up with grievances: H. On 01/25/16 at 2:54 pm during interview with Social Services Director (SSD) when asked what she does when she received a resident or family member complaint, she stated If it is made to me directly. I make a grievance. I bring it to the immediate attention of (Name of Administrator) or (Name of Director of Nursing (DON)). They do the investigation. The only thing they ask me to do, is one time I interviewed all the residents and asked if they were treated with respect. When asked how grievances are tracked, she stated If it is other that care, like they lost something, I get a copy of the inventory sheet and if it is there, I will go to Walmart and replace it. Anyone can do a grievance log. It should come back to me. More often than not, I am the only one that does the grievance log. If it is something to do with care, I give it to (Name of DON). Upon review of SSD grievance log, there was only one grievance related to care. Documentation was provided indicating that this was passed onto the DON. I. On 01/26/16 at 11:43 am during interview with the DON, when asked how are resident or staff complaints responded to, she stated Hopefully, we (Administration) would be contacted. If it was of an abusive nature, they (staff) would be suspended. It would be reported to the state. (Name of Administrator) does that. J. On 01/26/16, in the afternoon, the Administrator was asked how are resident grievances/complaints tracked. He brought back 2 file folders which he stated were reported to the state but never entered into the incident report log. K. On 01/26/16 at 4:50 pm during interview with the Corporate Nurse Specialist (NS), she stated that she looked in the DONs office for a grievance log book and was unable to locate anything. The NS confirmed that all grievance (related to care and lost items) should be in the same book, which include how the grievance was resolved. L. On 01/21/16 at 2:02 pm during interview with Family Member (FM) #3, he stated that he comes to visit R #85 and on numerous occasions he has assisted in wiping R #85 after her uses the restroom, and he has found that he is still dirty from the last bowel he had. FM #3 reported that he talked to the Director of Nursing (DON) a couple months ago because each time it was the same Certified Nurse Aide (CNA) that was taking care of R #85 that day. FM #3 stated that he was told by the DON that this CNA would not be working on the Skilled Unit anymore. FM #3 stated that today (01/21/16), he came and checked on R #85 and had to Wipe 7 times to clean left over bowel that was left between R #85's buttocks, and the same CNA is working with R #85 today. FM #3 stated that R #85 is continent but does have accidents sometimes, and R #85 needs assistance is getting to the toilet. M. Record review of the Incident Log Report from 07/01/15 to 01/19/16 revealed that no incident report was logged for R #85.
F 0226 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** Based on record review, interview and observation the facility failed to implement their policies and procedures on employing staff that have been terminated for abuse neglect or exploitation. The facility continued to employ a Certified Nurse Aide (CNA) after he had been terminated from the facility for abuse making him ineligible for re-hire. If the facility employs individuals that have a history of abuse, neglect, exploitation, mistreatment, and misappropriation of property, residents are at risk of being victims of abuse, neglect and exploitation. The findings are: A. Record review of the Employee Handbook dated 12/2012 revealed 1. The resident has a right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. 2. Former employees are eligible for re-hire if they left employment in good standing. 3. If an employee is rehired passed the 90 day window, rehired employees will be required to undergo the same pre-employment procedures as applicants seeking employment. B. Record review of Registered Nurse (RN) #2 statement dated 01/24/15 revealed that CNA #2 stated. (Name of CNA#1) had put several of the resident to bed wet and had not attempted to change them and he (CNA#1) had been very rough with (Name of R #177) when putting him to bed. 'At the early morning change, I observed (Name of CNA #1) being rough with (Name of R #73) while getting him changed.' (Name of CNA #1) displays a brusque manner with many of the residents which can cause some of the more sensitive residents to become hostile or agitated. C. Record review of statement dated 01/26/15 written by Interim Director of Nursing revealed, On the afternoon of 01/25/15 I received a phone call from (Name of Licensed Practical Nurse (LPN) #2) informing of a situation involving (Name of CNA #1).

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F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) I was here (at facility) before 6 pm to inform (Name of CNA #1) that he was not to work and why he was not being allowed to work. I informed him in Spanish that we had do an investigation related to a complaint about a resident he had cared for on 01/24/15 between the hours of 6a (am) to 6p (pm). I explained to him in Spanish that he was being suspended pending the investigation and he went home. On the morning of 01//26/15, I got this statement from (Name of CNA #2). (Name of R #177) was being put to bed but he was slow in standing up. (Name of CNA #1) grabbled him roughly and threw him onto bed, causing him to yell out. Another observation was that another resident was put to bed wet. This resident can be combative when he is being changed, and (Name of CNA #1) stated that he was not going to deal with it. D. Record review of letter of determination dated 01/26/15 by Acting Manager revealed, In light of the statements by the C.N.A. and two nurses, and after review of (Name of CNA #1)'s file, the determination was made to terminate (Name of CNA #1). E. Record review of the Staff Sign In Sheet dated 01/21/16 revealed that CNA #1 was working at the facility. F. On 01/22/16 at 4:09 pm during an interview with Regional Nurse, when asked how CNA #1 came to work at the facility, she replied They called down to (Name of other facility) to see if any of their staff can come over here. I was told 4 people (CNAs) were going to be off. When asked if the facilities communicate with one another regarding staff prior to hire, she replied Very few (staff) get through the holes. When informed of the numerous accusations against CNA #1 in the file, she confirmed that she had not read his entire employee record and she was unaware of the extent of these abuse accusations. G. On 01/22/16 in the evening, during interview with the Regional Nurse My understanding is that (Name of CNA #1) had been terminated from this facility and was not eligible for re-hire at any of our other facilities. I will call the other facility immediately and have him suspended pending investigation. H. On 01/29/16 at 4:40 pm during interview with Regional Nurse, she confirmed that the facility does not have a Policy and Procedure on abuse.
F 0241 **Level of harm** - Actual harm **Residents Affected** - Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promote care with dignity and respect for 11 (R # 20, 86, 89, 99, 104, 144, 148, 153, 173, 174 and 181) of 11 (R # 20, 86, 89, 99, 104, 144, 148, 153, 173, 174 and 181) residents reviewed during random observation by: 1. Waking R #104, 174 and 181 to see if they need changing or to give medication. 2. Not ensuring that R # 60, 89, 153 and 173 were not exposed to other residents or passerbyers from the hallways. 3. R #144 and R #174 having to wait for assistance to the toilet resulting in his soiling himself. 4. R #20, 86, 99, 148 and 174 having to wait for assistance, medications and/or meals. This deficient practice likely resulted in residents feeling embarrassed, ashamed, and as if their feelings and preferences and unimportant don't matter to the facility staff. The findings are: A. On 01/21/16 at 3:10 pm during interview with Anonymous Staff (AS), s/he stated that the Activities Director (AD) was pushing R #179 in her wheelchair down the hall from an activity, and the AD said She (R #179) stinks and R #179 responded No, I don't. Findings related to waking residents: B. On 01/21/16 at 3:10 pm during interview with Anonymous Staff, s/he stated that R #181 was woken up in the middle of the night by a CNA to see if he was wet. AS described that this CNA (unidentified) picked up his shirt, pulled down his pants and untied his brief to see if he was wet. C. On 01/21/16 at 4:07 pm during interview with R #181, when asked if he is ever woken in the night by staff, he confirmed he had been. R #181 stated that a female night CNA (unidentified) has come into his room while he is sleeping, pull his covers down, and untied his pajama pants to see if he is wet. R #181 confirmed that this has happened twice at about 3 am in the morning. R #181 stated, I don't even wet the bed. I don't know why they (staff) do that. D. On 01/22/16 at 9:53 am during interview with R #104, when asked if she is ever woken to get her medication, she stated I have [MEDICAL CONDITION]. The regular doctors prescription is at 6(pm) but I get the drops until 10:30 pm to 12 am. Several times they have said they have given them to me in my sleep. R #104 confirmed that they wake her up to give her medication and take her vitals. R #104 said I have asked the doctor to change the prescription for day time (because of being woken up), but he said it's best to have them (eye drops) at bedtime. Findings related to having to wait for assistance/meals: E. On 01/21/16 at 2:50 pm during interview with R #144, he described that he needs assistance from staff to go to the restroom, taking off the belt, pulling pants down, and have staff spot me incase my knees buckle. When asked if staff respond to his call light, he stated It depends. They usually get here. If I have to go to the bathroom, I know now that I have to give them (staff) time before it's urgent (Need to go to the bathroom). R #144 confirmed that he has had a couple accidents before from having to wait too long. R #144 said, I knew they were understaffed and a lot of staff called in. Either shift blames the other. I tried to retain my right to be dignified. To soil myself doesn't make me feel too good. I wrestle with that. F. On 01/22/16 at 8:21am, during observation and interview, the room tray cart was sitting in the hallway. R #20, 99 and 148 were sitting at a table in the tv room. R #20 stated that they had been waiting for 15-20 minutes for breakfast. When asked if food is ever cold, R #20 responded Sometimes. Scrambled eggs are cold all the time. R #148 confirmed that they have been waiting for the breakfast trays since 8:00 am. G. On 01/22/16 at 8:21 am during interview with R #148, she stated Agency staff are slow in passing out meds (medication). I get sleeping pills but they don't come until 11:00 pm at night. I'm usually in bed since 9 (pm). R #148 also stated that she is unable to wheel herself back to her room, and the other night she had to wait an hour after dinner to get back to her room because there wasn't enough staff. R #148 stated This is a nursing home and they are not staffed adequately. No matter what you do here, you have to wait. H. On 01/22/16 at 8:32 am during interview with an Anonymous Resident (AR), s/he stated If you complain too much they will fire back. They (staff) will be unpleasant, and not answer your call light. They (staff) heard me talking to other residents, complaining in general and they started treating me different. They either like you or they don't like you. AR stated s/he she has seen other residents not be treated well or have to wait a long time. AR was unable to identify the specific residents or staff mentioned. I. On 01/22/16 at 8:38 am during interview with another AR, s/he stated They're (staff) favorite excuse is 'Give me a minute' and when they say that you know they aren't going to show up. It's very frustrating. It's a nursing home, don't expect too much. I asked (Name of local hospital) if they can keep me longer, cause I knew I wouldn't get the right care I needed here. J. On 01/22/16 at 8:40 am during observation and interview, CNA #8 served R #99 her breakfast tray. At 8:46 am R #20 and R #148 were served their breakfast trays. CNA stated that trays are suppose to be passed out at 8:20 am however I am a little behind, cause 2 CNAs called in and I am helping them. K. On 01/22/16 at 8:47 am during interview with R #86, when asked if he ever has to wait for assistance, R #86 stated Getting medications. Mostly at night but in the day time too. Usually my night pills. I didn't get them until almost 10 o clock. L. On 01/22/16 at 3:19 pm during interview with R #174, she stated We don't get good healthcare. The food here is not great. They don't have enough help. I don't know if it's cause the CNAs don't get enough help. I don't know if they are quitting. Everybody knows it here (that things are bad). What they are bringing in is agency care. Some of them are ok. Some of them are rude. Some of them we (residents) have to wait (for assistance). We get our medications late in the evenings. We can't get help (transfer to bed) until after 8 o cock. We have to wait on the showers. They say to us, 'It's not 7 o clock.' (to get help in bed). We have to wait for CNAs (from night shift) to get in. I can't get in (bed) myself. Everyone (CNAs) says, 'I need help' and it has to be 2 people (to transfer R #174). We come out of the dining room and we have to stay sitting. Atleast 12 hours in the wheelchair. Since I've had surgery on my spine I can't stay in my chair that long. My back is

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F 0241 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 4) hurting. I press the call light and had to wait. When we (residents) have to use the restroom, they say 'Wait, wait.' Yes, sometimes I pee in my pants. I feel frustrated. I just want to leave this place and go somewhere else. They have to give our medications at 8 o clock but they don't give them until late. R #174 confirmed that she is woken up to be given medication and to be changed. Findings related to be exposed: M. On 01/27/16 at 9:49 am, on 01/28/16 at 8:43 am, and on 01/28/16 at 3:38 pm, R #60 was observed laying in bed with his hospital gown pulled up, exposing his briefs. This could be viewed from the hallway by passerbyers. N. On 01/22/16 at 3:16 pm and on 01/25/16 at 9:44 am during observation, R #89 was sitting in her room in her wheelchair moving towards the open door, with her pajama gown pulled up to her pelvis, exposing her legs and thighs. This was visible to passerbyes. O. On 01/21/16 at 10:30 am during an observation for the preparation of wound care CNA #8 positioned R #153 in bed then walked out of the residents room, leaving the door to the resident's room open. From the common hallway, R #153 was observed to be laying in bed with his pants down to his ankles and the resident's brief visible to passerbyes. P. On 01/22/16 at 8:29 am to 8:40 am during observation, R #173 was laying down in bed with his hospital gown on and bare buttocks facing towards the hallway. The door to resident's room was open. The Administrator was observed to walk by the resident's room twice during this time. Q. On 01/22/16 at 8:40 am, the Regional Nurse Specialist confirmed the above observation and closed R #173's room door.
F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** Based on interview and observation, the facility failed to ensure that 1 (R #180) of 1 (R #180) resident reviewed for food choices during random observation was receiving the foods of his preference. If residents are not receiving the food choices of their preference, then residents are likely to not eat what is served to them which can result in weight loss and frustration. The findings are: A. On 01/26/16 at 2:59 during a resident council meeting R #180 stated. I am a vegan (a person who omits all animal products from the diet) and I was served a hot dog for lunch and on several occasions have been served bacon or sausage and even eggs at times for breakfast. I have spoken several times to the Dietary Manager, there has been an improvement but there is still a problem. B. On 01/27/16 at 10:32 am during an interview with the Activity Director she stated. R #180 has voiced his complaints to me and the Administrator. I have spoken to the Dietary Manager about the issues in the past. I will continue to follow up and I will also let the Dietary Manager know. I don't think R #180 needs to bring those issues to the resident council meetings. C. On 01/27/16 at 10:40 am during an interview with the Dietary Manager he stated. R #180 has told me that he is not getting vegan meals. I try to make extra special meals for R #180 and he still complains. I don't know what more I can do for him, I try to accommodate his diet.
F 0243 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that private space is available in the nursing home for resident groups or residents' families to meet.** Based on record review and interview, the facility failed to ensure that Resident Council meetings were being organized and held regularly for residents to participate if they choose. By not holding a regular Resident Council meeting for residents to participate in, residents are not able to discuss any issues or concerns they may have, leaving those complaints and concerns unresolved. This has the potential to affect all 109 residents identified on the Census list provided by the Administrator on 01/15/16. The findings are: A. Record review of resident council minutes revealed there were no resident council meetings between 07/30/15 and 12/16/15. B. On 01/26/16 10:12 am during an interview with the Activity Director (AD), she stated. The gap in the resident council meeting documentation is due to the fact that for three months the facility did not have an Activity Director. The AD confirmed that there had been no Resident Council meetings during that time. C. On 01/29/16 at 4:11 pm during interview with the Administrator, he stated regarding Resident Council, We didn't have a Resident Council (meeting) for awhile but as soon as we got one (Activity Director), we corrected that problem.
F 0244 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Listen to the resident or family groups or act on their complaints or suggestions.** Based on record review and interview, the facility failed to ensure that the concerns of the resident council were addressed, by not communicating a response/decision to the resident council or specific residents with concerns. This deficient practice is likely to result in all 109 residents in the facility, listed on the Resident Census List provided by the Administrator on 01/15/16, being made to feel as if issues were not important, grievances were not taken seriously and they were being left uninformed about decisions that were made about their well-being. The findings are: A. On 01/26/16 at 2:59 pm during a Resident Council Meeting R#74, stated. When I asked CNA for something she literally tells me 'Why don't you do it yourself. This morning I asked for a razor and she told me she would get another CNA to help me. R #178's family member, stated. My wife is a resident here, and I think the communication could be a little better, we expected certain things in the way of therapy, we waited all day and no therapist came ever by (sic) to see my wife I went to the front desk and they didn't know who to go to. She wanted the alternate meal we didn't know how to get that. B. On 01/27/16 at 10:05 am during an interview with R #74 when asked if any staff had come to follow-up with her about her issues after the Resident Council Meeting yesterday, she stated. No, no one has come by to follow up. C. On 01/27/16 10:32 am during an interview with Activity Director (AD), she stated. In regards to the meeting yesterday, I type up all the minutes from the meeting, then I separate it all out to the different departments that had issues. Administrator will get a copy of all response forms. I expect a response back in a couple of days. The AD confiremd that she had not done anything yet to address any of the concerns brought up on the resident council meeting yesterday (01/26/16). She stated I was just so overwhelmed yesterday. I have to be honest this is the worst place I have worked at. D. Record review of the Resident Council Meeting Minutes dated 01/12/16 revealed Concerns: His (R #86) other concern is about the staffing and loss of employees. he stated he would speak with (Name of Administrator) directly about this issue. A handwritten note next to the concern dated 01/18/16 and signed by the Administrator stated Never has approached me yet. E. Record review of the Resident Council Concern Response Form dated 01/12/16 revealed Resident (Name of R #86) to spoke w (with)/ (Name of Administrator) about employees and staffing. This was signed by the Administrator on 01/18/16. F. On 01/22/16 at 8:47 am during interview with R #86, he stated The staffing is bad. They don't have any. Since I was a former a Resident Council President, I get a lot of information. I have from a firm source that the Director (Administrator) is going to bring in all new crew and let the people with seniority go. I don't think that is right. If I lose the Social Services, she (Social Services Director) does more for me and the staff and she is good. Then all of a sudden they want to replace her. He (Administrator) wants his crew to come in here. He's been bringing in a bunch of corporate people. This morning we only have one CNA, and borrowed one from the skilled unit to give them 2 (CNAs). They will have the nurse on the north also has to go on the Alzheimers Unit and I don't think that is right. They are trying to force (Name of Licensed Practical Nurse (LPN) #4) out also. The nurse and staff aren't getting the recognition. I have seen

