STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455804	A. BUILDING _____ B. WING _____	**04/28/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHGATE HEALTH AND REHABILITATION CENTER	**5757 N KNOLL SAN ANTONIO, TX 78240**

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 0156 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Give each resident a notice of rights, rules, services and charges. Tell each resident who can get Medicaid benefits about 1) which items and services Medicaid covers and which the resident must pay for.** Based on observation, interview and record review, the facility failed to prominently post written information in the facility about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds when payment was made on covered benefits; and to provide the resident on Medicare the appropriate liability and/or appeal notice(s) for 3 of 3 residents (#18,19,20) reviewed for Medicare discharged residents in that: 1. The facility did not have postings that provided information on Medicare and Medicaid benefits. 2. Medicare notification to resident/responsible parties was not provided to 3 discharged Medicare residents: #18, #19, and #20. These deficient practices could affect 81 residents who resided at the facility and could result in residents not being provided funding for which they were qualified. Also, the deficient practice on demand billing could affect 9 residents who resided in the facility and primary payment source was Medicare. The findings were: 1. Observation on 4/27/2015 at 10:50 a.m. of the bulletin boards with the facility postings in the front lobby area outside the Administrator's office revealed there was no posted written information on Medicaid and Medicare benefits. Interview with the administrator on 4/27/2015 at 11:07 a.m. revealed he thought all the required postings were displayed on the bulletin boards in the lobby area outside his office. The Administrator reported he was not certain if the postings were elsewhere in the facility. Observation on 4/27/15 at 11:30 a.m. of the facility halls, resident social areas, and administrative offices did not reveal the required Medicare and Medicaid postings. Interview with the Administrator on 4/27/15 at 11:35 a.m. revealed he had investigated further about the required Medicare and Medicaid postings and confirmed he did not have the information posted in the facility. 2. Record review of closed Medicare discharges for residents #18, #19, and #20 revealed that: resident #18, #19, and #20 were not provided with Medicare notification; nor were applicable responsible parties notified. Interview on 4/21/15 at 2:40 p.m. with the administrator revealed the facility had no demand bills in the past 6 months. Interview on 4/28/15 at 10:26 a.m. with Regional Area Collection Specialist revealed, no social worker was available to provide residents # 18, # 19, and # 20 with Medicare notification; and, she stated that the administrator did not provide the Medicare notification. Review of CMS Form-672 dated 4/21/15 revealed there were 81 residents who resided in the facility; and, 9 residents were under Medicare payment.
F 0164 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep each resident's personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide personal privacy during personal care for 2 of 11 residents (#1, 24) observed for personal care in that: 1. CNA FF and GG left resident #1's upper body exposed during perineal care. 2. CNA BB did not pull the privacy curtain around the foot of the bed during perineal care, leaving the resident exposed to anyone who walked by. This deficient practice could affect 18 residents who received incontinent care on the 100 Hall and 15 residents who received incontinent care on the 400 Hall and could result in a loss of dignity and self esteem. The findings were: 1. Review of the face sheet, dated 8/27/13, for resident #1 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Observation of perineal care on 4/21/15 at 4:10 p.m. for resident #1 with CNA FF and GG revealed resident #1's gown was wet. CNA FF and GG removed the gown and proceeded to provide incontinent care for resident #1. From 4:15 p.m. to 4:22 p.m. (7 minutes) resident #1 was uncovered leaving her upper body exposed to anyone entering the room. Interview immediately after the care with CNA FF confirmed she should have covered resident #1's upper body during the perineal care. Review of the facility policy and procedure titled Lippincott Procedures-Perineal care of the female patient, dated 2015, revealed to provide privacy. To minimize the patient's exposure and embarrassment, place the bath blanket over her with corners head to foot and side to side. Wrap each leg with a side corner, tucking it under the patient's hip. Then fold back the corner between the patient's legs to expose the perineum. 2. Review of the face sheet, dated 3/23/15, for resident #24 revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of perineal care on 4/21/15 at 3:40 p.m. for Resident #24 with CNA BB revealed the CNA only pulled the privacy curtain to the end of the bed and not around the foot of the bed which allowed anyone who used the bathroom to have full view of Resident #24's genital. Interview with CNA BB on 4/21/15 at 3:55 p.m. confirmed the privacy curtain was only pulled to the end of the bed and not around the foot of the bed. Review of the facility policy and procedure titled Lippincott Procedures-Perineal care of the male patient, dated 2015, revealed to provide privacy. A sheet provided by the facility revealed 18 residents on the 100 Hall required incontinent care and 15 residents on the 400 Hall required incontinent care.
F 0241 **Level of harm** - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to promote care to residents in a manner that maintains or enhances each resident's dignity and respect for 2 of 15 residents reviewed for dignity (Residents #2 and 24).

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

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

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F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) A.) Resident #24's incontinent brief was identified as diapers by CNA BB during perineal care. B.) Resident #2's incontinent brief was identified as diapers by CNA AA during catheter care. This failure could affect 5 residents on the 300 Hall and 15 residents on the 400 Hall who required incontinent care and cause mental anguish to the residents. Findings were: 1. Review of the face sheet, dated 3/23/15, for resident #24 revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of perineal care on 4/21/15 at 3:40 p.m. for Resident #24 with CNA BB revealed the CNA informed the resident he was to provide pericare on the resident and stated he was to Change your diaper. Interview with CNA BB on 4/21/15 at 3:55 p.m. confirmed he used the term diaper to describe the incontinent briefs. Interview with resident #24 on 4/22/15 at 1:10 p.m. revealed CNA BB had used the term diaper before to describe the incontinent brief and the resident reported it made him feel bad. 2. Review of Resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of catheter care on 4/23/15 at 3:07 p.m. for Resident #2 with CNA AA revealed the CNA stated to the resident she would take your diaper off as she unfastened the incontinent brief. Interview with CNA AA on 4/23/15 at 3:16 p.m. confirmed she used the term diaper to describe the incontinent brief. Interview with resident #2 on 4/24/15 at 8:06 a.m. revealed he calls the incontinent briefs diapers and stated they are what they are. Resident #2 reported it did not bother him to hear that term and he realized he had a need for them. Review of the facility Statement of Residents Rights from page 42 of the Admission Packet, undated, indicated An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual. A sheet provided by the facility revealed 5 residents on the 300 Hall required incontinent care and 15 residents on the 400 Hall required incontinent care.
F 0287 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode and automate the resident's assessment data.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were encoded and transmitted according to Centers for Medicare and Medicaid Services (CMS) requirements for 2 of 3 residents (#15 and 17)) reviewed for closed records and MDS transmission to CMS. 1. Resident #15's discharge MDS was not transmitted to CMS. 2. Resident #17's discharge MDS was not transmitted to CMS This deficient practice could affect 25 residents who were discharged in March 2015 and could cause resident records to be inaccurate. The findings were: 1. Review of Resident #15's closed clinical record revealed she was admitted to the facility on [DATE] with recent [DIAGNOSES REDACTED]. Resident #15's Physician Discharge Summary, not dated, revealed she was discharged from the facility on 3/23/15. Resident #15's final MDS transmission for the discharge was not found in her closed record. Interview on 4/28/15 at 9:45 a.m. with LVN M, after she checked her computer for resident #15 MDS records, confirmed a discharge MDS had not been done. 2. Review of resident #17's closed clinical record revealed he was admitted to the facility on [DATE] and had recent [DIAGNOSES REDACTED]. Resident #17's Physician Discharge Summary, not dated, revealed he was discharged from the facility on 3/3/15. Resident #17's final MDS transmission for the discharge was not found in his closed record. Interview on 4/28/15 at 9:45 a.m. with LVN M, after checking MDS records for resident #17, confirmed a discharge MDS had not been done. Review of CMS S & C: 13-56-NH, dated 8/23/13, p.3, under the heading, Importance and CMS Policy, revealed, A discharge MDS must be completed when the resident is discharged from the facility (whether or not return is expected) and A discharge MDS must be completed within 14 days after the discharge date and submitted 14 days after the completion date. Information provided by the facility revealed 25 residents were discharged from the facility in March 2015.