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F 0244 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) it. Regarding the CNAs, he stated Basically I have a new one every night. I don't know if they are from the agency or new people. When asked if he ever has to wait for assistance, R #86 stated Getting medications. Mostly at night but in the day time too. Usually my night pills. I didn't get them until almost 10 o clock. I am worried. Particularly the Alzheimer's (Unit), they know the staff that is down there. Like (Name of R #84 (R #86's wife)), she recognizes me still. Bringing in a new nurse, I am afraid that she will deteriorate and I have no place to go. It will make it unbearable for us to live. Mostly the care of (Name of R #84). I am afraid. It really bothers me that the good people that have worked and spent their time to help us, and then to just get rid of them. When asked if he has spoken to the Administrator, he stated I have not. He never seems to have the time for us.
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on observation and interview, the facility failed to ensure that the call light was within reach for 1 (R #60) of 1 (R #60) resident reviewed for call lights. This deficient practice is likely to result in residents being unable to request assistance while in the restroom such as needing help with transferring, after falling or other acute distress. The findings are: A. On 01/19/16 at 9:55 am during observation, the call light cord in the bathroom for R #44 was wrapped around a push pin stuck on the bathroom wall. The call light cord measured 32 inches from the ground. B. On 01/18/16 at 11:00 am during observation, the call light cord was wrapped around a push pin stuck on the wall. C. On 01/29/16 at 02:38 pm during an interview with Licensed Practical Nurse #3, she stated. (Name of R #44) is capable of going to the bathroom on his own with minimal assistance and call light should not be wrapped around the push pin (out of his reach).
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide housekeeping and maintenance services.** Based on observation and interview, the facility failed to ensure that housekeeping and maintenance services were provided for resident common areas and facility kitchen by: 1. Having a couch in the lounge that is soiled and has a foul odor. 2. Not maintaining the appropriate temperature (atleast 120 Fahrenheit) for the dish machine to ensure sanitation. 3. Not having hot water for residents to bathe. 4. Not having the shower room heated when residents are bathing. This deficient practice is likely to result in all 109 residents identified on the Alphabetical Census Record provided by the Administrator on 01/15/16. If housekeeping and maintenance services are not being maintained, then residents are not able to bathe according to their preference and are likely to be exposed to disease-causing organisms through inappropriate sanitation. The findings are. Findings related to couch: A. On 01/15/16 at 10:15 am during initial facility tour an observation of couch located in the lounge area was soiled in appearance and had a foul odor. At the time, unidentified residents were sitting on this couch. Findings related to the dish machine temperature: B. On 01/22/16 at 9:05 am during an observation of dish machine it was observed to be at 115 degrees Fahrenheit. C. On 01/22/16 at 9:10 am during an interview with Dietary Manager (DM), he stated. The hot water has been off and on for a couple of days now. We have not gotten it to go up to 120 degrees. We have been monitoring the temperature. We have had this problem for a few months now. I have talked to maintenance about it several times. D. On 01/26/20 at 8:18 am during an interview with DM, he stated. The water temperature is now at 121 degrees it fluctuates and is not stable. I don't know how long it will stay at that temperature. E. 01/26/16 at 8:50 am during an observation of the dish machine and an interview with DM, he stated. Dish machine is running between 115 degrees and 118 degrees. Findings related to hot water: F. On 01/21/16 at 1:48 pm during interview with an Anonymous Staff (AS), s/he stated that there has been no hot water to shower the residents for a couple days. G. On 01/22/16 at 8:27 am during interview with an Anonymous Resident (AS), s/he stated regarding shower You have to wait. The problem with the water here, there is no hot water. They tried the other night, but here was no hot water, so they dressed me and that was it. AS #2 confirmed that she was taken to the shower room and undressed while staff waited for the water to get hot. When the water did not get hot, they dressed her and took her back to her room. H. On 01/22/16 at 9:47 am during interview with Certified Nurse Aide (CNA) #10, he confirmed that the hot water is off. I. On 01/22/16 at 9:50 am during interview with R #159, he confirmed that he has been washing his hands and face in cold water, It's cold. We haven't had hot water in a few days. I usually take a shower everyday but I haven't taken one for about 3 days now. No one wants to take a cold shower. J. On 01/22/16 at 9:53 am during interview with R #104, when asked about the hot water, she said, It's terrible. It's really cold. It's been very unhandy, especially when everyone is sniffling and coughing. K. On 01/27/16 at 10:39 pm during interview with CNA #9, she stated We cannot shower people cause the water is too hot or too cold. Findings related to shower room heater: L. On 01/23/16 at 1:20 am, the Maintenance Director (MD) confirmed that there had been no heat in the Alzheimer's Unit hallway and shower room since last week since a part of the heater was broken. M. On 01/25/16 at 11:07 am, during an interview and interview, R#10 was leaving the shower room and stated, The shower was not cold, but the room was cold. Resident was shaking and cursing at the nurse (unidentified) and asking for a hot cup of coffee. At 11:15 am, the temperature of the shower room was taken and indicated that the temperature was 58 degrees Fahrenheit.
F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct initial and periodic assessments of each resident's functional capacity.** Based on interview, the facility failed to conduct initial and periodic comprehensive assessments upon admission, discharge, annually, quarterly and when there is a significant change in status. This deficient practice is likely to affect all 109 residents list on the Resident census provided by the Administrator on 01/15/16. If the MDS (Minimum Data Set) Assessments are not current, then care plans may not accurately reflect the residents current level of functioning and care needed. The findings are: A. On 01/27/16 at 4:33 pm during interview with the Corporate Revenue Integrity Manager (RIM), she confirmed that the MDS assessments have not been kept up to date for the last several months due to staff turnover. She confirmed that she and her staff were scheduled to come in last week to start working on the MDS. She stated We're working on all the MDS (assessments) that are outstanding. We prioritize those the residents that are still in house over discharge assessments. Yesterday, we were working on all the admission, changes or annuals that were either coming up or out of compliance. B. On 01/28/16 at 10:41 am during interview with Licensed Practical Nurse (LPN) #1, he confirmed that the Minimum Data Set (MDS) Nurse used to do the Care Plans but the facility has not had an MDS nurse for awhile.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to update the care plans for 7 (R #3, 8, 12, 72, 73, 80 and 175) of 11 (R # 3, 8, 12, 31, 43, 72, 73, 80, 81, 87 and 175) residents reviewed for pressure ulcers and during

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) random observation by: 1. Not updating the care plan for R #3 to reflect the change from weekly to daily skin checks. 2. Not revising the care plan to reflect fall interventions. If the facility is not ensuring that care plans are updated to reflect current interventions, then staff may be unaware of the care and treatment residents need. The findings are: Findings related to fall interventions: A. On 01/28/16 at 2:13 pm during observation, R #72 was in bed with a low bed and floor mat next to the floor. B. On 01/29/16 at 2:26 pm during observation, R #175 had a low bed. C. On 01/29/16 at 2:31 pm, during observation, R #8 had a low bed and a floor mat and R #12 was laying in bed with a floor mat next to the bed. D. On 01/29/16 at 2:32 pm during observation, R #80 had a low bed and floor mat, and R #73 had a low bed. E. Record review of the Care Plans for R # 8, 12, 72, 73, 80 and 175 identified each resident as a risk for falls, however the care plans were not updated to reflect floors mats and low beds as an intervention. F. On 01/29/16 at 10:18 am during interview with the Corporate Nurse Specialist (NS), she confirmed that all fall interventions should be updated in the care plans. She stated It should be there. We already knew that we were going to get a care plan tag. Findings for R #3: G. Record review of the Care plan for R #3 updated 10/05/12 revealed Impaired Skin Integrity AEB (As evidenced by) decreased mobility, has occasional incontinence, requires assist with tilting and peril-care with additional risks R/T (related to) skin breakdown. Care Plan identified that on 12/01/15, R #3 has an abscess to her right upper knee. The care plan did not identify that R #3 currently had any pressure ulcers. The care Plan also identified the intervention Weekly Skin Checks. H. Record review of the physician's orders [REDACTED]. This order was noted to be performed on a daily basis. I. Record review of the wound and skin status report dated 01/20/16 revealed the resident was noted to have two unstageable pressure ulcers; one located on the left ankle and the other located on the left side of her foot. Both of these pressure ulcers were noted to have been identified on 11/19/15 and were not present upon the resident's admission to the facility. The resident was also noted to have two other unstageable pressure ulcers to her right foot; one located on the lateral (outside) aspect of the heel and the other on the lateral aspect of the foot. Both of these pressure ulcers were noted to have been identified on 01/13/16 and were not present upon the resident's admission to the facility. J. On 01/28/16 at 10:41 am during interview with Licensed Practical Nurse (LPN) #1, he confirmed that the Care Plan for R #3 had not been updated to reflect her pressure ulcers and had not been updated to reflect the physician order [REDACTED].
F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement the care plan and follow physician orders [REDACTED].#3, 41, 45, 75, 172 and 175) of 10 (R #3, 31, 41, 43, 45, 75, 81, 87, 172 and 175) residents reviewed for pressure ulcers and during random observation during meal service. If the facility is not implementing the care plan and following physician's orders [REDACTED]. The findings are: Findings related to pressure ulcers for R #3: A. Record review of the wound and skin status report dated 01/20/16 revealed the resident was noted to have two unstageable pressure ulcers; one located on the left ankle and the other located on the left side of her foot. Both of these pressure ulcers were noted to have been identified on 11/19/15 and were not present upon the resident's admission to the facility. The resident was also noted to have two other unstageable pressure ulcers to her right foot; one located on the lateral (outside) aspect of the heel and the other on the lateral aspect of the foot. Both of these pressure ulcers were noted to have been identified on 01/13/16 and were not present upon the resident's admission to the facility. Treatment to include Waffle boots on when in bed and while up for off loading. Order Sherpa for suhioning to BIL feet to be applied at foot of bed and in chair if applicable. Apply when order is received then discontinue waffle boot. B. Record review of Physician order [REDACTED]. Apply to foot of bed, et wc (wheelchair) if appropriate. Apply when received then DC waffle boots. C. On 01/19/16 from 8:48 am to 9:32 am, during an observation, R #3, was reclining in a geri-chair (a type of wheelchair) in the common area next to the nurses' station. The resident had one waffle boot on her left foot with no waffle boot present on the resident's right foot. Three separate times during the observation the resident had her ankles crossed, with the outer aspect of the right ankle pressed up against the inner aspect of the left ankle. During the observation the resident was not offered to reposition or a cushion/pillow to relieve the pressure off of her feet/heels. D. On 01/19/16 from 9:52 am to 10:53 am, R #3 was reclining in a geri-chair in the common area next to the nurses' station. The resident had one waffle boot on her left foot with no waffle boot present on the resident's right foot. During the observation the resident was not offered to reposition or a cushion/pillow to relieve the pressure off of her feet/heels. E. On 01/21/16 from 9:19 am to 10:28, R #3 was reclined in the geri chair in the common area next to the nurses' station. The resident did not have waffle boots placed on either feet and both of the resident's heels were set directly on the foot rest of the geri-chair. During the observation the resident was not offered to reposition or a cushion/pillow to relieve the pressure off of her feet/heels. F. On 01/21/16 at 3:46 pm, during an interview with the resident she was asked if she had the strength to reposition herself on her own and stated, No, I can't do anything thing on my own, I'm helpless, they (staff members) have to do everything for me. G. On 01/21/16 at 3:47 pm, during an interview and observation with the wound care nurse Registered Nurse (RN) #11 she was asked if the resident should be wearing waffle boots on both of her feet while she rests in the geri-chair and stated, Yes. RN #11 confirmed that eventhough the resident cannot reposition herself, she frequently shifts while in the chair and the waffle boot often get removed. During an observation, RN #11 began performing wound care to the resident's pressure ulcers on her feet. When RN #11 removed the residents right sock, no wound dressing was present over the resident's pressure ulcer located closest to the ankle. RN #11 confirmed the resident should have had a dressing covering the pressure ulcer to protect it. H. On 01/22/16 at 8:55 am, R #3 was reclining in a geri-chair in the common area next to the nurses' station. The resident had waffle boots placed on both feet but the waffle boot on the right foot was deflated. The resident did not have a cushion/pillow to relieve the pressure off of her feet/heels I. On 01/22/16 at 3:07 pm R #3 was reclined in the geri chair in the common area next to the nurses' station. The resident did not have waffle boots placed on either feet. The resident had her ankles crossed, with the outer aspect of the right ankle pressed up against the inner aspect of the left ankle. The resident did not have a cushion/pillow to relieve the pressure off of her feet/heels. J. On 01/26/16 at 10:37 am during observation, R #3 was laying in her geri-chair in the television (TV) room. Her heels were resting on a Sherpa pad. K. On 01/27/16 at 9:08am during observation, R #3 was laying in her geri chair in the TV room. There was no boots or no sherpa pad under heels. L. On 01/27/16 at 10:37 am during observation, R #3 was laying in her geri chair in the TV room, the sherpa pad was under R #3's calves, however her heels were resting directly on the chair. M. On 01/28/16 at 8:52 am during observation, R #3 was laying in her geri chair in the TV room. R #3's heels were laying on the chair. No boots or sherpa pad under her feet. N. On 01/29/16 at 9:25 am during observation, R #3 was laying in her geri chair in the TV room, the sherpa pad was on the floor. R #3's heels were laying on the chair. O. On 01/29/16 at 2:16 pm, during observation, R #3 was laying in her geri chair in the tv room. The sherpa pad was half way off the chair, and no pad was under her heels. Findings related to Meal tickets: Findings for R #41:

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	325038	A. BUILDING _____ B. WING _____	01/29/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASA REAL	1650 GALISTEO STREET SANTA FE, NM 87505

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F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) P. Record review of monthly weight report for R #41 dated 12/29/15 revealed 1.21% weight loss in 1 month, 16.62% weight loss in 3 months, 12.83% weight loss in 6 months. Q. Record review of lunch meal ticket dated 01/29/16 revealed Mighty shakes (high calorie nutritional supplement) TID (Three times a day) w/meals, soups with every meal. R. On 01/29/16 at 12:27 pm during observation of lunch meal, R #41 was not given a mighty shake and she was not served any soup. S. On 01/29/16 at 12:31pm during an interview with the Dietary Manager (DM), he confirmed R #41 should be served a shake TID and she was not given a shake and soup for lunch. Findings for R #44: T. Record review of weight report dated 12/29/15 revealed a 1 month weight loss of 6.60%, 3 month weight loss of 9.98% and a 6 month weight loss of 13.92%. U. Record review of lunch meal ticket reveals, regular diet, high protein snacks between meals at HS (night) 2.0 med pass (high calorie supplement) 90 ml (milliter) tid w/meals. V. On 01/29/16 at 12:33 pm during an observation of the lunch meal, R #44 was not served the med pass as ordered on his tray ticket. W. On 01/29/16 at 12:36 pm DM state, R #44 should be getting his med pass with meals and that comes out of the kitchen if it is on the meal ticket. DM confirmed that R #44 was not served med pass for lunch. Findings for R #75: X. Record review of monthly weight report dated 12/29/15 reveals a 4.66% weight loss in 1 month, a 4.95% weight loss in 3 months and 9.65% in 6 months. Y. On 01/29/16 at 12:35 pm during an observation of lunch meal, R #75 was served a mighty shake that was partially frozen. The shake carton was tipped upside down on a cup, and minimally pouring out. Z. On 01/29/15 at 12:36 pm during an interview with DM, he stated. We just took them (mighty shakes) out to thaw we usually don't serve them like that, but they will thaw out that is why they (CNA's) are letting it drip into the glass. Findings for R #172: AA. Record review of monthly weight report dated 12/29/15 revealed 1.16% weight loss in 1 month, 1.16% weight loss in 3 months and 2.75% weight loss in 6 months. BB. Record review of lunch meal ticket dated 01/29/16 revealed, no knife on tray, sandwich of choice, soup of choice. CC. On 01/29/16 at 12:28 pm during observation of lunch meal, R #172's lunch consisted of beef enchiladas, parslied carrots, charro beans, corn torilla, sugar cookie. There was a knife on her tray, no sandwich or soup were observed on her plate. DD. On 01/29/16 at 12:28 during interview Social Services Director, she confirmed she should not have a knife and she did not have soup or a sandwich on her tray. Findings for R #179: EE. Record review of care plan dated 03/03/15 for R #179 revealed Regular CCD (Consistent Carbohydrate Diet for diabetics). To provide diet as ordered. FF. Record review of lunch meal ticket dated 01/29/16 revealed Renal diet. Beef Patty , LS (low sodium) Brown gravy, Parslied carrots, rice, corn tortilla, sugar cookie, milk and soup for Lunch. GG. On 01/29/16 at 12:29 during observation of lunch meal, R #179 was observed to be eating red chilies enchiladas and beans and carrots. There was no soup in front of R #179. HH. On 01/29/16 at 12:30 pm during interview Dietary Manager (DM) confirmed R #179 is non compliant with her renal diet, however, R #179 should be getting soup for lunch.
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being by not providing an environment free of gossip, intimidation and humiliation. This deficient practice is likely to affect all 109 residents identified on the resident cenus list provided by the Administrator on 01/15/16. If staff morale is low, this is likely to affect the care and services that the residents are receiving, resulting in a delay of health services and an increase in resident anxiety and depression. The findings are: A. On 01/19/16 at 10:25 am during interview with Anonymous Staff (AS), she/he stated (Name of DON) has a really rude demeanor and is racist against Hispanics. We get reprimanded in front of residents, staff and family members. It's embarrassing. I spoke with the Administrator and he said, basically she is your boss and she has the authority to do so. Other staff have complained and Administration doesn't do anything. I tried to speak to Corporate. Morale has drastically gone down. Staff have left because they felt like they were being bullied and threatened with their licenses. We have to walk on egg shells. A lot of staff have left. It affects the residents. There is no familiarity anymore. We used to have our regular units and be able to calm them (residents) down and use non-pharmaceutical interventions. B. On 01/21/16 at 1:48 pm during interview with Anonymous Staff (AS), she/he stated The negative treatment from management is getting worse. There is constant threat of termination from the Director of Nursing every time the staff voice their opinion about how short staffed they are but management paid no attention. AS stated that the staff are verbally abused and the residents are constantly denied services because there is no available staff to help. C. On 01/21/16 at 3:10 pm during interview with another AS, she/he stated I am scared that I am going to come to work one day and not have a job. (Name of Director of Nursing (DON)) walks down the hall and points at things and says 'That's a $5000 tag.' The residents are really unhappy too. AS described that at a mandatory meeting lead by the Administrator a couple weeks ago, he informed everyone that if he heard of anyone talking to the Ombudsman, they would be fired. D. On 01/21/16 at 5:02 pm during interview with another Anonymous Staff, she/he stated We got this memo that we could only use 5 briefs (per resident every other day). They (staff) called the ombudsman. We (staff) were told we were not allowed to talk to the Ombudsman and if we did, we could lose our jobs. (Name of Administrator) got a call from the Ombudsman and said that some staff had called the Ombudsman. He called all available staff to the dining room and said that someone had called, and said he would find out who talked to the Ombudsman, and said I know who called. We get belittle in the hallways in front of residents. (Name of DON) has gotten in people's (staff) faces with her fingers and starts yelling at people. When someone told her they couldn't work the weekend, (Name of DON) said 'You should have thought about that before.' They (Administration) intimidate the crap out of everybody. The CNAs that have been here are scared to lose their jobs. They (Administration) humiliates staff in front of family members. (Name of Director of Nursing (DON)) yells to the staff. Residents feel what is happening. Residents have been present when (Name of Activity Director, DON, and Administrator) yell at staff when family and residents are present. The care is getting so bad. We (staff) stay because we care. Med (medication) errors are happening. Skilled residents leave because the care is so bad. E. On 01/21/16 at 7:00 pm during interview with another Anonymous Staff, she/he stated that About a month ago or so we were told we could only use 5 incontinent briefs per day per resident and the adult wipes were also limited. It was very cruel as many residents go through 5 briefs on one shift. We were having to borrow from other residents. Its been very upsetting with this new administration, so many staff have left and are still leaving. Our 2 ADON's that have been here a long time, one has left and the other is leaving this week. The agency nurses aren't given any training, they're making me train them, I've never been trained to train. I've never seen any announcements regarding training or orientation. Once in awhile they tell us to take an inservice on the computer during our shift. There is no communication from management other than negativity and threatening us about being fired and reporting us to the Board or Nursing. The Agency staff is not trained and they have no idea what to do. Most aren't doing much of anything we have to come back after our 2 days off and fix everything they messed up. Just look at the MAR (Medication Administration Records)s there's so many blanks. On Wednesdays, its all agency staff, they do whatever they want. Today, I got written up because an agency CNA fell asleep. I was told if that happens one more time I will be fired. In the end, it's the residents that suffer because Administration doesn't care. Residents are not getting their showers. Complaining about cold food. Having to wait a long time when they call for assistance. We're licensed staff) always being threatened with our licenses, called 'Trailer Trash'- its' awful, I don't even live in a trailer. I hope I don't get fired and that you guys can help us. F. On 01/22/16 at 8:13 am during observation and interview, Registered Nurse (RN) #5 was observed handing R #33 a small cup

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F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 8) of yogurt. R #33 refused to take it. When asked about what happened, RN #5 confirmed that R #33 refused to take his antibiotic crushed in yogurt. She stated I am not sure who takes it in yogurt and who takes it whole. When asked how she could find out, RN #5 confirmed that she was unsure. RN #5 stated that she would have to waste (dispose) of the yogurt cup and order a new medication from the pharmacy to replace the medication that was wasted. RN #5 stated that when she started working at the facility, she was never oriented. She confirmed that she has worked at the facility atleast 5 times. RN #5 confirmed that it wasn't until after she had already worked several shifts was she provided a 6 hour orientation. RN #5 recalled that the first time she worked at this facility, she was put on the Alzheimer's Unit and when she asked for orientation, she was told No, honey. You're going to work by yourself.' RN #5 stated It was scary. I'm not going to sugar coat it. G. On 01/22/16 at 8:47 am during interview with R #86, he stated The staffing is bad. They don't have any. Since I was a former a Resident Council President, I get a lot of information. I have from a firm source that the Director (Administrator) is going to bring in all new crew and let the people with seniority go. I don't think that is right. If I lose the Social Services, she (Social Services Director) does more for me and the staff and she is good. Then all of a sudden they want to replace her. He (Administrator) wants his crew to come in here. He's been bringing in a bunch of corporate people. This morning we only have one CNA, and borrowed one from the skilled unit to give them 2 (CNAs). They will have the nurse on the north also has to go on the Alzheimer's Unit and I don't think that is right. They are trying to force (Name of LPN #4) out also. The nurse and staff aren't getting the recognition. I have seen it. Regarding the CNAs, he stated Basically I have a new one every night. I don't know if they are from the agency or new people. When asked if he ever has to wait for assistance, R #86 stated Getting medications. Mostly at night but in the day time too. Usually my night pills. I didn't get them until almost 10 o clock. I am worried. Particularly the Alzheimer's (Unit), they know the staff that is down there. Like (Name of R #84 (R #86's wife)), she recognizes me still. Bringing in a new nurse, I am afraid that she will deteriorate and I have no place to go. It will make it unbearable for us to live. Mostly the care of (Name of R #84). I am afraid. It really bothers me that the good people that have worked and spent their time to help us, and then to just get rid of them. When asked if he has spoken to the Administrator, he stated I have not. He never seems to have the time for us. H. On 01/22/16 at 10:30 am during observation Licensed Practical Nurse (LPN) #3 was passing medications . She confirmed that she was passing the morning medications. She stated that she starts passing medications after report at about 6:30 am or 7:00 am. She confirmed that she stops medication pass during breakfast so that she can monitor residents for potential choking and then resumes medication pass after breakfast until about about 10:00 or 10:30 am. At that point, LPN #3 states that she starts with the 12:00 pm medications because she will again have to go to the dining room for lunch, and when lunch is over then she can finish the medications. She states the facility used to have medication aids but no longer does so she has no help with the medications and still is expected to go stand in the dining room during meal times. She stated that the nurses on the floor don't have any help from the new administration. She stated that the new administration tell us what has to be done regardless if there is enough staff or not. She states Many staff have left, the new administration is very different, unsupportive and doesn't care if the staff stays or leaves. She stated There is a lot of agency staff and they come and go. Never the same ones. If something happens we just get yelled at or written up. The ADON's (Assistant Director of Nursing) used to always be on the floors and asking us if we were ok or needed help. But they left. I. On 01/22/16 at 10:46 am during interview with Family Member #1, she stated The staff has told me 'We can't speak Spanish and that we're called pigs.' I fear for the care that my brother will receive with agency staff that doesn't know how he functions and what he needs. Staff are walking on pins and needles or have left. What a sad, sad thing. I tell them all, stick to your guns and don't go anywhere. Report it. I have thought about calling the company that manages it. FM #1 described an experience in which the Director of Nursing (DON) spoke rudely to her. She stated, I thought 'Really. That's the wasy You want me to feel about my brother being here.' In 9 years, I bet we have had 7 administrators. They don't stay. All they want to do is look at the bottom line. Get rid of the people that have been here and hire people. Please don't let them get rid of the people that know what they are doing. They are bilingual and can speak to the residents that only know Spanish and they have a right to know what's going on daily. If there was another place that would take good care of my brother and I could afford it, I would move him. If they want to know what needs to be approved, I can tell them. I have been here for 9 years. I fear for what will happen when you (surveyors) are gone. J. On 01/22/16 at 12:00 pm Registered Nurse (RN) #5 was charting in the Medication Administration Record [REDACTED]. Then I continue with the noon medications until about 2:00 or 3:00 pm, as sometimes the residents aren't in their room and some residents take quite a few medications. K. On 01/22/16 at 3:19 pm during interview with R #174, she stated We don't get good healthcare. The food here is not great. They don't have enough help. I don't know if it's cause the CNAs don't enough help. I don't know if they are quitting. Everybody knows it here (that things are bad). What they are bringing in is agency care. Some of them are ok. Some of them are rude. Some of them we (residents) have to wait (for assistance). We get our medications late in the evenings. We can't get help (transfer to bed) until after 8 o cock. We have to wait on the showers. They say to us, 'It's not 7 O clock.' (to get help in bed). We have to wait for CNAs to get in. I can't get in (bed) myself. Everyone (CNAs) says, 'I need help' and it has to be 2 people (to transfer her). We come out of the dining room and we have to stay sitting. At least 12 hours in the wheelchair. Since I've had surgery on my spine I can't stay in my chair that long. My back is hurting. I press the call light and had to wait. When we (residents) have to use the restroom, they say 'Wait, wait.' Yes, sometimes I pee in my pants. I feel frustrated. I just want to leave this place and go somewhere else. They have to give our medications at 8 o clock but they don't give them until late. R #174 confirmed that she is woken up to be given medication and to be changed. L. On 01/22/16 at 7:00 pm during observation RN #6 is passing medications. When asked what medications she is passing she stated she is finishing the dinner time medications and starting the 8:00 pm and bedtime medications. When asked how long it takes her or until what time does she pass medications, she replied she will be passing medications until about 11:00 pm. She stated that Some residents don't have a picture in their MAR. I have to find someone to identify the resident for me. Sometimes even if they have a picture it's an old one. Also now everytime a resident requests a pain medication or has one scheduled I have to go find another nurse to sign the Narcotic sign out sheet with me, something must have happened, I've never seen or heard of that before. M. On 01/23/16 at 11:52 am during interview with Family Member (FM) #2, she stated that staff informed her that they were not allowed to speak Spanish to the residents. FM #2 stated that she observed the Director of Nursing and Activity Director being mean to the staff, especially those speaking Spanish by degrading them, talking down to them, yelling at them in public and threatening them with their jobs. FM #2 stated that she observed the Activity Director yelling at an Assistant and accusing him of being on drugs in front of residents and other family members. N. On 01/24/16 at 8:34 am during interview with LPN #4, she said I don't like it when people gossip. Yes, I believe they are letting me go after [AGE] years. I've been written up. Once it was because someone left the door open back here with a rock. It wasn't me but I was written up. I haven't told anyone (residents) but people hear things around here. I don't say anything to the residents that would upset them. O. On 01/26/16 at 11:43 am during interview with the Director of Nursing (DON) when asked if there have been any problems with staffing, she stated Typical things. A nurse is a nurse. There are times where people don't call in. What I found out here in New Mexico is a lack of judgement. I don't know if they (nurses) take their job serious. P. On 01/26/16 at 2:59 pm during observation of the Corporate Nurse Specialist (NS) addressing the Resident Council, she said (There is) talk from employees that the facility is closing. I am trying to tell you the facility is not closing. You will all see some changes. There may be some employees that are not here either by choice or not. To set your mind at ease, we are not closing. If (Name of Social Services Director (SSD)) choose to leave that will be on (Name of SSD). Q. On 01/26/16 at 8:40 am during interview with Anonymous staff, she/he stated Morale is down. (Name of Administrator) said 'You need to put your foot up those CNAs (Certified Nurse Aide) butt, if not I will put my boot up your butt.' R. On 01/26/16 at 4:22 pm during interview with Anonymous Staff, she/he stated that she/he is afraid of retaliation. She/he stated Some of us need our jobs. That one time they told us we couldn't be calling the Ombudsman lady. S. On 01/27/16 at 10:39 pm during interview with Certified Nurse Aide (CNA) #9, she stated There are big issues. Staff is not happy because we work so hard to make it right. You cannot shower people because the water is too hot or too cold. We run out of soap. In the last 2 weeks, we haven't had enough briefs, before that we had to look all over to find briefs. Staff are angry cause they cannot do what they have to. We do not have supplies to check blood pressures. We have one