F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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 observation, interview and record review the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 3 of 14 residents (#1, 2, 3) reviewed for care in that: 1. Resident #1 was yelling and crying during perineal care and wound care and was not medicated or assessed for pain. Resident #1 had been out of [MEDICATION NAME] (Controlled narcotic pain medication) for 4 days. 2. Resident #2's urinary catheter tubing was pulled during catheter care. 3. Resident #3's urinary catheter bag was attached to his wheel chair above the level of the bladder. An Immediate Jeopardy (IJ) was identified on 04/22/15. While the IJ was removed on 04/23/15 prior to exit. The facility remained out of compliance at a severity level of actual harm with a scope of pattern. The plan of removal was still being monitored for compliance. This deficient practice could affect 41 residents on a pain management program and could result in pain not being managed; and placed 8 residents with urinary catheter at risk for an urinary tract infection. The findings were: 1. Review of the face sheet, dated 8/27/13, for resident #1 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Consolidated Physician's orders, dated 4/1/15, for resident #1 revealed an order for [REDACTED]. Review of the Individual Control Drug Record for resident #1 for [MEDICATION NAME] with APAP 7.5-325 mg 2 tabs per tube every 4 hours revealed 180 tablets were sent on 2/1/15. The first dose was administered on 2/6/15 and the last dose was administered on 4/18/15. Review of the April 2015 MAR for resident #1 revealed an entry for [MEDICATION NAME]-[MEDICATION NAME] 7.5 mg/325 mg 2 tablets per gastrostomy every 4 hours as needed. [MEDICATION NAME] was administered on 4/1-4/8, 4/10-4/14 and 4/17 and 4/18 in the morning between 8:00 a.m. and 11:00 a.m. On 4/8 and 4/10 resident #1 was medicated twice that day. Resident #1 had a pain scale of 7 (Hurts whole lot)(The scale of pain was listed on the MAR) each day she received the pain medication except on 4/18 the pain scale was 8 (Hurts whole lot). Review of the Individual Control Drug Record for resident #1 revealed a total of 22 doses was administered in April. Further review of the MAR indicated [REDACTED]. Review of the March 2015 MAR for resident #1 revealed an entry for [MEDICATION NAME]-[MEDICATION NAME] 7.5 mg/325 mg 2 tablets per gastrostomy every 4 hours as needed. [MEDICATION NAME] was documented as administered 26 days with two of the days resident #1 received the [MEDICATION NAME] twice in a day. Resident #1's pain scale ranged between a 7 and 8. Review of the Individual Control Drug Record for resident #1 revealed a total of 39 doses was administered in March. (On two days only one [MEDICATION NAME] was given instead of two). Review of the February 2015 MAR for resident #1 revealed an entry for [MEDICATION NAME]-[MEDICATION NAME] 7.5 mg/325 mg 2 tablets per gastrostomy every 4 hours as needed. [MEDICATION NAME] was documented as administered 9 days with a pain scale of 6, 7 and 8. Review of the Individual Control Drug Record for resident #1 revealed a total of 30 doses was administered starting on 2/6/15. Review of the January 2015 MAR for resident #1 revealed an entry for [MEDICATION NAME]-[MEDICATION NAME] 7.5 mg/325 mg 2 tablets per gastrostomy every 4 hours as needed. [MEDICATION NAME] was documented as administered 2 days with a pain scale of 7. Review of the Annual MDS with an assessment reference date of 2/24/15 for resident #1 revealed she had a BIMS (Brief Interview for Mental Status) of 2 out of 15 (2 indicating severe impairment). The MDS indicated resident #1 usually makes self understood and usually understands others. Speech was documented as clear. Under the section for Behaviors no

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) behaviors were documented. Activities of Daily Living to include dressing, eating, toilet use and personal hygiene required total assistance. Under the Pain Management section Have you had pain or hurting at any time in the last 5 days? Answer yes was marked. Under pain frequency How much of the time have you experienced pain or hurting over the last 5 days? Unable to answer was marked. Under Pain Intensity Please rate the intensity of your worst pain over the last 5 days. Unable to answer was marked. Staff assessment for pain included non-verbal sounds, vocal complaints of pain and facial expressions. Contractures revealed impairment on both sides. Review of the comprehensive plan of care, dated 9/19/11 with a review date of 2/25/15 for resident #1 revealed problem/ need was resident #1 complains of increased pain/discomfort. Resident #1 will yell out and cry when she is in pain. Pain related to generalized pain in bilateral lower extremities and contractures. Goal: Will maintain current ADLs and pain/discomfort will be relieved with in one hour after intervention over next 90 days. Approach included 1) Observe for s/s (signs/symptoms) of increased pain/discomfort-assess resident for possible causes give meds (medications), txs (treatments), physical and relaxation modalities, etc. assess for relief. 2) Provide pressure relieving and positioning devices- as needed. 3) Assist with ADLs and comfort measures- as needed. 4) Allow to verbalize feelings of pain and discomfort. 5) Encourage socialization and activity attendance-as tolerated. Review of the comprehensive plan of care, dated 9/19/11 with a review date of 2/25/15 for resident #1 revealed problem/ need was resident has impaired communication evidenced by: Resident #1 mumbles at times when she speaks. Needs time to formulate her thoughts to words at times. Misses parts and intents of statements. Goal: Staff will anticipate and meet all needs that the resident is not able to communicate effectively over the next 90 days. Approach included 1) reduce or remove all interfering enviromental stimuli. 2) Use terms, gestures that resident can understand--repeat PRN. 3) Approach in a calm manner, call by name. 4) Allow time for resident to digest information--do not rush. Review of the Pain Evaluation, dated 3/2/15, for resident #1 revealed: 1. Pain Management: She received PRN (as needed) pain medications and received non-medication intervention for pain. 2. Pain Interview: Ask Resident Have you had pain or hurting at any time in the last 5 days? The answer marked was unable to answer. 3. Location of Pain/Hurting: The back was marked. 4. Potential Underlying Cause: included immobility, contracture and ulcer/wound. 5. Intensity of pain on scale 0-10: worst pain/hurting gets 7 (indicated hurts whole lot). 6. What Relieves the Pain/Hurting? Rest, massage, medication administration. 7. Describe Quality of Pain/Hurting: Throbbing. 8. Timing and Contributing Factors: Repositioning, with ADLs (Activities of Daily Living). 9. Manner of Expressing Pain & Associated Symptoms: Grimacing, Groaning and Screaming. 10: Has Pain Interfered with any of the Following: unable to verbalize. Review of a Physician's Progress Note, dated 1/15/15, for resident #1 by Physician HH revealed according to nursing staff's verbal report there had been no recent aggression or agitation towards staff or others, does at times yell out, scream but mostly b/c (because) of pain. Review of a Progress Note, dated 2/24/15 for resident #1 revealed [DIAGNOSES REDACTED]. Review of the Nursing Weekly/Monthly Summary, dated 3/2015, revealed resident #1's mental status was alert, unaware, confused, memory loss, orientation fluctuates, short-term and long-term. Cognition indicated frequently loses train of thought in conversation, attention deficit and disorientation. Pain revealed daily, moderate, back, relieved by medication. Observation on 4/21/15 at 1:30 p.m. revealed resident #1 lying in bed. Resident #1 was verbal, but hard to understand what she was saying at times. Observation on 4/21/15 at 4:10 p.m. with CNA FF and GG revealed they provided incontinent care for resident #1 in her room. When CNA FF and GG began to remove the covers and place resident #1 on her back she began to cry out. During the perineal care and repositioning resident #1 was crying out. A Stage II pressure sore was noted to the sacrum and excoriation to the rectal area. Observation on 4/22/15 at 11:45 a.m. revealed wound care with the Treatment Nurse for resident #1. Resident was crying out during the care. The Treatment Nurse said resident #1 likes to be left alone. Resident #1 had a soft formed stool which was cleaned by the Treatment Nurse. Excoriation was noted to the rectal area. The Treatment Nurse stated resident #1 had issues with diarrhea. During the cleaning of the stool and the wound care resident #1 was crying and yelling during the care. Four wounds were provided care. Resident #1 said she was hurting when she was asked by the staff after the care. During an interview on 4/22/15 at 12:10 p.m. the Treatment Nurse said she thinks resident #1 had a [MEDICATION NAME] Patch. The Treatment Nurse said Resident #1 had an [MEDICATION NAME]. We deal with this daily. When asked about medicating resident #1 for pain the Treatment Nurse said we definitely could medicate her for pain. Interview on 4/22/15 at 12:35 p.m. with LVN E, charge nurse revealed resident #1 was out of pain medication, [MEDICATION NAME]. She stated she had faxed resident #1's physician prior to resident #1 running out of the medication (did not remember the date) and had refaxed the physician again on 4/20/15 for a refill. LVN E provided a copy of the fax sent on 4/20/15. LVN E stated she had told ADON V resident #1 was out of her [MEDICATION NAME]. LVN E said resident #1's physician was in the building yesterday morning (4/21/15). When asked what she would do if resident #1 needed a pain medication she was unable to provide an answer. LVN E stated resident #1 did not have pain unless they were working with her and then she gets upset and agitated. During interview on 4/22/15 at 12:50 p.m. ADON V said it was like pulling teeth to get a triplicate from Physician J. Physician J has been changing all of his residents' [MEDICATION NAME] to Tylenol #3 (pain medication). The process for getting a refill was to call the physician a few days before a resident ran out of medication. During interview on 4/22/15 at 3:20 p.m. ADON V said the facility did not have an emergency narcotic kit. During interview on 4/22/15 at 3:25 p.m. LVN I, Charge Nurse, said when you start to provide care for resident #1 she tries to hit and uses foul words. LVN I confirmed she had contractures. LVN I said resident #1 had Tylenol and [MEDICATION NAME] as needed. LVN I said he did not notice resident #1 yelling when he applied the cream yesterday (4/21/15). LVN I said resident #1 can verbalize pain. LVN I was unaware resident #1 was out of her pain medication. Interview on 4/23/15 at 8:30 a.m. with the Treatment Nurse revealed resident #1 had excoriation from the stool. an order for [REDACTED]. When the slough was gone the area was a Stage III. The Treatment Nurse said Resident #1 now has a healing Stage III and excoriation to the buttocks and inner thighs. The Treatment Nurse said she assessed for pain and would medicate her if necessary prior to treatment. Resident #1 had behaviors and tells us to leave her alone. Resident #1 will tell us sometimes if in pain. The Treatment Nurse said she knew the excoriation was painful, and was not aware resident #1 was out of pain medication until yesterday (4/22/15). The Treatment Nurse said she asks resident #1 if in pain prior to beginning treatment. Interview on 4/27/15 at 11:48 a.m. with the Treatment Nurse revealed the Triad Colopast was a barrier cream. It was not an [MEDICATION NAME], but the physician ordered it to use to control pain. Interview on 4/22/15 at 3:45 p.m. with LVN E revealed she assessed the residents for pain. If a resident was verbal she would use the 0-10 scale. For a nonverbal resident she would watch for facial expressions, eyes get bigger. LVN E heard resident #1 yelling, and resident #1 can tell her yes or no. LVN E said she gave resident #1 her pain medication ([MEDICATION NAME]) in the morning when resident #1 told her she had pain. [MEDICATION NAME] was last given on 4/18/15. LVN E said between 4/18/15 and 4/22/15 resident #1 had not had pain. Surveyor observation on 4/21 and 4/22 revealed resident #1 was in pain during perineal care and wound care. LVN E said the Medical Director had not been contacted in regards to resident #1 being out of pain mediation. LVN E said there was no phone call to the Physician after she faxed the two requests to the Physician. The Administrator, DON and Regional Nurse were notified of the IJ on 4/22/15 at 5:12 p.m. Interview on 4/24/15 at 9:50 a.m. with the DON revealed she should be informed when medications are not available. The DON said she was not aware of resident #1 being out of [MEDICATION NAME] until 4/22/15 when the Tylenol #3 came in for resident #1. The DON said pain assessments were done on the monthly and quarterly summaries, on a change in condition and assessed on their ADLs by the CNAs. If the residents exhibit a change the CNA reports to the nurse who will assess the resident. The facility submitted a plan of removal dated 4/23/15 at 8:15 a.m. to remove the immediacy consisting of the following actions: Medication availability

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) 1) The facility immediately contacted the physician and requested that if he insisted on DCing [MEDICATION NAME] that he could provide an alternative. MD again stated he was not going to continue resident on [MEDICATION NAME] and DCd [MEDICATION NAME], ordered Tylenol 3. Tylenol 3 delivered from pharmacy. This was completed on (4/22) and Tylenol 3 was received from pharmacy at 3:30pm. 2) The facility immediately assessed all residents who receive [MEDICATION NAME] routine and/or PRN for pain management to verify that those residents had [MEDICATION NAME] available. This was completed on (4/22) 3) All residents who are on [MEDICATION NAME] were identified as at risk for pain due to medication availability issues. There were 8 residents on halls 1 & 2 who receive [MEDICATION NAME] for pain management and residents 10 on Rosewood who receive [MEDICATION NAME] for pain. 4) Staff education was conducted for how to handle pain medication availability issues, assessing for pain, and notification of DON when unable to obtain pain medications for residents. RN and LVNs in serviced on notification of the Medical Director when unable to obtain pain medication to request medical director to help facility to obtain medication. All RNS and LVNs were in serviced by (4/22) with the exception of 4 who were out of town. These 4 will be in serviced by (4/23), prior to working any shift. 5) The DON and/or designee will check each hall for pain medication availability each day. DON will report any issues to QA subcommittee weekly for 1 month, and monthly for 2 months. 6) Date of correction 4/22/15 Pain Assessment 1) The facility immediately started in-servicing LVN/RN on how to conduct appropriate pain assessments. All RNs and LVNs were in serviced by (4/22) with the exception of 4 who were out of town. These 4 will be in serviced by (4/23) prior to working any shift. 2) Facility will begin pain assessments on all 81 residents utilizing the facility pain assessment form. These assessments will be complete by 11:00 pm on (4/22) 3) Any resident who is identified as flagging for pain, the MD will be notified and the care plan updated. Completed by (4/22) 4) DON will review all residents who are found to have pain, these will be reviewed with the QA subcommittee weekly for 1 month and monthly for 2 months. 