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 9) machine for all four units. Sometimes the nurses will lend us their (personal supplies) to check vitals because they need to be checked. T. On 01/29/2016 at 9:14 am during interview with Registered Nurse (RN) #9 and Anonymous Staff (AS), RN #9 stated that he is running behind with med pass as the night shift stayed an hour after their shift using the med cart. Anonymous staff (AS) confirmed that staff, including agency staff have not had any training regarding med pass, and no visit from the consultant pharmacist either. AS stated The ADONs used to come to the units and see if anyone needed help now there are no ADONs only Administration nurses but they do not help anyone. They sit in the ADON office all day. Come out and go smoke but they don't offer any help to the nurses on the floor at all. They come in wearing scrubs like they're going to work but instead they just sit there and watch us and look at their watch and say You better get med pass done on time or you'll get written up.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that 1 (R #3) of 5 (R #3, 31, 43, 81 & 87) residents reviewed for pressure ulcers received the necessary services to prevent the development of new pressure ulcers by: 1. Not monitoring the condition of the resident's feet. 2. Not providing appropriate pressure relieving cushioning while the resident was resting in a geri-chair (a type of wheelchair). 3. No ensuring one of the resident's pressure ulcers was covered with an appropriate wound dressing. This deficient pact likely resulted in the resident developing multiple avoidable pressure ulcers. The findings are. A. Record review of the physician's orders [REDACTED]. This order was noted to be performed on a daily basis. B. Record review of the treatment administration record dated 11/01/15 to 11/30/15 revealed no indication that daily foot checks were performed during the entire month. Under the section where daily foot checks were to be performed at 8:00 am was a strickthrough note that was re-written to be performed PRN (as needed). C. Record review of the wound and skin status report dated 01/20/16 revealed the resident was noted to have two unstageable pressure ulcers; one located on the left ankle and the other located on the left side of her foot. Both of these pressure ulcers were noted to have been identified on 11/19/15 and were not present upon the resident's admission to the facility. The resident was also noted to have two other unstageable pressure ulcers to her right foot; one located on the lateral (outside) aspect of the heel and the other on the lateral aspect of the foot. Both of these pressure ulcers were noted to have been identified on 01/13/16 and were not present upon the resident's admission to the facility. Treatment to include Waffle boots on when in bed and while up for off loading. Order Sherpa for suhioning to BIL feet to be applied at foot of bed and in chair if applicable. Apply when order is received then discontinue waffle boot. D. Record review of Physician order [REDACTED]. Apply to foot of bed, et wc (wheelchair) if appropriate. Apply when received then DC waffle boots. E. On 01/19/16 from 8:48 am to 9:32 am, during an observation, R #3, was reclining in a geri-chair (a type of wheelchair) in the common area next to the nurses' station. The resident had one waffle boot on her left foot with no waffle boot present on the resident's right foot. Three separate times during the observation the resident had her ankles crossed, with the outer aspect of the right ankle pressed up against the inner aspect of the left ankle. During the observation the resident was not offered to reposition or a cushion/pillow to relieve the pressure off of her feet/heels. F. On 01/19/16 from 9:52 am to 10:53 am, R #3 was reclining in a geri-chair in the common area next to the nurses' station. The resident had one waffle boot on her left foot with no waffle boot present on the resident's right foot. During the observation the resident was not offered to reposition or a cushion/pillow to relieve the pressure off of her feet/heels. G. On 01/21/16 from 9:19 am to 10:28 R #3 was reclined in the geri chair in the common area next to the nurses' station. The resident did not have waffle boots placed on either feet and both of the resident's heels were set directly on the foot rest of the geri-chair. During the observation the resident was not offered to reposition or a cushion/pillow to relieve the pressure off of her feet/heels. H. On 01/21/16 at 3:46 pm, during an interview with the resident she was asked if she had the strength to reposition herself on her own and stated, No, I can't do anything thing on my own, I'm helpless, they (staff members) have to do everything for me. I. On 01/21/16 at 3:47 pm, during an interview and observation with the wound care nurse Registered Nurse, (RN) #11 she was asked if the resident should be wearing waffle boots on both of her feet while she rests in the geri-chair and stated, Yes. RN #11 confirmed that eventhough the resident cannot reposition herself, she frequently shifts while in the chair and the waffle boot often get removed. During an observation, RN #11 began performing wound care to the resident's pressure ulcers on her feet. When RN #11 removed the residents right sock, no wound dressing was present over the resident's pressure ulcer located closest to the ankle. RN #11 confirmed the resident should have had a dressing covering the pressure ulcer to protect it. J. On 01/22/16 at 8:55 am, R #3 was reclining in a geri-chair in the common area next to the nurses' station. The resident had waffle boots placed on both feet but the waffle boot on the right foot was deflated. The resident did not have a cushion/pillow to relieve the pressure off of her feet/heels K. On 01/22/16 at 3:07 pm R #3 was reclined in the geri chair in the common area next to the nurses' station. The resident did not have waffle boots placed on either feet. The resident had her ankles crossed, with the outer aspect of the right ankle pressed up against the inner aspect of the left ankle. The resident did not have a cushion/pillow to relieve the pressure off of her feet/heels. L. On 01/26/16 at 10:37 am during observation, R #3 was laying in her geri-chair in the television (TV) room. Her heels were resting on a Sherpa pad. M. On 01/27/16 at 9:08am during observation, R #3 was laying in her geri chair in the TV room. There was no boots or no sherpa pad under heels. N. On 01/27/16 at 10:37 am during observation, R #3 was laying in her geri chair in the TV room, the sherpa pad was under R #3's calves, however her heels were resting directly on the chair. O. On 01/28/16 at 8:52 am during observation, R #3 was laying in her geri chair in the TV room. R #3's heels were laying on the chair. No boots or sherpa pad under her feet. P. On 01/29/16 at 9:25 am during observation, R #3 was laying in her geri chair in the TV room, the sherpa pad was on the floor. R #3's heels were laying on the chair. Q. On 01/29/16 at 2:16 pm, during observation, R #3 was laying in her geri chair in the tv room. The sherpa pad was half way off the chair, and no pad was under her heels.
F 0322 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** Based on observation, interview and record review the facility failed to ensure that 1 (R #153) of 1 (R #153) residents reviewed for tube feedings received the necessary services to prevent gastric (stomach) tube complications by not verifying

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F 0322 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) correct placement of a percutaneous endoscopic gastrostomy (PEG) tube prior to using it for medications administer. This deficient practice is likely result in medication being administered outside of the stomach causing pain, poor medication absorption and infection. The findings are. A. On 01/21/16 at 8:06 am, during medication pass observation Registered Nurse (RN) #10 administered R #153's morning medications via (by way of) his PEG tube. Prior to administering the medications via his PEG tube, RN did not check for the correct placement of the PEG tube. B. On 01/21/16 at 8:43 am during an interview with RN #10 she was asked when the placement of the resident's PEG tube should be checked and stated, When we do his feedings at 2400, 0600, 1200 and 1800. RN was asked if it was necessary to check the placement of the PEG tube prior to administering medications, she confirmed that she relied upon the nurse from the pervious shift verifying that the placement was correct before the residents 6:00 am tube feeding. C. Record review of the Policy and Procedure on Medication Administration - Enteral Tubes dated December 2012 revealed that prior to administering medications via an enternal tube, staff are to, Verify tube placement.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on observation and interview, the facility failed to provide an environment that is free from accidents and hazards for all 109 residents listed on the Census List provided on 01/15/15 (#1-109) residents residing in the facility by: 1. Not ensuring the electrical room door was locked. 2. Staff not being aware of what the wander guard door alarm indicated. 3. Not ensuring that the front door (right side) remained locked when the wander guard is triggered to prevent residents from leaving the facility. This deficient practice is likely to result in residents that should not leave the facility, be able to leave the facility undetected, exposing them to risk of harm. If staff do not secure doors to hazardous areas then residents are likely to incur harm or injury from exposure to high voltages and other hazardous components of an unsecured electrical room. The findings are: Findings related to electrical room: A. On 01/15/16 at 10:51 am during observation, the electrical room door was found to be unlocked. B. On 01/15/16 at 10:55 am, the Administrator confirmed the door was not locked and should be locked. C. On 01/27/16 at 10:52 pm during an observation, door to electrical room was found to be left unlocked. D. On 01/27/16 at 10:53 pm during an interview with Certified Nurse Aide (CNA) #4, she confirmed that the door to the electrical room was unlocked and stated It should be locked all the time. E. On 01/28/16 at 7:46 am during observation, the electrical room door was unlocked. F. On 01/28/16 at 7:55 am during interview with the Regional Manager, he stated that the door was open and should be closed and locked. Findings related to: Wander guard: G. On 01/26/16 at 4:22 pm during interview with Certified Nurse Aide (CNA) #4 when asked about the wander guard, she stated They (residents) find a way to get out. Maybe they should have a lock. I think it just beeps. When we go for doctor's appointments (with residents), it (wander guard alarm) sounds but it doesn't lock. H. On 01/28/16 at 8:17 am during observation of front door to facility, the right door of the double doors did not lock or sound the alarm when the surveyor wearing a wander guard pushed the door and walked outside. This was confirmed by the receptionist, Business Office Manager and the Maintenance Director. I. On 01/28/16 at 9:35 am during interview with the Receptionist, when asked how often someone attempts to elope from the facility, she stated, Maybe once a week. She provided a list of residents with a wander guard. Receptionist also stated, Now, I'm going to check the other door (right hand exit door on the way out) to see if it's locked. I'll check it twice a day. Anyone here in the office should respond. The alarm goes off at the nurses stations. J. On 01/28/16 at 9:43 am during interview with Licensed Practical Nurse (LPN) #1 when asked what happens when the alarm goes off for the wander guard, he stated that the alarm goes off everywhere and then staff is required to reset the alarm. K. On 01/27/16 at 10:28 pm during an observation and interview, the wander guard alarm went off. Registered Nurse (RN) #4 was asked what that alarm sound indicated, she replied she did not know what the alarm indicated, stating that it was probably a tab alarm or fall pad and continued charting on the Medication Administration Record (MAR). As Certified Nurse Aid (CNA) #2 approached, she was asked if she knew what the alarm sounding indicated, she stated she did not know what the alarm meant and stated she would go check the resident rooms in case it was a resident needing assistance.
F 0332 **Level of harm** - Minimal harm or potential for actual harm **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 the facility failed to insure the medication error rate did not exceed 5% by performing 5 medication errors out of 68 opportunities for 3 (R #104, 153 and 174) of 14 (R #26, 27, 35, 65, 76, 90, 91, 98, 104, 113, 142, 144, 153 and 174) residents reviewed during medication pass. This resulted in a medication error rate of 7.3%. If medications are administered in error, resident are likely to experience medication side effects including allergic reactions, medication interactions and under/overdosing. The findings are. Findings for R #153 A. On 01/21/16 at 8:10 am during an observation of medication pass, Registered Nurse (RN) #6 administered the following medications via the resident's PEG tube: [MEDICATION NAME] 5 milligrams (mg), [MEDICATION NAME] 10 mg and [MEDICATION NAME] 50 mg. During preparation, RN crushed all three medications and mixed them into a single cup of water. When the medications were administered, all three were instilled into the residents PEG tube at the same time. RN did not administer and flush each medication individually into the resident's PEG tube. Findings for R #104 B. Record review of the physician's orders [REDACTED]. On 01/21/16 at 8:20 am during an observation of medication pass, RN #6 administered a single tablet of the medication Vitamin D3 - 1000 international units (IU). Findings for R #174: C. Record review of the physician's orders [REDACTED]. D. On 01/22/16 at 8:17 am during an observation and interview, Licensed Practical Nurse (LPN) #1 prepared the morning medications for R #174, LPN #1 confirmed the resident was scheduled to receive the medication [MEDICATION NAME] 500 mg, but did not receive the medication related to the last capsule already being used and not having more medication available. Findings related to late medication pass: E. On 01/22/16 at 10:30 am during observation Licensed Practical Nurse (LPN) #3 was passing medications . She confirmed that she was passing the morning medications. She stated that she starts passing medications after report at about 6:30 am or 7:00 am. She confirmed that she stops medication pass during breakfast so that she can monitor residents for potential choking and then resumes medication pass after breakfast until about about 10:00 or 10:30 am. At that point, LPN #3 states that she starts with the 12:00 pm medications because she will again have to go to the dining room for lunch, and when lunch is over then she can finish the medications. She states the facility used to have medication aids but no longer does so she has no help with the medications and still is expected to go stand in the dining room during meal times. She stated that the nurses on the floor don't have any help from the new administration. She stated that the new administration tell us what has to be done regardless if there is enough staff or not. She states Many staff have left, the new administration is very different, unsupportive and doesn't care if the staff stays or leaves. She stated There is a lot of agency staff and they come and go. Never the same ones. If something happens we just get yelled at or written up. The ADON's (Assistant Director of Nursing) used to always be on the floors and asking us if we were ok or needed help. But they left.