5) Date of correction: 4/22/15 Verification of Plan of Removal: Observation of resident #1 on 4/23/15 at 7:40 a.m. revealed she was lying in bed with head of bed elevated. Resident #1 had her eyes closed and appeared to be comfortable. Interview on 4/23/15 at 2:50 p.m. with LVN D revealed that he had received an in-service on pain management and the documentation of pain both physical and non-verbal. Interview on 4/23/15 at 3:05 p.m. with LVN E revealed that she had received an in-service on pain management and the documentation of pain both physical and non-verbal. Interview on 4/23/15 at 3:15 p.m. with LVN F revealed that he had received an in-service on pain management and the documentation of pain both physical and non-verbal. On 4/23/15 at 2:40 p.m. the Administrator was informed the IJ was removed. However the facility remained out of compliance at a severity level of actual harm with a scope of pattern. 2. Review of resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of catheter care on 4/23/15 at 3:07 p.m. for resident #2 with CNA AA revealed the CNA pulled the penis back towards the abdomen, which resulted in the catheter tubing to become taut and was stretched. Interview with CNA AA on 4/23/15 at 3:16 p.m. revealed she had not had much experience providing catheter care to residents. The CNA confirmed the catheter tubing was pulled during the catheter care to resident #2. Interview with resident #2 on 4/24/15 at 8:06 a.m. revealed he did not have any pain during catheter care on 4/23/15 with CNA AA. Resident #2 stated it's always kind of sensitive down there in that area. 3. Review of resident #3's face sheet dated 4/9/15 revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of resident #3's medical record revealed a hospital discharge progress note dated 4/9/15 that indicated the resident was being discharged from the hospital to the facility with a urinary catheter due to [MEDICAL CONDITION]. A Physician Telephone Order in resident #3's medical record, dated 4/10/15, revealed an order to make an appoinment with a Urologist for [MEDICAL CONDITION] Bladder. Additionally, a care plan, dated 4/9/15, located in the record revealed resident #3 was non-compliant with anchoring his catheter on his wheel chair above the level of the bladder, placing him at risk for Urinary Tract Infections. Observation on 4/21/15 at 7:51 a.m., during initial rounds with ADON N on 400 Hall, revealed resident #3 was near the nurses station on the Rosewood side (300 and 400 Hall) in an electric motorized wheel chair. Closer observation of the resident revealed he had a urinary catheter bag attached to the arm rest on his wheel chair, causing the catheter bag to be raised above the level of the bladder, as well as not having a privacy bag. ADON N, who also observed the catheter bag attached to the wheel chair arm rest and without a privacy bag, asked LVN P to escort resident #3 to his room and assist him with attaching a privacy bag on his wheel chair for his catheter. Observation on 4/21/15 at 7:58 a.m. revealed resident #3 leaving his room in his electric wheel chair, and LVN P following behind him. Closer observation of the wheel chair revealed the resident's catheter had been placed in a privacy bag, however, the privacy bag was attached to the arm rest of the resident's wheel chair, causing the catheter to be above the level of the bladder. Interview on 4/21/15 at 8:12 a.m. with ADON N revealed she had not seen the catheter bag attached to the arm rest as resident #3 and LVN P left his room. The ADON went on to say he had probably gone outside to smoke a cigarette, but she would check it when he returned. Observation on 4/21/15 at 9:15 a.m., after finishing initial rounds with ADON N on 400 Hall, revealed resident #3 had returned from outside and he was heading toward his room in his electric wheel chair. Observation of his powered chair revealed the catheter bag was attached to the chair's arm rest, which caused the catheter to be above the level of the bladder. ADON N confirmed LVN P should have lowered the catheter bag when she attached it to his wheel chair. Review of the facility policy and procedure titled Lippincott Procedures-Indwelling catheter care and management, revised 10/3/2014, revealed: When cleaning the periurethral area, clean the area carefully to prevent catheter movement and urethral traction, which increase the risk of CAUTI (Catheter Acquired Urinary Tract Infection); Provide enough slack before securing the catheter to prevent tension on the tubing, which could injure the urethral lumen and bladder wall.; and .keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI. Review of CMS-672 Resident Census and Condition of Residents, completed by the facility on 4/21/15, revealed 41 residents (out of 81 census) were on a pain management program and 8 residents had indwelling or external catheters.
F 0314 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 2 of 3 residents (#1, 2) observed for wound care in that: 1. Resident #1's wound was cleaned with a back and forth movement instead of circular from inside the wound outward by RN U. 2. Resident #2's wound vac was set at 150 mmHg instead of the 125 mmHg as ordered by the physician. This deficient practice could affect 5 residents with pressure sores and 2 residents with wound vac treatments and could result in the spread of infection and further skin breakdown.

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F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) The findings were: 1. Review of the face sheet, dated 8/27/13, for resident #1 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Physician's Telephone Orders, dated 4/22/15 revealed to cleanse wound and periwound with normal saline, apply Triad barrier cream daily to wound and periwound. A second order, dated 4/22/15, revealed excoriation to buttocks and periarea: Cleanse areas with normal saline, apply Triad barrier cream daily to wounds and periwound skin. Observation of wound care on 4/22/15 at 11:45 a.m. for resident #1 by RN U revealed the wound to the sacrum was cleaned with normal saline and gauze. RN U used the gauze with normal saline and wiped the wound back and forth instead of using circular motion from center to outside of wound. During interview on 4/23/15 at 8:30 a.m. RN U said she wiped back and forth on the wound for resident #1 when asked about her technique. 2. Review of resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Physician's Telephone Orders, dated 4/17/15 revealed on the sacral wound to apply wound vac dressing, setting negative pressure to 125 mmHg continuous. Observation on 4/21/15 at 1:40 p.m. revealed the wound vac machine for resident #2 was set at 150 mmHg. Observation on 4/22/15 at 7:50 a.m. revealed the wound vac machine for resident #2 was set at 150 mmHg. Interview with RN U, on 4/22/15 at 10:20 a.m. during wound care, revealed the wound vac setting for resident #2 was suppose to be at 125 mmHg but the nurse practitioner turned it up to 150 mmHg on Monday (5/4/15) but did not write an order for [REDACTED]. Further interview with RN U on 4/24/15 at 10:10 a.m. revealed a wound vac set at a higher level than ordered could increase pressure to the excoriated area and cause a deep tissue injury. RN U reported the nurse practitioner had increased the wound vac setting to ensure the dressing had a good seal. Review of CMS-672 Resident Census and Condition of Residents, completed by the facility on 4/21/15, revealed 5 residents had pressure ulcers. Information provided by the facility on 4/28/15 revealed 2 residents received wound vac treatment.
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident's with indwelling catheters received the appropriate treatment and services for 2 of 3 residents (#2 and 3) reviewed for catheters, in that: 1. Resident #2's urinary catheter tubing was pulled during catheter care. 2. Resident #3's urinary catheter bag was attached to his wheel chair above the level of the bladder. This deficient practice could affect 8 residents with urinary catheters and could result in an increase in urinary tract infections. Findings were: 1. Review of resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of catheter care on 4/23/15 at 3:07 p.m. for resident #2 with CNA AA revealed the CNA pulled the penis back towards the abdomen, which resulted in the catheter tubing to became taut and was stretched. Interview with CNA AA on 4/23/15 at 3:16 p.m. revealed she had not had much experience providing catheter care to residents. The CNA confirmed the catheter tubing was pulled during the catheter care to resident #2. Interview with resident #2 on 4/24/15 at 8:06 a.m. revealed he did not have any pain during catheter care on 4/23/15 with CNA AA. Resident #2 stated it's always kind of sensitive down there in that area. 2. Review of resident #3's face sheet dated 4/9/15 revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of resident #3's medical record revealed a hospital discharge progress note dated 4/9/15 that indicated the resident was being discharged from the hospital to the facility with a urinary catheter due to [MEDICAL CONDITION]. A Physician Telephone Order in resident #3's medical record, dated 4/10/15, revealed an order to make an appointment with a Urologist for [MEDICAL CONDITION] Bladder. Additionally, a care plan, dated 4/9/15, located in the record revealed resident #3 was non-compliant with anchoring his catheter on his wheel chair above the level of the bladder, placing him at risk for Urinary Tract Infections. Observation on 4/21/15 at 7:51 a.m., during initial rounds with ADON N on 400 Hall, revealed resident #3 was near the nurses station on the Rosewood side (300 and 400 Hall) in an electric motorized wheel chair. Closer observation of the resident revealed he had a urinary catheter bag attached to the arm rest on his wheel chair, causing the catheter bag to be raised above the level of the bladder, as well as not having a privacy bag. ADON N, who also observed the catheter bag attached to the wheel chair arm rest and without a privacy bag, asked LVN P to escort resident #3 to his room and assist him with attaching a privacy bag on his wheel chair for his catheter. Observation on 4/21/15 at 7:58 a.m. revealed resident #3 leaving his room in his electric wheel chair, and LVN P following behind him. Closer observation of the wheel chair revealed the resident's catheter had been placed in a privacy bag, however, the privacy bag was attached to the arm rest of the resident's wheel chair, causing the catheter to be above the level of the bladder. Observation on 4/21/15 at 9:15 a.m., after finishing initial rounds with ADON N on 400 Hall, revealed resident #3 had returned from outside and he was heading toward his room in his electric wheel chair. Observation of his powered chair revealed the catheter bag was attached to the chair's arm rest, which caused the catheter to be above the level of the bladder. ADON N confirmed LVN P should have lowered the catheter bag when she attached it to his wheel chair. Review of the facility policy and procedure titled Lippincott Procedures-Indwelling catheter care and management, revised 10/3/2014, revealed: When cleaning the periurethral area, clean the area carefully to prevent catheter movement and urethral traction, which increase the risk of CAUTI (Catheter Acquired Urinary Tract Infection); Provide enough slack before securing the catheter to prevent tension on the tubing, which could injure the urethral lumen and bladder wall.; and .keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI. Review of CMS-672 Resident Census and Condition of Residents, completed by the facility on 4/21/15, revealed 8 residents had indwelling or external catheters.
F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident maintained acceptable parameters of nutritional status and received a therapeutic diet when there was a nutritional problem for one Resident (Resident #2) of two residents reviewed for unplanned weight loss or gain. Resident #2 had weight loss and had not received yogurt for extra calories as indicated on the resident's tray card. This failure could place one resident identified with weight loss or gain at risk of further weight loss or gain, increased risk of pressure ulcers and an overall decline in their physical, and psychosocial condition. Findings were: Review of resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].

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F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) Review of the Hospital Reconciliation Report where resident #2 was discharged from, dated 4/16/15, revealed the resident was to continue to receive, upon discharge, a chocolate high protein milkshake at the noon meal. Review of resident #2's admission orders [REDACTED]. No chocolate high protein milkshake was listed on the orders to be served at the noon meal. Review of the physician telephone orders revealed no order for a chocolate high protein milkshake to be served at the noon meal. Interview with ADON N on 4/24/15 at 7:40 a.m. confirmed chocolate high protein milkshake at the noon meal was listed on the Hospital Reconciliation Report where resident #2 had been discharged from. ADON N looked through the admission orders [REDACTED]. Further interview with ADON N on 4/28/15 at 8:27 a.m. revealed she spoken with the FSS who obtained resident #2's food preferences. The FSS reported resident #2 stated he did not like drinking milk products but was willing to receive yogurt instead, so yogurt was added to his tray card to be served at all meals, in place of the chocolate high protein milkshake. Review of the dietitian's Medical Nutritional Assessment, dated 4/20/15, revealed Resident #2 estimated caloric need was 2585 calories per day. The dietitian estimated [MEDICATION NAME] 1.5 at 100 cc/hour for 12 hours provided 1800 calories. Under WEIGHT TRACKING section, the dietitian had noted resident #2's weight at the hospital was 176.8 pounds and his admission weight at the facility was 162.5 pounds. The Desirable Body Weight range listed for Resident #2 was 182-222 pounds. Under the ASSESSMENT section, the dietitian noted resident #2 fed himself after tray set up with adaptive equipment which consisted of built-up utensils and a divided plate. The dietitian noted resident #2 had dysphagia with a history of poor intake per the hospital notes and the resident had increased (nutritional) needs for (wound) healing. The dietitian's goal was for resident #2 was to maintain weight. Observation of Resident #2 in his room on 4/22/15 from 12:51 p.m. to 12:56 p.m. revealed on his noon meal tray was served a container of yogurt, 4 ounces of juice, [MEDICATION NAME] pie, corn, cornbread, and tapioca pudding. Interview with Resident #2 at this time revealed he had only consumed the yogurt and drank the juice. Review of Resident #2's tray card on his breakfast tray, on 4/23/15, revealed yogurt - 4 oz was listed near the bottom. Observation of Resident #2's breakfast tray in his room, on 4/23/15 at 8:35 a.m. revealed the resident was served ground sausage and pancakes on a flat plate, bowl of bran cereal and 1 carton of 2% milk. There were orange peels on the tray. Interview with the resident at this time confirmed he only ate the orange and a few bites of cereal and did not receive any yogurt as indicated on his tray card. Interview with LVN R on 4/24/15 at 11:12 a.m. revealed resident #2 was weighed on 4/22/15 and his weight was 162 pounds. Review of CMS-672 Resident Census and Condition of Residents, completed by the facility on 4/21/15, revealed 1 resident had unplanned weight loss or gain.
F 0366 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Offer other nutritional food to each resident who will not eat the food served.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a meal substitution of similar nutritive value for foods on the planned menu for 1 of 2 meals observed. Resident #2 was not offered a food substitute from the regular menu when he only had consummed 4 ounces of yogurt and juice at the noon meal. This failure could place 74 residents who received food prepared in the kitchen at risk for unsatisfactory meal choice, weight loss. Findings were: Review of resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of resident #2's admission orders [REDACTED]. Observation of Resident #2 in his room on 4/22/15 from 12:51 p.m. to 12:56 p.m. revealed on his noon meal tray was served a container of yogurt, 4 ounces of juice, [MEDICATION NAME] pie, corn, cornbread, and tapioca pudding. Interview with Resident #2 at this time revealed he had only consumed the yogurt and drank the juice." Observation of Resident #2 in his room revealed CNA AA entered the room and spoke to the resident. CNA AA encouraged Resident #2 to finish the last bit of juice in the glass and encourage the resident to eat some of the food on the tray. CNA AA did not attempt to offer Resident #2 an alternate or substitute. Interview with CNA AA on 4/22/15 at 1:03 p.m., outside of resident #2's room, confirmed the resident had only consumed the yogurt and juice. CNA AA confirmed she had not asked Resident #2 if he wanted an alternate or substitute entree and vegetable. Information provided by the facility on 4/28/15 revealed 74 residents received food from the kitchen.