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F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) F. On 01/22/16 at 12:00 pm Registered Nurse (RN) #5 was charting in the Medication Administration Record [REDACTED]. Then I continue with the noon medications until about 2:00 or 3:00 pm, as sometimes the residents aren't in their room and some residents take quite a few medications. G. 01/22/16 at 7:00 pm during observation RN #6 is passing medications. When asked what medications she is passing she stated she is finishing the dinner time medications and starting the 8:00 pm and bedtime medications. When asked how long it takes her or until what time does she pass medications, she replied she will be passing medications until about 11:00 pm. She stated that Some residents don't have a picture in their MAR. I have to find someone to identify the resident for me. Sometimes even if they have a picture it's an old one. Also now everytime a resident requests a pain medication or has one scheduled I have to go find another nurse to sign the Narcotic sign out sheet with me, something must have happened, I've never seen or heard of that before.
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 record review, observation and interview, the facility failed to ensure that residents are free of any significant medication errors by not: 1.) checking residents Capillary Blood Glucose (CBG) levels as ordered by the treating physician, and 2.) administering medications and insulin as ordered by the treating physician, and within the scheduled time frame. This deficient practice is likely to affect all 8 residents (R #14, 20, 40, 67, 157, 174, 176 and 182) that are insulin dependent. If nursing staff is not checking residents CBGs and administering their insulin as ordered, then residents are likely to experience medication ineffectiveness resulting in the need for medical intervention and unmonitored elevated CBGs without timely intervention has the potential to result in kidney damage and [MEDICAL CONDITION]. The findings are: A. On 01/22/16 at 10:30 am during observation Licensed Practical Nurse (LPN) #3 was passing medications . She confirmed that she was passing the morning medications. She stated that she starts passing medications after report at about 6:30 am or 7:00 am. She confirmed that she stops medication pass during breakfast so that she can monitor residents for potential choking and then resumes medication pass after breakfast until about about 10:00 or 10:30 am. At that point, LPN #3 states that she starts with the 12:00 pm medications because she will again have to go to the dining room for lunch, and when lunch is over then she can finish the medications. She states the facility used to have medication aids but no longer does so she has no help with the medications and still is expected to go stand in the dining room during meal times. She stated that the nurses on the floor don't have any help from the new administration. She stated that the new administration tells us what has to be done regardless if there is enough staff or not. She states Many staff have left, the new administration is very different, unsupportive and doesn't care if the staff stays or leaves. She stated There is a lot of agency staff and they come and go. Never the same ones. If something happens we just get yelled at or written up. The ADON (Assistant Director of Nursing) used to always be on the floors and asking us if we were ok or needed help. But they left. B. On 01/22/16 at 12:00 pm, Registered Nurse (RN) #5 was charting in the Medication Administration Record [REDACTED]. Then I continue with the noon medications until about 2:00 or 3:00 pm, as sometimes the residents aren't in their room and some residents take quite a few medications. C. 01/22/16 at 7:00 pm, during observation RN#6 is passing medications. When asked what medications she is passing she stated she is finishing the dinner time medications and starting the 8:00 pm and bedtime medications. When asked how long it takes her or until what time does she pass medications, she replied she will be passing medications until about 11:00 pm. She stated that Some residents don't have a picture in their MAR. I have to find someone to identify the resident for me. Sometimes even if they have a picture it's an old one. Also now everytime a resident requests a pain medication or has one scheduled I have to go find another nurse to sign the Narcotic sign out sheet with me, something must have happened, I've never seen or heard of that before. Finding for R #182 D. Record review of the Medication Administration Record [REDACTED]. The scheduled times are 6:30 am, 11:30 am and 4:30 pm as ordered by the physician. E. Record review of the meal times provided by the Administrator on 01/15/16 revealed breakfast is served between 7:40 am and 8:30 am, depending upon the dining room location, lunch is served between 11:40 am and 12:30 pm depending upon the dining room and dinner is served between 4:40 pm to 5:30 pm depending upon the dining room. F. Record review of the Diabetic Monitoring Flow Sheet for R #182 dated 01/01/16 through 01/23/16 revealed CBG was checked and insulin was administered at the following times: 1. 01/01/16 at 5:30 am, CBG was 234 and 5 units of [MEDICATION NAME]was given. 2. 01/02/16 at 11:30 am, CBG was 225 and at 4:30 pm CBG was 244. There was no record of insulin administration for both times. 3. 01/03/16 at 5:30 am, CBG was 132. CBG was not documented for the 11:30 am and 4:30 pm schedule. There was no record of insulin administration for the entire day. 4. 01/04/16 at 5:30 am, CBG was 184. There was no record of insulin administration. At 4:30 pm CBG was 284. There was no record of insulin administration. 5. 01/05/16 at 5:30 am, CBG was 203. There was no record of insulin administration. At 11:30 am, CBG 240. There was no record of insulin administration 6. 01/06/15 at 5:30 am, CBG was 187. There was no record of insulin administration. At 4:30 pm there was no record of CBG or insulin administration. 7. 01/07/16 at 5:30 am, CBG was 237. There was no record of insulin administration. At 4:30 pm, CBG was 242. There was no record of insulin administration. 8. 01/08/16 at 5:00 am, CBG was 142. There was no record of insulin administration. At 11:30 am there was no record of CBG or insulin administration. 9. 01/09/16 at 5:30 am, CBG was 157 and 5 units [MEDICATION NAME]was given. At 4:30 pm CBG was 133. There was no record of insulin administration. 10. 01/10/16 at 5:00 am, CBG was 243. There was no record of insulin administration. At 4:30 pm there was no record of CBG or insulin administration. 11. 01/11/16 at 5:30 am, CBG was 203. There was no record of insulin administration. At 11:30 am and 4:30 pm there was no record CBG or insulin administration. 12. 01/12/16 at 5:30 am, CBG was 211. There was no record of insulin administration. 13. 01/13/16 at 5:30 am, CBG was 191. There was no record of insulin administration. At 11:30 am, CBG was 220. There was no record of insulin administration. At 4:30 pm, CBG was 175. There was no record of insulin administration. 14. 01/14/16 at 5:00 am, CBG was 168. There was no record of insulin administration 15. 01/15/16 at 5:00 am, CBG was 186. There was no record of insulin administration. At 11:30 am there was no record of CBG or insulin administration. At 4:00 pm, CBG was 231. There was no record of insulin administration. 16. 01/16/16 at 6:00 am, CBG was 231. There was no record of insulin administration. At 11:30 am, CBG was 244. There was no record of insulin administration. At 4:00 pm, CBG was 256. There was no record of insulin administration. 17. 01/17/16 at 5:30 am, CBG was 189. There was no record of insulin administration. 18. 01/18/16 at 5:30 am, CBG was 213. There was no record of insulin administration. 19. 01/19/16 at 5:30 am, CBG was 190. There was no record of insulin administration. At 4:30 pm there was no record of CBG or insulin administration. 20. 01/20/16 at 5:30 am, CBG was 182. There was no record of insulin administration 21. 01/21/16 at 5:00 am, CBG was 210. There was no record of insulin administration. 22. 01/22/16 at 5:00 am, CBG was 189. There was no record of insulin administration. At 11:30 am, was CBG 218. There was no record of insulin administration. At 10:00 pm, CBG was 144. There was no record of insulin administration. 23. 01/23/16 at 6:00 am, CBG was 257. There was no record of insulin administration. G. On 01/25/16 at 2:56 pm, during interview with LPN #3 regarding R #182's missing CBG results and insulin administration documentation. She replied that If it's on Sundays (Name of R #182) goes with her son to church then out to eat, and she is

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F 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) not here for the 11:30 am CBG and the insulin injection. When asked if R #182's CBG will be checked again, she replied Well they should check her when she arrives back to the facility. I then asked who checks the 6:30 am CBG, she replied that the night shift does before they leave at 6:00 am. When asked when the 6:30 am insulin is given, she replied that the Night shift nurse does it when she (nurse) checks the CBG. LPN #3 then grabbed a flyer taped to the desk. H. Record review of flyer dated 09/04/15 indicated Effective immediately all CBG's will be done at 6:00 am. I. On 01/25/16 at 3:10 pm, during interview with RN #2, regarding the 6:30 am CBG and insulin administration, she acknowledged that the night shift is checking the CBG, however she stated that They should be done at 6:30 am not 5:00 am or 5:30 am because it's too early to give insulin coverage at that time. J. On 01/25/16 at 4:13 pm, during interview with RN #8, she stated that the night shift checks the CBG's and day shift gives the insulin. I know there's a lot of holes in the MAR. I do mine (CBG checks and insulin administration) but I can't speak for the rest. It looks scary, I know. If you look most of that mess is when agency staff was working. Findings for R #67: K. Record review of the MAR indicated [REDACTED] 1. [MEDICATION NAME] 100 units/ml for CBG 1-150 0 units, 151-350 give 4 units, higher than 351 give 6 units, higher than 400 call the doctor (Page 1) 2. [MEDICATION NAME] sliding scale for CBG 131-170 give 1 unit, 171-210 give 2 units, 211-250 give 3 units, 251-290 give 4 units, 291-330 give 5 units, 331-370 give 6 units, if higher than 370 call the doctor (Page 5). L. On 01/26/2016 at 8:54 am during interview with LPN #1 regarding the 2 sliding scale Insulin orders on the MAR for R #67, he confirmed there are 2 sliding scales on the MAR, he stated the one on page 1 is the correct one, the one on page 5 is old from when R #67 first got to the facility. He stated that regarding all the holes (blank spaces) in the MAR, we have a lot of agency nurses they don't do things the right way. The Director of Nurses (DON) has been made aware, apparently she is trying to figure out a way to makes things easier and so things work the way they should. When asked who checks the 6:30 am CBG, he replied the night shift checks the CBG and we give the insulin if they need it right before breakfast. If its an agency nurse at night then another agency nurse in the morning they probably don't know what to do. A lot of them don't know the residents, and were given no training or orientation. M. Record review of the Diabetic Monitoring Flow Sheet dated 01/01/16 through 01/26/16 revealed the CBG was checked and insulin was administered at the following times: 1. 01/01/16 at 5:30 am, CBG was 94. At 11:30 am, CBG was 164. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 2. 01/02/16 at 5:30 am, CBG was 188. There was no record of insulin administration. At 11:30 am and at 4:30 pm there was no record of CBG or insulin administration. 3. 01/03/16 at 5:30 am, CBG was 135. At 11:30 am and 4:30 pm there was no record of CBG or insulin administration. 4. 01/04/16 at 5:00 am ,CBG was 129. At 11:30 am CBG was 251. There was no record of insulin administration. At 11:50 pm CBG was 225. There was no record of insulin administration. 5. 01/05/16 at 6:00 am, CBG was 171. There was no record of insulin administration. At 11:30 am there was no record of CBG or insulin administration. 5. 01/06/16 at 11:30 am there was no record of CBG or insulin administration. At 10:00 pm, CBG was 230. There was no record of insulin administration. 6. 01/07/16 5:40 am, CBG was 203. There was no record of insulin administration. At 11:30 am there is no record of CBG or insulin administration. At 9:30 pm, CBG 189. There is no record of insulin administration. 7. 01/08/16 at 8:00 pm there is no record of CBG or insulin administration. 8. 01/09/16 at 5:30 am, CBG was 127. At 11:30 am there was no record of CBG or insulin administration. At 4:30 pm, CBG was 205. There was no record of insulin administration. At 8:00 pm CBG, was 195. There was no record of insulin administration. 9. 01/10/16 at 11:30 am CBG was 154. There was no record of insulin administration. At 4:30 pm there was no record of CBG or insulin administration. 10. 01/11/16 at 5:30 am, CBG was 110. At 11:30 am and 4:30 pm there was no record of CBG or insulin administration. 11. 01/12/16 at 11:30 am and 4:30 pm there was no record of CBG or insulin administration. 12. 01/13/16 at 6:30 am there was no record of CBG or insulin administration. At 8:00 pm CBG, was 204. Resident refused insulin was documented. 13. 01/14/16 at 5:30 am CBG, was 123. At 11:30 am and 4:30 pm there was no record of CBG or insulin administration. At 8:00 pm, CBG was 204. Resident refused insulin was documented. 14. 01/15/16 at 8:00 pm there was no record of CBG or insulin administration. 15. 01/16/16 at 5:30 am CBG was 150. At 10:00 pm, CBG was 222. Resident refused insulin was documented. 16. 01/17/16 at 5:00 am, CBG was 165. There was no record of insulin administration. At 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 17. 01/18/16 at 4:30 pm, CBG was 200. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 18. 01/19/16 at 5:30 am and at 11:30 am there was no record of CBG or insulin administration. 19. 01/21/16 at 5:00 am CBG was 135. At 11:30 am there was no record of CBG or insulin administration. At 8:00 pm, CBG was 202. There was no record of insulin administration. 20. 01/22/16 at 6:30 am there was no record of CBG or insulin administration. At 10:30 pm ,CBG 177. Resident refused insulin was documented. 21. 01/23/16 at 6:00 am, CBG was 176. Resident refused insulin was documented. At 5:20 pm, CBG was 168. Resident refused insulin documented. At 8:00 pm there was no record of CBG or insulin administration. 22. 01/24/16 at 4:30 pm, there is no record of CBG or insulin administration. At 11:00 pm, CBG was 262 and 2 units of [MEDICATION NAME]was given per residents request was documented. 23. 01/25/16 at 5:00 am, CBG was 82. Recommend soda was documented. At 12:00 pm, CBG was 179. There was no record of insulin administration. At 4:30 pm there was no record of CBG or insulin administration. N. On 01/26/2016 at 9:00 am during interview with LPN #1, when asked regarding R#67's refusal of insulin coverage at bedtime, he stated that The new nurses and the agency nurses are still passing medications at 11:00 pm and 11:30 pm at times and (Name of R #67) knows it's too late because he is very aware of how he feels when his blood sugar is low and he knows his blood sugar will drop quickly so he refuses it because its already over 3 hours late. O. On 01/26/16 at 9:30 am during interview with R #67 when asked if he knew the times he is to have the insulin given to him, he stated I do but I don't think some of the Nurses do. I asked him if he is ever awakened late at night to check his CBG and offered the insulin at that time. He stated that The night nurse does come in sometimes close to midnight and I refuse the insulin because it will drop my sugar too much as I won't have anything to eat until breakfast. I know when I am low and I will not take the insulin. P. On 01/26/16 at 1:28 pm, during interview with R #67, he stated The staff wakes me up at 6:00 am to test my blood sugar before giving insulin. R #67 confirmed that he always has dry mouth. Finding for R #176: Q. Record review of the MAR indicated [REDACTED]. Scheduled at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm as ordered by the physician. R. Record review of the Diabetic Monitoring Flow Sheet dated 01/17/16 through 01/26/16 for R #176 revealed CBG was checked and insulin was administered at the following times: 1. 01/18/16 at 6:00 am, CBG was 193. There was no record of insulin administration. 2. 01/19/16 at 5:30 am, CBG was 163 and 1 unit [MEDICATION NAME]was given. 3. 01/21/16 at 6:00 am, CBG was 226. There was no record of insulin administration. 4. 01/23/16 at 5:30 am, CBG was 167. There was no record of Insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 5. 01/25/16 at 8:00 pm, CBG was 177. There was no record of insulin administration. S. On 01/26/16 at 11:15 am, during interview with R #176, he stated that he gets insulin 3 times a day. When asked if he is ever woken up to receive medication, he stated Yes, they wake me up in the evening every time I get medication. I tell them how thirsty I am but nobody cares.