F 0369 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide special eating equipment and utensils for each resident who needs them.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide special eating equipment and utensils for residents who need them for 2 of 11 residents (Resident #2 and 11) reviewed for meal assistance and assistive devices, in that: 1. Resident #2 did not receive a divided plate for one meal as ordered. 2. Resident #11 did not receive a built up fork for one meal as ordered. This deficient practice could affect the 11 residents who used adaptive equipment during meals, and could place them at risk for decreased independence during meals, potential weight loss, and potential loss of dignity. Findings were: 1. Review of resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's physician's telephone orders revealed on 4/17/15 OT (Occupational Therapist) wrote a clarification order that stated pt (patient) to have wide grip utensils for all meals, divided plate all meals. Observation of Resident #2's breakfast tray in his room, on 4/23/15 at 8:35 a.m. revealed the resident was served ground sausage and pancakes on a flat plate, not a divided plate. Interview with the resident at this time confirmed his food was not served on a divided plate. Review of the tray card on Resident #2's breakfast tray revealed a divided plate was listed at the bottom above the resident's name. 2. Review of Resident #11's face sheet, dated 2/28/15, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's medical record revealed the resident was transferred to the hospital on [DATE] due to coffee ground emesis and was readmitted to the facility on [DATE]. Review of Resident #11's physician's telephone orders revealed on 3/3/15 OT wrote a clarification order that stated pt to have plate guard and built up utensils c (with) all meals. Observation of Resident #11 on 4/21/15 at 9:08 a.m. revealed the resident had a built-up spoon and a plate guard on her breakfast tray but no built-up fork. The resident reported at this time that she did not get the built up fork today or yesterday. Interview with LVN R on 4/21/15 at 9:17 a.m. confirmed Resident #11 had not received a built-up fork with her breakfast tray. Interview with OTA (Occupational Therapist Assistant) EE on 4/28/15 at 9:52 a.m. revealed Resident #11 continued to have a need for the built-up utensils when she returned from the hospital and the order for the built-up utensils was to be continued when she was readmitted . Information provided by the facility on 4/28/15 on a hand written note revealed 11 residents used adaptive equipment at meal time.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** Based on observation and interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 kitchen in that:

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F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) 1. Two of three dietary employees (Cook Y and the FSS) did not immerse the cook ware in the sanitizing water for 60 seconds as required for sanitation. 2. Cook Y did not wash a tomato before cutting and placing on a salad. 3. The microwave had food particles splattered inside the microwave for 2 of 2 observations. 4. The ice machine had black spots and a yellow substance on the white chute inside the ice machine for 1 of 2 observations. This deficient practice could affect 74 residents at the facility who were served meals/snacks from the facility kitchen by contributing to foodborne illness and cross contamination. Findings were: 1. Observation of Cook Y on 4/22/15 from 9:33 a.m. to 9:35 a.m. revealed when washing cook ware in the 3-compartment sink, he dipped a steam table pan into the sanitizing water and immediately removed it. Cook Y did not immerse the steam table pan in the sanitizing water for 60 seconds as required for sanitation. Observation of Cook Y on 4/22/15 at 11:35 a.m. revealed when washing the food processor in the 3-compartment sink, he dipped it into the sanitizing water and immediately removed it. Cook Y did not immerse the food processor in the sanitizing water for 60 seconds as required for sanitation. Observation of Cook Y on 4/22/15 at 11:37 a.m. revealed when washing the cutting board, half-size steam table pan, and a cone strainer in the 3-compartment sink, he dipped them into the sanitizing water and immediately removed. Cook Y did not immerse the cutting board, half-size steam table pan, and a cone strainer in the sanitizing water for 60 seconds as required for sanitation. Observation of the FSS on 4/22/15 at 12:45 p.m. revealed when washing the food processor in the 3-compartment sink, she dipped it into the sanitizing water and immediately removed it. The FSS did not immerse the food processor in the sanitizing water for 60 seconds as required for sanitation. Observation of a laminated sign above the 3-compartment sink on 4/23/15 at 1:30 p.m., titled Manual Pot & Pan Wash Procedures, indicated Submerge in sanitizer sink for one minute. Interview with the FSS on 4/23/15 at 4:22 p.m. revealed after the FSS looked at the chart on the wall that cook ware should be submerged for 60 seconds for sanitation. Review of the policy titled Manual Ware Washing, revised 5/2014, revealed service ware and a cook ware that are not washed in the dishmachine would be manually washed and sanitized. Record review of the Texas Food Establishment Rules (TFER), p. 99, §229.165 (p) revealed equipment food-contact surfaces and utensils shall be sanitized. 2. Observation of Cook Y on 4/22/15 at 11:26 a.m. revealed he obtained a tomato from the walk-in cooler and proceeded to cut and dice the tomato without washing it first. Cook Y placed the diced tomato onto 6 salad bowls. Interview with the FSS on 4/23/15 at 4:22 p.m. revealed fresh produce should be washed before it was cut. Review of the policy titled Food Preparation, revised 5/2014, revealed staff would was raw fruits and vegetables as appropriate. Review of the TFER, p. 46, §229.164(f)(6)(A) revealed raw fruits and vegetables shall be thoroughly washed in water to remove soil and other contaminants before being cut, combined with other ingredients, cooked, served, or offered for human consumption in ready-to-eat form. 3. Observation of the microwave on 4/21/15 at 8:30 a.m. revealed on the interior were food particles splattered on the door. Observation of the microwave on 4/22/15 at 4:56 p.m. revealed on the interior were brown food particles splattered on the door and interior bottom of the microwave. Interview with the FSS on 4/23/15 at 4:37 p.m. revealed the microwave should be cleaned every time it is dirty. The FSS reported she had heated up some food for a resident and had made the mess in the microwave about an hour ago and had not cleaned it up. Review of the TFER, p. 93, §229.165(m)(2) revealed equipment and nonfood-contact surfaces shall be clean to sight and touch. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 4. Observation of the ice machine on 4/21/15 at 8:40 a.m. revealed on the interior white chute were black spots and a yellow substance. Interview with the FSS on 4/21/15 at 8:41 a.m. confirmed there were black spots and a yellow substance on the interior white chute of the ice machine. The FSS stated that it looked like it needed to be cleaned. Review of the TFER, p. 96, §229.165(n)(1)(E)(iv)(I)-(II) revealed equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment shall be cleaned at a frequency specified by the manufacturer; or absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. Information provided by the facility on 4/28/15 on a handwritten note revealed 74 residents received meals and snacks from the kitchen.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services to assure accurate acquiring, receiving, dispensing, administering and documenting of all drugs to meet the needs of 5 of 17 residents (#1, 2, 3, 22, 25) reviewed for medications. Expired medication in 1 of 2 medication rooms. 1A. Resident #1 had an order for [REDACTED]. B. Resident #1's Exelon Patch (used for dementia) was not removed as ordered. 2. Resident #2's Sertraline (used for depressive disorder), Docusate Sodium (used for constipation), Metoprolol Tartrate (used for high blood pressure), and Amiodarone (used for high blood pressure) were not documented as given for 1 day. 3. Resident #3's Pantoprozole (used to treat gastroesophageal reflux disease), Effexor (used to treat depression), Vitamin D, Flomax (used to treat difficult urination), Aspirin, Plavix (used to prevent blood clots), Bentyl (used to treat irritable bowel syndrome), Lactobacillus, Metoprolol Tartrate (used to treat high blood pressure), and Flagyl were not documented as not given for 1 day. 4A. Resident #22 had an order for [REDACTED]. B. Resident #22's Xarelto (used to prevent blood clots) and Gabapentin (used to treat neuropathy) were not documented as given for 1 day. 5. MA T discarded a Lasix (diuretic) tablet in the trash for resident #25 instead of in a secure place. 6. One bottle of Sodium Bicarbonate (sodium supplement) in the medication room had an expiration date of 3/15. These deficient practices could affect 8 residents on Hydrocodone on the 100 and 200 Halls, 4 residents who received Tylenol #3 on the 100 Hall, 1 resident on Gabapentin on 100 Hall,1 resident on Xarelto on 100 Hall, 2 residents on Sertraline on 300 Hall, 1 resident on Docusate Sodium on 300 Hall, 1 resident on Metoprolol Tartrate on 300 Hall, 6 resident with medication patches on 100-200 Halls and 1 resident on Amiodarone on 300 Hall and could result in medication errors or residents not being medicated for pain as needed. The findings were: 1. Review of the face sheet, dated 8/27/13, for resident #1 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Observation on 4/22/15 at 12:30 p.m. of the 100 Hall Nurse's MAR Book revealed the narcotic count sheets. Further observation revealed a sheet folded in half in the MAR Book for resident #1. The narcotic sheet was for Hydrocodone for resident #1 and the last dose to be administered was on 4/18/15 at 8:00 a.m. The narcotic sheet had a zero balance in the amount remaining column. No other narcotic sheets were found in the book for Hydrocodone. The only other narcotic sheets in the book for resident #1 was for Ativan (used for anxiety). During interview on 4/22/15 at 12:35 p.m. with LVN E, charge nurse revealed resident #1 was out of her pain medication, Hydrocodone. She stated she had faxed resident #1's physician prior to resident #1 running out of the medication (did not remember the date) and had refaxed the physician again on 4/20/15 for a refill. LVN E provided a copy of the fax sent on

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F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) 4/20/15. LVN E stated she had told ADON V resident #1 was out of her Hydrocodone. LVN E said resident #1's physician was in the building yesterday morning (4/21/15). When asked what she would do if resident #1 needed a pain medication she was unable to provide an answer. LVN E stated resident #1 did not have pain unless they were working with her and then she gets upset and agitated. During interview on 4/22/15 at 12:50 p.m. ADON V said it was like pulling teeth to get a triplicate from Physician J. Physician J had been changing all of his residents' Hydrocodone to Tylenol #3 (pain medication). The process for getting a refill is to call the physician a few days before the resident runs out of medication. During interview on 4/22/15 at 3:20 p.m. ADON V said the facility did not have an emergency narcotic kit. B. Observation on 4/22/15 at 10:15 a.m. revealed LVN E administering medications to resident #1. LVN E placed an Exelon Patch 13.3 mg on resident #1's right upper arm. The Exelon Patch was dated 4/22/15. Review of the Consolidated physician's orders [REDACTED]. Ensure that old patch is removed prior to placing new patch. Further review of the orders did not reveal any other patches ordered. Observation on 4/24/15 at 2:10 p.m. during an observation of attempted wound care with the Treatment Nurse and the DON observing revealed a medication patch on resident #1's right upper arm with a handwritten date of 4/22/15. Interview with the DON at this time confirmed the medication patch was dated 4/22/15. 2. Review of resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of resident #2's admission orders [REDACTED]. Review of resident #2's April MARs revealed the 8 p.m. doses of Sertraline, Docusate Sodium, Metoprolol Tartrate, and Amiodarone were not initialed as given on 4/19/15. Interview with ADON N on 4/27/15 at 3:50 p.m. confirmed the p.m. doses of Sertraline, Docusate Sodium, Metoprolol Tartrate, and Amiodarone were not initialed as given on 4/19/15. During the interview, the ADON N reported she had contacted the MA who administered the medications on 4/19/15 and the MA reported she was certain the medications were administered to resident #2. 3. Review of resident #3's face sheet, dated 4/13/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of resident #3's admission orders [REDACTED]. 2 tablets by mouth every day, Flomax 0.4 mg 1 capsule by mouth every day, Aspirin 81 mg 1 tablet by mouth every day, Plavix 75 mg 1 tablet by mouth every day, Bentyl 10 mg 1 capsule by mouth 4 times a day, Lactobacillus two capsules by mouth every day, Metoprolol Tartrate 25 mg 1/2 tablet by mouth 2 times a day, and Flagyl 500 mg 1 tablet 3 times a day. Review of resident #3's MAR indicated [REDACTED]. In an interview with ADON N on 4/23/15 at 9:30 a.m. she confirmed that there were no initials in resident #3's MAR indicated [REDACTED]. Interview with ADON N on 4/23/15 at 10:55 a.m. revealed she had spoken to LVN P, who had worked on 4/14/15 during the times that the medications were not initialed on the MAR. ADON N stated LVN P had not given the medications to resident #3 because he was out of the building to an appointment. ADON N confirmed LVN P should have indicated on the MAR indicated [REDACTED]. 4. Review of Resident #22's face sheet, dated 10/14/14, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #22's Consolidated Physician order [REDACTED]. Review of Resident #22's April 2015 MARs revealed on 4/20/15 the 8 p.m. dose of Gabapentin was not initialed as administered and on 4/24/15 the 8 p.m. dose of Xarelto was not initialed as administered. Interview with MA DD on 4/27/15 at 2:55 p.m. revealed she had worked on the evenings of 4/20/15 and 4/24/15 and had given the Gabapentin and Xarelto to Resident #22. MA DD confirmed the Gabapentin and Xarelto were not initialed as administered on 4/20/15 and 4/24/15 respectively. Review of Resident #22's telephone orders revealed an order dated 4/3/15 to discontinue Norco 5 mg-325 mg (a pain medication) and to start Tylenol #3 two tabs by mouth every 6 hours as needed for pain. Review of Resident #22's April 2015 MARs revealed next to Norco 5 mg-325 mg was hand written D/C'd 4/3/15. Further review of the MARs revealed no order for Tylenol #3. Interview with LVN E on 4/27/15 at 3:05 p.m. confirmed Tylenol #3 was not listed on the April MARs. LVN E looked through the physician's telephone orders and confirmed a telephone order had been written on 4/3/15 for Tylenol #3. LVN E stated Resident #22 had not complained of any pain in the last month. 5. During observation of medication pass on 4/22/15 at 8:40 a.m. with MA T revealed she popped a Lasix 20 mg out of a blister pack for resident #25 and then realized the Lasix was not to be administered that day. MA T discarded the Lasix tablet in the trash on the medication cart. During interview on 4/22/15 at 9:35 a.m. MA T said she had thrown the Lasix in the trash. She said she should have crushed the Lasix before discarding the medication. Review of the Pharmacy Services and Procedures Manual, dated 2013, revealed a policy titled Disposal/Destruction of Expired or Discontinued Medications. The policy revealed at 13.2 Wasted single doses of medication for disposal should be disposed of in a manner that limits access to them by unauthorized personnel or residents. 6. Observation on 4/23/15 at 1:45 p.m. of the Barrington Hall (100 & 200 Halls) medication room with LVN X revealed a large bottle of Sodium Bicarbonate 10 grain (650 mg) with an expiration date of 3/15. Interview with LVN X during the observation revealed the bottle of Sodium Bicarbonate had expired last month. Review of the Pharmacy Services and Procedures Manual, dated 2013, revealed a policy titled Disposal/Destruction of Expired or Discontinued Medications. The policy revealed at 4. Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. Information provided by the facility revealed 1 resident on Pantoprozole on 400 Hall, 2 residents on Effexor on 400 Hall, 7 residents on Vitamin D on 400 Hall, 5 residents on Flomax on 400 Hall, 7 residents on Aspirin on 400 Hall, 1 resident on Plavix on 400 Hall, 1 resident on Lactobacillus on 400 Hall, 6 residents on Metoprolol Tartrate on 400 Hall, 1 resident on Bentyl on 400 Hall, 1 resident on Flagyl on 400 Hall, 4 residents on Tylenol #3 on 100 Hall, 1 resident on Gabapentin on 100 Hall, 1 resident on Xarelto on 100 Hall, 2 residents on Sertraline on 300 Hall, 1 resident on Docusate Sodium on 300 Hall, 1 resident on Metoprolol Tartrate on 300 Hall, 6 resident with medication patches on 100-200 Halls and 1 resident on Amiodarone on 300 Hall.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure drugs were labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions for 1 of 6 residents (#1) observed during medication pass in that: Ativan (used for anxiety) for resident #1 was labeled by mouth instead of per gastrostomy tube (tube in the stomach for the administration of nutrition and medications). This deficient practice could affect 7 residents who received medications through a gastrostomy tube and could result in a resident receiving a medication by the wrong route. The findings were: Review of the face sheet, dated 8/27/13, for resident #1 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Consolidated physician's orders [REDACTED].#1 revealed an order for [REDACTED]. Observation on 4/22/15 at 10:15 a.m. during the medication pass revealed LVN E administered resident #1 Ativan 1 mg tablet through the gastrostomy tube. Further observation of the blister pack after the administration of the Ativan with LVN E revealed the label read by mouth.