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	325038	A. BUILDING _____ B. WING _____	01/29/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASA REAL	1650 GALISTEO STREET SANTA FE, NM 87505

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 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) Findings for R #20: T. Record review of the MAR indicated [REDACTED]. U. Record review of the Diabetic Monitoring Flow Sheet dated 01/01/16 through 01/22/16 revealed CBG was checked and insulin was administered at the following times: 1. 01/01/16 at 5:30 am, CBG was 212 and 4 units [MEDICATION NAME]was given. At 8:00 pm there was no record of CBG or insulin administration. 2. 01/02/16 at 5:30 am, CBG was 222 and 4 units [MEDICATION NAME]was given. At 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 3. 01/03/16 at 5:30 am, CBG was 221 and 4 units [MEDICATION NAME]was given. At 8:00 pm there was no record of CBG or insulin administration. 4. 01/04/16 at 8:00 am, CBG was 409 and 6 units [MEDICATION NAME]was given. At 11:30 am and 8:00 pm there was no record of CBG or insulin administration. 5. 01/05/16 at 5:30 am, CBG was 176 and 4 units [MEDICATION NAME]was given. At 8:00 pm there was no record of CBG or insulin administration. 6. 01/06/16 at 4:30 pm and at 8:00 pm there was no record of CBG or insulin administration. 7. 01/07/16 at 8:00 pm there was no record of CBG or insulin administration. 8. 01/08/16 at 5:00 am, CBG was 254 and 4 units [MEDICATION NAME]was given. At 8:00 pm there was no record of CBG or insulin administration. 9. 01/09/16 at 8:00 pm there was no record of CBG or insulin administration. 10. 01/10/16 at 5:00 am, CBG was 184 and 4 units [MEDICATION NAME]was given. At 8:00 pm there was no record of CBG or insulin administration. 11. 01/11/16 at 5:30 am, CBG was 292. There was no record of insulin administration. At 11:30 am there was no record of CBG or insulin administration. At 4:30 pm, CBG was 203. There was no record of insulin administration. 12. 01/12/16 at 6:00 am, CBG was 221. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 13. 01/13/16 at 5:30 am, CBG was 229. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 14. 01/14/16 at 5:30 am CBG was 285. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 15. 01/15/16 at 5:00 am, CBG was 229 and 4 units [MEDICATION NAME]was given. At 11:30 am and at 8:00 pm there was no record of CBG or insulin administration. 16. 01/16/16 at 8:00 pm, there was no record of CBG or insulin administration. 17. 01/17/16 at 5:30 am, CBG was 285 and 4 units [MEDICATION NAME]was given. At 8:00 pm there was no record of CBG or insulin administration. 18. 01/18/16 at 5:30 am, CBG was 229. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 19. 01/19/16 at 6:30 am there was no record of CBG or insulin administration. At 4:30 pm and at 8:00 pm there was no record of CBG or insulin administration. 20. 01/20/16 at 5:30 am, CBG was 191. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 21. 01/21/16 at 5:30 am, CBG was 264. There was no record of insulin administration. At 8:00 pm the was no record of CBG or insulin administration. 22. 01/22/16 at 5:30 am, CBG was 277 and 4 units [MEDICATION NAME]was given. V. On 01/26/16 at 11:07 am, during interview with R #20 when asked if she has ever refused her medication because it was too late or she was sleeping, she stated Yes. I've received it late. R #20 stated that she has experienced thirst, confusion, blurred vision and increased urination. Findings for R #157: W. Record review of the MAR indicated [REDACTED]. Scheduled at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm as ordered by the physician. X. Record review of the Diabetic Monitoring Flow Sheet dated 01/11/16 through 01/26/16 for R#157 revealed CBG was checked and insulin was administered at the following times: 1. 01/11/16 at 5:30 am, CBG was 131. At 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 2. 01/12/16 at 5:30 am, CBG was 155. There was no record of insulin administration. At 11:00 am, CBG was 151. There was no record of insulin administration. At 4:30 pm CBG 196. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration 3. 01/13/16 5:30 am, CBG 166. There was no record of insulin administration. At 11:30 am, CBG 174. There was no record of insulin administration. At 4:30 pm, CBG was 208. There was no record of insulin administration. At 8:00 pm there was no record of CBG or insulin administration. 4. 01/14/16 at 5:30 am CBG was 249. There was no record of insulin administration. 5. 01/15/16 5:30 am, CBG was 147. 6. 01/16/16 5:00 am, CBG was 114. At 8:00 pm there was no record of CBG or insulin administration. 7. 01/17/16 at 6:30 am there was no record of CBG or insulin administration. 8. 01/18/16 at 11:30 am and 4:30 pm there was no record of CBG or insulin administration. 9. 01/19/16 at 5:30 am CBG was 141. At 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 10. 01/23/16 at 11:30 am and 4:30 pm there was no record of CBG or insulin administration. 11. 01/25/16 at 5:45 am, CBG was 187. There was no record of insulin administration. At 9:00 pm CBG was 303 and 6 units [MEDICATION NAME]given. 12. 01/26/16 at 5:30 am CBG was 206. There was no record of insulin administration. Findings for R #40: Y. Record review of the Diabetic Flow Sheet dated 01/01/16 through 01/25/16 for R#40 read [MEDICATION NAME] 100 units per milliliter, CBG before meals and bedtime for CBG 0-150 0 units, 151-300 4 units, 301-350 6 units, higher than 350 call physician. Scheduled at 6:30 am, 11:30 am, 4:30 pm and 8:30 pm as ordered by the physician. Z. Record review of the Diabetic Monitoring Flow Sheet dated 12/27/15 through 01/23/16 revealed CBG was checked and insulin was administered at the following times: 1. 12/28/15 at 8:30 pm there was no record of CBG or insulin administration. 2. 12/29/15 at 5:30 am, CBG was 136. At 4:30 pm there was no record of CBG or insulin administration. 3. 12/30/15 at 5:30 am, CBG was 150. At 11:30 am, 4:30 pm and 8:30 pm there was no record of CBG or insulin administration. 4. 12/31/15 at 5:30 am, CBG was 121. At 8:00 pm there was no record of CBG or insulin administration. 5. 01/01/16 at 5:30 am, CBG was 133. 6. 01/04/16 at 5:30 am, CBG was 163. There was no record of insulin administration. At 11:30 am and 4:30 pm there was no record of CBG or insulin administration. 7. 01/05/16 at 5:30 am, CBG was 170 and 4 units [MEDICATION NAME]was given. At 11:30 am, 4:30 pm and 8:30 pm there was no record of CBG or insulin administration. 8. 01/06/16 at 6:30 am there was no record of CBG or insulin administration. At 12:00 pm, CBG was 152. There was no record of insulin administration. At 8:30 pm there was no record of CBG or insulin administration. 9. 01/07/16 at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 10. 01/08/16 at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 11. 01/09/16 at 6:30 am there was no record of CBG or insulin administration. At 4:30 pm and 8:30 pm there was no record of CBG or insulin administration. 12. 01/10/16 at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration.

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F 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) 13. 01/11/16 at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 14. 01/12/16 at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 15. 01/13/16 at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 16. 01/14/16 at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm there was no record of CBG or insulin administration. 17. 01/16/16 at 8:00 pm there was no record of CBG or insulin administration. 18. 01/17/16 at 6:30 am there was no record of CBG or insulin administration. 19. 01/18/16 at 11:30 am and 4:30 pm there was no record of CBG or insulin administration. 20. 01/19/16 5:30 am, CBG was 129. At 8:00 pm there was no record of CBG or insulin administration. AA. On 01/26/16 at 11:13 am during interview with R #40, she confirmed that her blood sugar is only checked 2 times a day. R #40 also confirmed that she has experienced thirst, confusion once in a while and increased urination. Findings for R #174: BB. Record review of Diabetic Flow Sheet dated 01/01/16 to 01/25/16 for R #174 read [MEDICATION NAME] 100 units per milliliter, CBG before meals if CBG 0-150 no insulin, 151-300 given 4 units, if over 300 give 6 units. The following dates and times documented on the Diabetic Monitoring Flow Sheet are not as ordered by the physician: CC. Record review of the Diabetic Monitoring Flow Sheet dated 01/04/16 to 01/25/16 revealed CBG was checked and insulin was administered at the following times: 1. 01/04/16 at 5:00 am, CBG was 293 and 4 units [MEDICATION NAME]given. At 11:30 am there was no record of CBG or insulin administration. At 5:00 pm CBG was 342. There was no record of insulin administration. 2. 01/05/16 at 5:00 am, CBG was 176 and 4 units [MEDICATION NAME]given. 3. 01/06/16 There was no record of CBG or insulin administration was recorded for this date. 4. 01/07/16 There was no record of CBG or insulin administration was recorded for this date. 5. 01/08/16 There was no record of CBG or insulin administration was recorded for this date. 6. 01/09/16 at 5:30 am, CBG was 184. There was no record of insulin administration. At 11:30 am and 4:30 pm there was no record of CBG or insulin administration. 7. 01/10/16 There was no record of CBG or insulin administration was recorded for this date. 8. 01/11/16 at 6:00 am, CBG was 292. There was no record of insulin administration. At 11:30 am there was no record of CBG or insulin administration. At 4:30 pm CBG was 201. There was no record of insulin administration. 9. 01/13/16 at 6:30 am there was no record of CBG or insulin administration. 10. 01/16/16 at 5:30 am, CBG was 223 and 4 units [MEDICATION NAME]was given. 11. 01/17/16 at 5:30 am, CBG was 233 and 4 units [MEDICATION NAME]was given. 12. 01/19/16 at 5:20 am, CBG was 248 and 4 units [MEDICATION NAME]was given. 13. 01/21/16 at 5:30 am, CBG was 114. 14. 01/22/16 at 5:30 am, CBG was 105. 15. 01/23/16 at 6:30 am there was no record of CBG or insulin administration. 16. 01/24/16 at 6:30 am there was no record of CBG or insulin administration. At 4:30 pm there was no record of CBG or insulin administration DD. On 01/26/16 at 11;51 am during interview with R #174, she confirmed that staff wake her up to give her her evening medication. R #174 also confirmed that she has dry mouth all the time and gets very thirsty. Findings for R #14: EE. Record review of the MAR indicated [REDACTED]. Scheduled at 6:30 am, 11:30 am, 4:30 pm and 8:00 pm as ordered by the physician. FF. Record review of the Diabetic Monitoring Flow Sheet dated 01/19/16 through 01/25/16 revealed CBG was checked and insulin was administered at the following times: 1. 01/19/16 at 8:00 pm there was no record of CBG or insulin administration. 2. 01/20/16 at 6:00 am, CBG was 138. There was no record of insulin administration. At 11:30 am, CBG was 221. There was no record of insulin administration. At 4:30 pm there was no record of CBG or insulin administration. 3. 01/21/16 at 4:30 pm, CBG was 137. There is no record of insulin administration. 4. 01/22/16 at 6:00 am, CBG was 147. There was no record of insulin administration. 5. 01/24/16 at 5:45 am, CBG was 97. 6. 01/25/16 at 5:45 am ,CBG was 153. There was no record of insulin administration. At 4:30 pm CBG was 304. There was no record of insulin administration. 7. 01/26/16 at 5:30 am, CBG 147. There was no record of insulin administration. GG. On 01/22/16 at 10:57 am, during interview with Registered Nurse (RN) #11 confirmed that Nurses do not write in the Medication Administration Record [REDACTED]. RN #11 confirmed that medications should be administered within a 2 hour window of when it is ordered, one hour before or one hour after scheduled time. HH. On 1/25/16 at 4:40 pm, during interview with Pharmacist #1 (RX1) when asked what are the risks to the residents if medications are not being administered at the times scheduled, on time or at the same times each day. She replied that With most medications the staff has a 2 hour window when passing medications. I asked her how long the medication pass should take. She replied Again it shouldn't take longer than 2 hours as you have one hour before the scheduled time and one hour after. I asked what about the capillary blood glucose (CBG) checks and insulin administration. She replied I know this is taking the staff longer now as they used to have med techs and now they don't but I've talked to them about this and those CBG's should be checked right before going to eat, maybe they can start at 6:00 am but 5:30 am and 5:00 am is way too early. She also stated There shouldn't be all those holes in the MAR, I know they have a lot of agency nurses, but somebody needs to be checking that, and monitoring the residents for hypo (low blood sugar) and [MEDICAL CONDITION] (high blood sugar) as well as other potential side effects depending on the medications the residents are taking. When asked for some medications that should be administered as scheduled, at the same times every day if there are any that if not given consistently could have a negative outcome for the residents. She replied, Well defiantly Insulin, as well as blood pressure medication, [MEDICAL CONDITION] medication, mood or [MEDICAL CONDITION] medications, pain medications and even antibiotics and sleeping meds as the goal is to maintain effectiveness, consistent levels, pain control etc and minimize the potential ill effects if not being consistent with the administration times. But definitely med pass should not be taking 4 and 5 hours. II. On 01/26/2016 at 9:51 am during interview with Medical Director (MD) #1 regarding the CBG's and insulin not being administered as ordered or documented, CBG's not being done at 6:30 am, instead it's being done by the night shift before they
F 0364 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.** Based on observation and interview, the facility failed to serve food at the proper and resident preferred temperature for 7 (R #18, 20, 35, 49, 79, 99 and 148) of 7 (R #18, 20, 35, 49, 79, 99 and 148) residents reviewed for food quality and through random observation. If residents are served food that is not at their preferred temperature, they are likely to eat less of their meal which could result in malnutrition and weight loss. The findings are: A. On 01/19/16 at 8:29 am during an observation of the distribution of room trays Dietary Manager (DM) was asked to take the temperature of R #35's breakfast tray. The meal consisted of fried eggs and pureed beans, the temperature was 90 degrees Fahrenheit on both items. After the temperature was taken, CNA #4 served R #35's tray. DM asked What should I do? Tray was then taken from R #35 and she was told they would bring her another plate. B. On 01/19/16 at 8:40 am during an interview with R #35, she stated, A lot of times my food is served cold, I just eat it cause it takes to long to get another plate and sometimes that plate is cold too. C. On 01/22/16 at 8:21am, during observation and interview, the room tray cart was sitting in the hallway. R #20, 99 and 148 were sitting at a table in the tv room. R #20 stated that they had been waiting for 15-20 minutes for breakfast. When asked if food is ever cold, R #20 responded Sometimes. Scrambled eggs are cold all the time. R #148 confirmed that they have been waiting for the breakfast trays since 8:00 am.

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F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) D. On 01/22/16 at 8:35 am during observation of dining room R #79 stated her eggs were cold and she would like some warm eggs. E. On 01/22/16 at 8:40 am during observation and interview, Certified Nurse Aide (CNA) #8 served R #99 her breakfast tray. At 8:46 am R #20 and R #148 were served their breakfast trays. CNA #8 stated that trays are suppose to be passed out at 8:20 am however I am a little behind, cause 2 CNAs called in and I am helping them. F. 01/22/16 at 8:48 am during an observation of dining room R #49's breakfast meal was set at the table and resident was not seated at the table. G. On 01/22/16 at 8:55 am during observation of dining room R #49 was observed to enter the dining room and sat down to breakfast. DM was asked to take the temperature of the eggs, he stated. They are 129 degrees. They should be at least 135 degrees. R #49 stated her eggs were cold. R #49 was served the cold tray. When DM was asked if he should have served R #49 the cold eggs, he stated I will get her another tray. H. On 01/26/16 at 2:59 pm during a resident council meeting, R #18 stated I do not like cold food and especially not cold eggs, I will order another tray sometimes but, it takes so long for them to bring another tray, so sometimes I just eat my food cold.
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 record review, interview and observation, the facility failed to ensure that food was stored and prepared under sanitary conditions by: 1. Not wearing beard guards while in the food preparation area 2. Not placing perishable foods on ice when out of the refrigerator. 3. Not using sanitizing solution in the sanitizer bucket. 4. Not dating food with the received/opened/used by dates in nourishment rooms. 5. Not ensuring that the facility kitchen was kept clean and free of grease and grime. 6. Not ensuring that dish machine was at the appropriate temperature when sanitizing dishes. 7. Not changing gloves when going from dirty dishroom to clean dishes. 8. Staff being unaware on how to sanitize a thermometer. This deficient practice is likely to result in all 109 residents identified on the Resident Census list provided by the Administrator on 01/15/16 being exposed to foodborne illnesses. The findings are: Findings for beard restraints: A. On 1/15/16 at 10:17 am during initial of the facility kitchen Dietary Aide's (DA) #2,3 and 4 were observed in the food preparation area not wearing beard restraints. B. On 01/15/16 at 10:26 am during an observation of facility kitchen, the Dietary Manager (DM) was observed without a beard restraint, in the food preparation area while lunch was being prepared. C. On 01/19/16 at 3:24 pm during an observation and interview with DM he was observed in the facility kitchen and was not wearing a beard restraint. When asked if staff should wear beard restraints while in the kitchen, DM stated. Yes, staff do need to wear beard guards if they are cooking or serving on the tray line. I do not need to wear a beard guard because I do not do the cooking. D. On 01/29/16 at 12:13 pm, during observation, DA #2 and 3 were wearing a beard restraints but they were rested under their chin and not covering their beards. At this point, the DM instructed DA #2 and 3 to put the beard restraints on correctly. Findings for food not on Ice: E. On 01/15/16 at 10:37 am during an observation and interview of medication cart in the memory care unit, 2 thick and easy, 1 4 ounce Yoplait red raspberry yogurt were not on ice. Licensed Practical Nurse (LPN) #5 the in memory care stated, he (Administrator) just told me to replace the ice since it's melted. F. On 01/23/16 at 8:55 am during record review, observation and interview with DA #5. A carton of 18 eggs were sitting on the table next to the stove and a 64 ounce box of Silk (Soy Milk) was on the serving line. DA #5 stated we keep the Silk on the shelf. We do not put it in the refrigerator and I just took out the eggs. Label on the Silk states. Refrigerate After Opening. G. On 01/25/16 at 2:20 pm during an interview with DM, he stated. The eggs and the Silk should be on ice. H. On 01/29/16 12:10 pm during observation of the facility kitchen and interview with the DM, a box of frozen chicken and a bag of french fries were observed to be sitting on the counter next to the deep fryer not on ice. DM stated, They just pulled it out of the freezer to use for a lunch alternate, they are going to put it away now. Findings for Kitchen cleanliness: I. On 01/15/16 at 10:26 am during initial tour and observation of the facility kitchen, the floor and doors appeared to have grease and grime build up, there was debris on the floor, rust and grime under the steam table, tray line had dried food spills, crumbs and pieces of plastic wrap. J. On 01/20/16 at 8:50 am during an observation of facility kitchen and interview. A 3 gallon empty container of rice was on floor behind stove. A lid and various debris was throughout the kitchen floor. The food shipment was sitting on the dirty floor. DA #4, stated. That (debris and shipment) should not be on the floor. Findings for unlabeled and undated food: H. On 01/15/16 10:34 am during observation of the north side nourishment room refrigerator, there was a small (Name of Restaurant) salad, a bowl of pasta, one 8 ounce cup of McDonalds coffee cup. There was no date on any of these items. I. On 01/27/16 at 10:29 pm south side nourishment room, there was a Walmart bag with a bowl that appears to be salad, a bottle of 16 oz zesty Italian dressing, a lemon and plastic ware that was in the refrigerator un labeled and undated. In the cabinet was a Styrofoam bowl with a piece of chocolate cake. J. On 01/27/16 at 10:30 pm during interview with Certified Nurse Aide (CNA) #2, she stated food should be labeled and dated. K. On 01/27/16 at 10:35 am during observation in the north side nourishment room refrigerator, there was a Lowe's bag and in the bag was a bowl that appeared to be pasta. There was also an 8 ounce cup of McDonalds coffee, half empty. L. 01/27/16 10:39 pm during an interview with LPN #6, he stated. There should not be any food unlabeled or undated in the refrigerators. Findings on dishmachine temperatures: M. On 01/22/16 at 9:05 am during an observation of dish machine it was observed to be at 115 degrees Fahrenheit. N. On 01/22/16 at 9:10 am during an interview with the Dietary Manager (DM), he stated. The hot water has been off and on for a couple of days now we have not gotten it to go up to 120 degrees. We have been monitoring the temperature. We have had this problem for a few months now. I have talked to maintenance about it several times. O. On 01/26/20 at 8:18 am during an interview with he DM, he stated. The water temperature is now at 121 degrees. It fluctuates and is not stable. I don't know how long it will stay at that temperature. P. 01/26/16 at 8:50 am during an observation of the dish machine and an interview with the DM, he stated Dish machine is running between 115 degrees and 118 degrees. Findings for sanitizer not in sanitizing bucket: Q. On 01/29/16 at 12:13 pm during observation and interview, the DM tested the sanitizer bucket and confirmed that there was no sanitizer in the bucket near the sink. The DM stated There should be sanitizer in this bucket, but I think I threw a dirty dish rag and that broke the sanitizer down. Findings on sanitizing a thermometer: R. On 01/22/16 at 12:03 pm during observation and interview, Cook #1 he was asked to take a tray temperature. Cook #1 stated they have no wipes in the dining room, so he brought a bucket with water and a paper towel. Cook #1 dipped the thermometer in the bucket, pulled out a paper towel from his pocket, wiped the thermometer dry and then proceeded to take the food temperature. Cook #3 repeated this process multiple times, wiping the dirty thermometer on the same paper towel repeatedly. S. On 01/27/16 at 12:31 pm during interview with interview with Health Care Services Manager (HCSM), she confirmed that cooks do get training on taking food temperatures and infection control practices, however she stated Cooks are not trained to take temps (temperatures) out in the hallway. It is out of their scope of practice. Cooks can not take temperatures anywhere else but in the kitchen.

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F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 16)
F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observation, the facility failed to ensure that: 1. medications were accusable only to authorized persons by not locking a medication cart near the nurses' station while it was not being actively used. 2. a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. These deficient practices are likely to result in all 109 residents identified on the resident census list provided by the Administrator on 01/15/15 having free access to medications, and not having narcotic medications available. If residents are allowed free access to medications residents are likely to experience medication interactions and overdose as a result of un-supervised self administration. If narcotic medications are not counted and reconciled at each shift change than medications can be absconded or taken by staff on duty, medications will not be available when residents request them and or residents being under the care of impaired staff. The findings are. A. On 01/22/16 from 7:11 pm and 7:26 pm, during observation of medication pass Licensed Practical Nurse (LPN) #6 prepared and administered the evening medications of R #91 and 26. At 7:11 pm after preparing the medications for R #91, LPN #6 walked away from the medication cart and down the common hallway to administer the residents medications, leaving the medication cart unlocked and accessible to unauthorized personal. At 7:26 pm after preparing the medications for R #26, LPN #6 walked away from the medication cart to administer the resident's medications, leaving the medication cart unlocked and accessible to unauthorized personal. At 7:27 pm, the Director of Nursing walked by the medication cart and locked it for LPN #6. B. Record review of the Daily Narcotic and Controlled Drug Count sheets for unit A revealed on: 1. 01/02/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. 2. 01/11/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. 3. 01/15/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. No signature at 6:00 am shift going off. 4. 01/18/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. C. Record review of the Daily Narcotic and Controlled Drug Count sheets for unit B revealed on: 1. 01/03/16 no signature at 6:00 am shift going off. 2. 01/09/16 no signatures at 6:00 pm shift coming on or at 6:00 am shift going off verifying Narcotic count correct. 3. 01/13/16 no signatures at 6:00 pm shift coming on or at 6:00 am shift going off verifying Narcotic count correct. 4. 01/14/16 no signature at 6:00 pm shift going off. 5. 01/15/16 no signature at 6:00 pm shift going off. 6. 01/17/16 no signature at 6:00 am shift going off. D. Record review of the Daily Narcotic and Controlled Drug Count sheets for unit C revealed on: 1. 01/04/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. 2. 01/05/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. No signature at 6:00 am shift going off. 3. 01/08/16 no signatures at 6:00 pm shift coming on or at 6:00 am shift going off verifying Narcotic count correct. 4. 01/12/16 no signature at 6:00 am shift going off. E. Record review of the Daily Narcotic and Controlled Drug Count sheets for unit C revealed on: 1. 01/02/16 no signature at 6:00 am shift going off. 2. 01/03/16 no signatures at 6:00 pm shift coming on or at 6:00 am shift going off verifying Narcotic count correct. 3. 01/04/16 no signatures at 6:00 pm shift coming on or at 6:00 am shift going off verifying Narcotic count correct. 4. 01/11/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. 5. 01/12/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. 6. 01/13/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. 7. 01/18/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. 8. 01/19/16 no signatures at 6:00 am shift coming on or at 6:00 pm shift going off verifying Narcotic count correct. F. On 01/22/16 at 9:10pm during interview with Director of Nursing (DON), she confirmed that Narcotic medications should be counted at each shift change by 2 nurses and both nurses are to sign the Daily Narcotic and Controlled Drug Count sheets.
F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the following was discovered. 1. A couple of residents were placed on contact precautions, however besides the presence of the medical cart outside the door, there was no notice/signage instructing other residents or visitors that they should take precautions before entering the room. 2. Centers for Disease Control and Prevention (CDC) approved cleaning products were not being used for a resident that staff was informed has [DIAGNOSES REDACTED]. (Clostridium difficile). 3. Paper products were not being used for residents on contact precautions. 4. The dish machine was not at the appropriate temperature to sanitize the dishes. This resulted in Immediate Jeopardy being called on 01/26/16 at 12:35 pm. The Administrator was notified at this time. A Plan of Removal was received and and rejected on 01/26/16 at 4:55 pm, 5:13 pm and 6:50 pm. A fourth Plan of Removal was received and approved on 01/26/16 at 7:08 pm. The scope and severity was decreased from a Level 4, L to a Level 2, F The Plan of Removal included: 1. Staff training within the kitchen regarding dish machine procedures/temperatures. 2. Frequent testing of the dish machine temperature. 3. Plumbers to re-route hot water line to regulate fluctuating temperatures. 4. Staff inservice regarding isolation protocol, hand washing, cleaning rooms with residents on isolation, and infection control process. 5. Infections for January will be identified and placed on Infection Report Form. Based on record review and interview, the facility failed to establish and maintain an Infection Control Program designed to provide safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection by: 1. Not accurately tracking resident infections and using the information to investigate, control and prevent infections in the facility. 2. Not appropriately notifying residents and visitors when a resident is on isolation precautions to prevent other residents and visitors from contracting the infection/disease. 3. Not using appropriate cleaning products approved by the CDC when cleaning rooms of someone diagnosed with [REDACTED]. 4. Not using paper products for meal service to prevent cross contamination. 5. Not ensuring the catheter drainage bag of R #6 remained off of the floor. This deficient practice is likely to affect all 109 residents on the Resident census list provided by the Administrator on 01/15/16. If proper infection control practices are not maintained, residents are likely to be exposed to disease causing organisms resulting in infection. The findings are Findings related to infection control program: A. On 01/26/16 at 10:00 am during interview with Staff Development Coordinator (SDC), regarding the facility infection control program, she stated The information is collected by the ADONs (Assistant Director of Nursing) and passed onto me

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F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 17) and I place it in certain categories. SDC stated that she then passes the information onto the Administrator. When asked about isolation precautions, she stated We have been asking that before entering the room to see Nursing staff and visitors so they would know what measures to be taken before entering the room. SDC confirmed that guests should be notified immediately by the Charge Nurse. SDC confirmed that she only started 2 weeks ago and she has seen problems however the Administrator and Director of Nursing are trying to fix them. B. On 01/26/16 at 11:33 am, during interview with the Administrator, he stated (Name of SDC) started with us on the 11th of this month (January 2016). Prior to that it was the ADONs in the building. Directly, I have not had involvement (with infection control program). When asked what the ADONs did, he stated They were to gather the infections and collaborate them and put them in a report for the DON (Director of Nursing) and Corporate. Don't know what happens after all the information is put together. When asked if there were any residents on contact precautions, he responded Yes. She (R #40) is on contact isolation and staff is instructed to follow regime of contact isolations. C. Record review of the Monthly Infection Control Analysis Dated August 2015 to November 2015 revealed the following infection rate percentage for the month: August 2015: 5% September 2015: 4 % October 2015: 5% November 2015: 23% D. On 01/26/16 at 2:45 pm during interview with the Nurse Specialist (NS) after reviewing the facility Infection Control sheets from October to November 2015, she confirmed that the facility has not been appropriately tracking the community and nosocomial (contracted within the facility) infections together, therefore their tracking sheets are inaccurate. Finding related to precaution signage: Findings related to R #40: E. Record review of Physician telephone orders for R #40 dated 01/22/16 revealed Stool for culture and parasite, ua (urinalysis) and .C. Diff. F. On 01/24/16 at 8:45 am during observation and interview, there was a medical cart (containing precaution supplies, ie gown, gloves, mask) outside R #40's room. During interview with the CNA (Certified Nurse Aide) scheduler, when asked why there was a medical cart outside R #40's door, she stated, We have positive confirmation of C.diff (Clostridium difficile). G. On 01/24/16 at 8:55 am during interview with the Director of Nursing (DON), when asked why there wasn't a sign on the door warning that isolation precautions were necessary, the DON responded, It would be a HIPAA (Health Information Portability and Accountability Act) violation to put something on the door. Corporate says that with the cart outside the door that alerts visitors that something is going on with the resident. H. On 01/24/16 at 9:01 am, during interview with LPN #1 when asked if the facility puts a caution sign on the door, he responded, We used to put a sign on the door that read, 'PLEASE SEE NURSE BEFORE ENTERING.' LPN #1 confirmed that they were instructed not to do that anymore. I. On 01/25/16 at 10:10 am, during interview with Certified Nurse Aide (CNA) #11, when asked how she knows if there is a resident with an infection in a room, she stated, There's a cart outside the door with the gloves, mask and gown and there's a sign on the door saying you have to ask the nurse before you go into the room. J. On 01/25/16 at 10:19 am during observation, there was no signage on R #40's door indicating that there was a precaution. K. On 01/25/16 at 10:26 am, during interview with R #86 when asked how he would know if there was an infection in the building, he stated, Well, there would be a sign outside the door and the cart in front of that room. When asked if there were any infections in the buildings at that time, he responded, No, because you would see the notice. L. On 01/25/16 at 10:28 am during interview with an Anonymous Volunteer, when asked how they would know if someone had contact precautions, s/he stated Well I would expect someone to tell me. When you go to the hospital, they let you know that you have to put on a gown and gloves and a mask. M. On 01/26/16 at 11:43 am during interview with the Director of Nursing (DON) when asked what is isolation protocol, she stated Corporate said to no longer put out the note. They felt it was a HIPAA violation. Findings related to R #153: N. On 01/15/16 at 10:32 pm during observation, a medical cart (containing precaution supplies, ie gown, gloves, mask) was observed outside R #153 door. There was no notice/signage indicating that there was isolation precaution or that residents, visitors or staff should be cautious before entering the room. O. Record review of the Department Notes For R #153 revealed: 01/18/16 D/C (discharge) isolation. P. On 01/23/16 at 12:50 pm during observation and interview, a medical cart was observed outside R #153 door. There was no notice/signage indicating that there was isolation precaution or that residents, visitors or staff should be cautious before entering the room. The Regional Nurse (RN), when asked if there should be a sign on the door indicating that there was a precaution for R #153 and the RN confirmed that there should be. Q. On 01/26/16 at 10:38 am during interview with Registered Nurse (RN) #2, she confirmed that R #153 had MRSA (Methicillin resistant Staphylococcus aureus) in his lungs and he was on isolation and contact precautions. RN #2 stated that staff and visitors who were going to be within 3 feet of him, needed to mask, gown and gloves and there would be a cart outside the door. RN #2 also confirmed that there should be a sign on the door for anyone who wanted to enter, to see the nurse. R. On 01/26/16 at 11:43 am during interview with the Director of Nursing (DON) when asked what is isolation protocol, she stated Corporate said to no longer put out the note (signage). They felt it was a HIPAA violation. S. On 01/29/16 at 5:04 pm during interview with Licensed Practical Nurse (LPN) #3 when asked if a resident has MRSA what type of precautions does the facility employ, she responded that they are placed on contact precautions and the infection control cart is placed outside the door, staff is informed through report at change of shift and a sign is placed on the door alerting anyone before going in to see the nurse. T. Record review of the Infection Control Policy and Procedure Manual: MRSA- Management of recurrent skin and soft tissue revised 2011 revealed Using CDC recommended cleaners appropriate for surface being cleaned. Findings related to cleaning products: U. On 01/26/16 at 10:19 am, during observation and interview, R #40's room was observed to have carpet. During interview with Housekeeper (HK) #1 when asked what type of product is used for cleaning a room which has isolation precautions, she indicated that she is using Airx75 Antibacterial cleaning. V. On 01/26/16 during interview and through email communication with the CDC regarding appropriate cleaning products necessary to clean a room in which a resident has [DIAGNOSES REDACTED], they indicated, C. diff can be transmitted both by direct contact with the organism during patient/resident care activities and indirectly by contact with contaminated surfaces. [DIAGNOSES REDACTED] is a spore-forming organism that requires disinfectants capable of destroying the spore. Not all disinfectants have these properties; therefore, we recommend using one of the EPA-registered disinfectants found on their website. The product used at the facility (Airx75) was not on the list. Other precautions listed by the CDC included, Carpeting and rugs can harbor microorganisms and be difficult to clean and disinfect. Smooth, hard surface floor coverings are easier to maintain. Similarly, furniture selections in resident care areas should be selected based on their compatibility with cleaning agents and ease of use. Findings related to changing gloves: W. On 01/23/16 at 9:00 am during an observation of the dish room and interview with Dietary Aide (DA) #1. DA #1 was observed loading the dish machine with dirty dishes and then proceeded to put away the clean dishes without changing his gloves or washing his hands. He stated, I guess I should change my gloves. Findings related to Dish machine temperature: X. On 01/22/16 at 9:05 am during an observation of dish machine it was observed to be at 115 degrees Fahrenheit. Y. On 01/22/16 at 9:10 am during an interview with the Dietary Manager (DM), he stated. The hot water has been off and on for a couple of days now we have not gotten it to go up to 120 degrees. We have been monitoring the temperature. We have had this problem for a few months now. I have talked to maintenance about it several times.

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F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 18) Z. On 01/26/20 at 8:18 am during an interview with he DM, he stated. The water temperature is now at 121 degrees. It fluctuates and is not stable. I don't know how long it will stay at that temperature. AA. 01/26/16 at 8:50 am during an observation of the dish machine and an interview with the DM, he stated Dish machine is running between 115 degrees and 118 degrees. When asked if there are any residents on precautions, the DM confirmed that there are no residents on precautions that would require the use of paper products. DM stated, To my knowledge, we have never had anyone on paper precautions. Findings related to catheter bag: AA. On 01/20/16 from 2:50 and 3:10 pm, during an observation, R #6 was sitting in a wheelchair in a common hallway with the resident's catheter drainage bag hanging from the underside of the wheelchair. The lower portion of the catheter drainage bag was resting directly on the floor without a barrier covering the drainage bag. BB. Record review of the Policy and Procedure on Urinary Catheter Care - section infection control dated October 2010 revealed, Be sure the catheter tubing and drainage bag are kept off the floor.
F 0464 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.** Based on observation and interview, the facility failed to provide sufficient space for 14 Residents (R #18, 33, 35, 67, 69, 73, 82, 85, 86, 90, 113, 156, 160 and 174) of 14 Residents (R #18, 33, 35, 67, 69, 73, 82, 85, 86, 90, 113, 156, 160 and 174) who eat in the independent dining room. This deficient practice is likely to result in residents not being able to freely enter and leave the dining room without disturbing another resident while they are having their meal. The findings are: A. On 01/27/16 at 8:30 am during an observation of the independent dining room, the room was crowded with 5 tables and 10 chairs and several residents in wheel chairs. R #67 was observed trying to get to his breakfast plate but was unable to get there without the assistance of Certified Nurse Aide (CNA) #3, who moving R #73 and R #86 who were already seated having their breakfast. B. On 01/27/16 at 8:35 am during an interview with R #67, he stated. We always have this problem. Today, it is not so bad. When it is full in here, we all get moved around to make room for everybody that eats in here. It's terrible. Sometimes they bang into each other and some residents get upset. C. On 01/27/15 at 8:40 am during interview with Certified Nurse Aide (CNA) #1, she stated When all of the residents are in here, it is very crowded. Sometimes we have 24 to 25 residents (in the independent dining room). I am here by myself most days and the wheelchairs make it hard for them to move around and some of the residents get upset when we move them around.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**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, record review and interviews, the following was discovered. 1. Medication pass at the facility is taking 3-5 hours, which in the evening is resulting in residents being woken up for evening medication pass, which at times the resident will refuse those medications. 2. Residents dependent on insulin are not having their blood sugars checked as ordered, and are not receiving insulin as ordered. 3. A couple of residents were placed on contact precautions, however besides the presence of the medical cart outside the door, there was no notice/signage instructing other residents or visitors that they should take precautions before entering the room. 4. Centers for Disease Control and Prevention (CDC) approved cleaning products were not being used for a resident that staff was informed has [DIAGNOSES REDACTED]. ([MEDICAL CONDITION]). 5. Paper products were not being used for residents on contact precautions. 6. The dish machine was not at the appropriate temperature to sanitize the dishes. This resulted in Immediate Jeopardy being called on 01/26/16 at 12:35 pm. The Administrator was notified at this time. A Plan of Removal was received and and rejected on 01/26/16 at 4:55 pm, 5:13 pm and 6:50 pm. A fourth Plan of Removal was received and approved on 01/26/16 at 7:08 pm. The scope and severity was reduced from Level 4, L to a Level 2, F. The Plan of Removal included: 1. Facility will identify med pass process for all shifts and adjust medication administration times under physician direction. 2. Consider availability of contract staff to replace current agency staff. 3. Staff inservice with current licensed staff regarding passing medications timely. 4. Residents will be identified who need blood sugars and insulin will be administered timely. 5. Monitoring timely medication pass daily for 3 days and weekly. 6. Pharmacy consultant will provide on-site medication pass audit on 01/27/16 and ongoing. 7. Staff training within the kitchen regarding dish machine procedures/temperatures. 8. Frequent testing of the dish machine temperature. 9. Plumbers to re-route hot water line to regulate fluctuating temperatures. 10. Staff inservice regarding isolation protocol, hand washing, cleaning rooms with residents on isolation, and infection control process. 11. Infections for January will be identified and placed on Infection Report Form. Based upon observation, record review and interview, the facility failed to be administered in a manner that enables it to maintain the highest practicable physical, mental and psychosocial well-being of each resident by: 1. Not accurately tracking resident infections and using the information to investigate, control and prevent infections in the facility. 2. Not appropriately notifying residents and visitors when a resident is on isolation precautions to prevent other residents and visitors from contracting the infection/disease. 3. Not ensuring that residents are receiving medication within their scheduled time frames. 4. Not ensuring that insulin dependent resident are receiving their blood sugar checks and insulin as ordered. 5. Not ensuring that residents are treated with respect and dignity. 6. Not maintaining a positive work and living environment 7. Offering temporary employment to a Certified Nurse Aide (CNA) from a sister facility that had been terminated from this facility for abuse making him ineligible for re-hire. 8. Not keeping track of resident and resident family member grievances including how they were resolved. This deficient practice is likely to affect all 109 residents identified on the census list provided by the Administrator on 01/15/16. The findings are: Reference F225 Reference F241 Reference F244 Reference F309 Reference F333 Reference F441 Surveyor: Velarde, Ben
F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.**

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F 0498 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 19) Based on interview, the facility failed to ensure that nurse aide evaluations are conducted annually. This deficient practice is likely to affect all 109 residents identified on the census list provided by the Administrator on 01/15/16. If the facility is not ensuring that Certified Nurse Aides are competent in the areas of care that they are required to perform, then residents are likely to not get appropriate care needed. The findings are: A. Record review of the Policy and procedure on Performance and Compensation Reviews revealed Each employee may expect to periodically receive a written performance review. It is recommended that a written review be provided annually at a minimum. B. On 01/29/16 at 4:40 pm during interview with Human Resource Director (HRD), she stated We are 2 to 3 months behind in evaluations. We haven't had steady managers to complete evaluations. C. On 01/29/16 at 7:48 am during interview with the Regional Director of Operations (RDO), he confirmed that the facility is behind on evaluations and training due to management turnover.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain accurate clinical records for 4 (R# 20, 40, 86 and 176) of 4 (R# 20, 40, 86 and 176) records reviewed for medication and during random observation. If staff are not accurately documenting, verifying physician orders, medication labels and Medication Administration Records for accuracy, other staff or chart reviewers may be unable to determine what the is the correct dosage of medication, the route of administration resulting in residents receiving an inaccurate amount of medication, receiving medication via the wrong route, or receiving too much medication. If clinical records are not kept neat and accessible, then staff may not be aware of important health information and history. The findings are: A. Record review of the Medication Administration Record [REDACTED] 1. Vitamin D3(vitamin D supplement) 5,000 units caps weekly for 6 weeks. No route or diagnosis listed. 2. [MEDICATION NAME] (medication used for [MEDICAL CONDITION] reflux disease) DR 40 milligrams (mg) tablet by mouth every day. No diagnosis listed. 3. [MEDICATION NAME] (medication for enlarged prostate) 4 mg tablet every day. No route of administration or diagnosis listed. 4. Senna (laxative medication) 8.6 mg tablet one by mouth at bedtime. No diagnosis listed. 5. Atorvastatin (medication for high cholesterol) 40 mg tablet every day. No route of administration or diagnosis listed. 6. No physician or physician telephone number, and no height or weight listed. 7. No full signatures to identify initials of staff administering medication B. Record review of the MAR indicated [REDACTED] 1. [MEDICATION NAME] (antipsychotic medication) 30 mg given one by mouth every morning. No form of medication listed. 2. [MEDICATION NAME] (diuretic medication)20 mg tablet give one by mouth every morning. No route of administration listed. 3. [MEDICATION NAME] (nonsteroidal [MEDICAL CONDITION] medication used for mild pain) 800 mg tablet give one every 12 hours. No route of delivery listed. 4. Breo Ellipta (medication for [MEDICAL CONDITION]) 200-25 mcg inhalation. No dosage or frequency listed. 5. [MEDICATION NAME] (antibiotic medication) 500 mg by mouth 4 times a day for 7 days. No start date or diagnosis listed. 6. [MEDICATION NAME] (medication to treat constipation) powder give one tablespoon in 4-6 ounces of water daily as needed for constipation. No strength or route listed. 7. [MEDICATION NAME] (antacid medication) 30 ml give by mouth 4 times as needed. No form or dosage frequency listed. C. Record review of Controlled Drug Record dated 01/14/16 for R #40 read: Moxifloxacin (antibiotic) 400 mg tablet take 1 tab by mouth daily for 10 days. First dose pill number 10 was signed as given on 01/15/16, pill number 9 was signed as given on 01/16/16, pill number 8 was signed as given on 01/17/16, pill number 7 was signed as given on 01/1/8/16. Pills number 6, 5, 4 ,3, 2, and 1 remain unsigned as given. D. Record review of the Controlled Drug Record for R #86 reads: [MEDICATION NAME]-[MEDICATION NAME] (pain medication) 5-325 take 1 tab by mouth twice daily as needed for pain, quantity 60 tabs. On the following dates and times 2 tablets were signed out and documented as given: 1. On 01/11/16 at 8:00 pm 2 tablets were signed out. 2. On 01/12/16 at 7:30 pm 2 tablets were signed out. 3. On 01/13/16 at 8:00 pm 2 tablets were signed out. 4. On 01/14/16 at 5:30 pm 2 tablets were signed out. 5. On 01/15/16 at 9:30 pm 2 tablets were signed out. 6. On 01/16/16 at 9:00 pm 2 tablets were signed out. 7. On 01/17/16 at 7:00 pm 2 tablets were signed out. 8. On 01/18/16 at 8:00 pm 2 tablets were signed out. 9. On 01/20/16 at 8:00 pm 2 tablets were signed out. 10. On 01/21/16 at 8:00 pm 2 tablets were signed out. 11. On 01/22/16 at 8:00 pm 2 tablets were signed out. E. Record review of Physicians orders dated January 2016 for R #86 state [MEDICATION NAME] 5-325 (Generic: [MEDICATION NAME]) tablet give two tablets twice daily as needed for pain. F. On 01/22/16 at 8:50 pm during interview with RN #5 regarding the discrepancy between the physicians order and the Controlled Drug Record for R #86, she confirmed the discrepancy and stated she would leave a note for the day nurse to inform the DON as it appears the order changed and no one changed it on the Controlled Drug sheet. G. On 01/21/16 at 10:27 am during record review of the medical record for R #20 revealed the following documents were not in the right tab in the medical record: 1. PRN (as needed) Flowsheet for [MEDICATION NAME] was under the chart tab titled, Dietary. 2. (Name of Psychiatric Clinic) Progress Note was under the tab consults while other Psychiatric Progress Notes were listed under the Mental Health tab. 3. ED (Emergency Department) Patient Discharge Summary was under the Progress Notes tab while other Discharge Summaries were listed under the tab titled Consults. H. On 01/21/16 at 10:38 am during interview with the Director of Nursing (DON), she confirmed that the documents in R #20's medical record were not under the correct tab. DON confirmed that they (Administration) have identified that there is a problem with the medical records and they are working on fixing it.
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on interview, the facility failed to ensure that the Quality Assessment and Assurance (QAA) Committee consists of at least 3 other members of the facility's staff. This deficient practice is likely to affect all 109 residents identified on the census list provided by the Administrator on 01/15/16. If the facility is not ensuring that the QAA consists of all required members, then the facility may miss an opportunity to obtain additional information and obtain important feedback regarding the residents and facility processes. The findings are: A. On 01/29/16 at 4:11 pm during interview with the Administrator, he stated that the last QAA meeting was on 12/17/15 and consisted of the Administrator, Medical Director, Corporate Nurse Specialist and the Director of Nursing. The Administrator

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CASA REAL	**1650 GALISTEO STREET SANTA FE, NM 87505**

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 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 20) confirmed that the required 3 additional staff members were not present at this meeting.