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	455804	A. BUILDING _____ B. WING _____	04/28/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHGATE HEALTH AND REHABILITATION CENTER	5757 N KNOLL SAN ANTONIO, TX 78240

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F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) In an interview with LVN E during the observation revealed the Ativan blister pack should read per gastrostomy tube. Information provided by the facility revealed 7 residents received medications through a gastrostomy tube.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for 5 of 11 residents (Resident #4, 24, 3, 12 and 2) observed for infection control in that: 1. LVN E did not remove her gloves after providing tracheostomy care to resident #4 and then used the ambu bag with the same soiled gloves used to do the trach care. 2. CNA BB did not use sanitizer or wash his hands after removing soiled gloves when perineal care was provided to Resident #24 and CNA BB handled clean linen with soiled gloves. 3. CNA AA did not use sanitizer or wash her hands after removing soiled gloves when catheter care was provided to Resident #2. 4. CNA Z and CNA CC did not use sanitizer or wash their hands after removing soiled gloves when catheter care was provided to Resident #3. 5. CNA Z and CNA CC did not use sanitizer or wash their hands after removing soiled gloves when perineal care was provided to Resident #12. This deficient practice could affect 2 residents with a tracheostomy, 8 residents with indwelling or external catheters, 5 residents on the 300 Hall and 15 residents on the 400 Hall who required incontinent care and could result in the spread of infection and disease. The findings were: 1. Observation on 4/24/15 at 11:10 a.m. with LVN E revealed she provided tracheostomy care for resident #4. LVN E placed a pair of sterile gloves on and then removing the cannula and cleaned the cannula in hydrogen peroxide and rinsed the cannula in sterile water. LVN E replaced the cannula with the sterile gloves on and then removed an ambu bag from a plastic bag, with the same soiled gloves used to clean the cannula, and provided two breaths of oxygen to resident #4. LVN E placed the ambu bag back in a plastic bag and then removed the soiled gloves used to clean the cannula. During interview on 4/24/15 at 11:35 a.m. LVN E said she changed her gloves after cleaning the cannula and using the ambu bag. 2. Review of the face sheet, dated 3/23/15, for resident #24 revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of perineal care on 4/21/15 at 3:40 p.m. for Resident #24 with CNA BB revealed the CNA removed his soiled gloves and donned clean gloves three times with out washing his hands or using hand sanitizer before the clean gloves were applied. During the perineal care, CNA BB placed a clean incontinent brief under the resident. The CNA then asked the resident to roll to his side and the CNA removed the soiled brief and incontinent pad with his gloved hands. With the same soiled gloves, CNA BB straightened the incontinent pad and incontinent brief. Interview with CNA BB on 4/21/15 at 3:55 p.m. confirmed he did not change his soiled gloves after handling the soiled brief and incontinent pad and he did not use hand sanitizer or wash his hands after soiled gloves were removed. 3. Review of Resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of catheter care on 4/23/15 at 3:07 p.m. for Resident #2 with CNA AA revealed the CNA did not change gloves after they were soiled from cleaning the catheter and penis before touching the incontinent brief. Interview with CNA AA on 4/23/15 at 3:16 p.m. confirmed she did not remove the soiled gloves before touching the incontinent brief. 4. Review of Resident #3's face sheet, dated 4/13/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of catheter care on 4/24/15 at 10:15 a.m. for Resident #3 with CNA Z and CNA CC revealed the CNAs did not wash their hands or use hand sanitizer after soiled gloves were removed and before clean gloves were donned. 5. Review of Resident #12's face sheet, dated 4/23/15, revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of perineal care on 4/24/15 at 11:46 a.m. for Resident #12 with CNA Z and CNA CC revealed the CNAs did not wash their hands or use hand sanitizer after soiled gloves were removed and before clean gloves were donned. Interview with CNA Z and CNA CC on 4/24/15 at 12:05 p.m. confirmed they did not use hand sanitizer or wash their hands every time a soiled glove was removed. Review of the facility's policy from Lippincott Procedures-Hand Hygeine, 2015, revealed Using an alcohol-based hand rub is appropriate for decontaminating the hands .before putting on gloves;.after removing gloves;. Review of CMS-672 Resident Census and Condition of Residents, completed by the facility on 4/21/15, revealed 8 residents had indwelling or external catheters and 2 residents required tracheostomy care. A sheet provided by the facility revealed 5 residents on the 300 Hall and 15 residents on the 400 Hall required incontinent care.
F 0456 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Keep all essential equipment working safely.** Based on observation and interview, the facility failed to maintain essential, electrical equipment in safe operating condition when build-ups of dust, lint, and debris were observed in 3 of 3 dryers. Two dryers had a build-up of lint on the screens and one dryer had a build-up of lint on the floor of the dryer. This deficient practice could affect 81 residents in the facility and place them at risk of fire and injury. The findings were: Observation on 4/27/15 at 11:10 a.m. revealed 2 of 3 dryers in the facility laundry room that was attached to the facility had a build-up of lint, approximately 1 inch thick on the lint screen. One dryer had an inch thick build-up of lint on the floor. Interview on 4/27/15 at 11:15 a.m. with the Laundry Supervisor revealed the laundry staff were suppose to clean the lint screen every hour, and record that it was done. He went on to say with the amount of lint on the screens he did not believe the screens had been cleaned today. The Laundry Supervisor reviewed the record where staff record the lint had been removed hourly and nothing it had not been signed for 5 hours. Interview on 4/27/15 at 11:20 a.m. with Laundry Employee (LE) Q, who had been working in the laundry since 6:00 a.m. and was in charge of cleaning the lint screens, revealed she had not cleaned the lint screens that day. An in-service provided by the Laundry Supervisor titled Lint Screen Cleaning, dated 12/15/14, revealed to keep accumulating lint inside dryers from traveling up to the top of the dryers near the flame, dryers are attached with screens to catch the lint. If the lint screens are not cleaned, the screens will prevent air from circulating through the dryers and is a definite fire hazard. The in-service reported the lint screen should be cleaned every two or three loads. At the bottom of the in-service, staff had signed to confirm they had attended the in-service and were trained on lint screen cleaning. LE Q had signed the in-service confirming she had been trained on cleaning the lint screens. The facility completed CMS 672, dated 4/21/15 reflected a census of 81.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 2 of 5 CNAs (FF, AA) were able to demonstrate competency in skills and techniques necessary to care for residents needs for 2 of 6 residents (#1, 2) observed for incontinent care and indwelling catheter care in that:

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F 0498 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) 1. CNA FF wiped Resident #1's rectal area toward the vaginal area instead of from vaginal to rectal area. 2. CNA AA tugged on Resident #2's urinary catheter, pulling it taut. This deficient practice could affect 18 residents incontinent on the 100 Hall and 8 residents with indwelling catheters and could result in infection. The findings were: 1. Observation on 4/21/15 at 4:10 p.m. with CNA FF and GG revealed they provided incontinent care for resident #1 in her room. During the care CNA FF wiped the rectal area from the rectal area toward the vaginal area instead of from the vaginal area to the rectal area. Interview with CNA FF after the care revealed she thought she wiped down from rectal area, but stated she could not remember. Review of the facility policy and procedure titled Lippincott Procedures-Perineal care of the female patient, dated 2015 revealed clean, rinse, and dry the anal area, starting at the posterior vaginal opening and wiping from front to back. After cleaning the perineum, apply a moisture-barrier skin protectant, as needed. 2. Review of Resident #2's face sheet, dated 4/20/15, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation of catheter care on 4/23/15 at 3:07 p.m. for Resident #2 with CNA AA revealed the CNA pulled the penis back towards the abdomen, which resulted in the catheter tubing to become taut and was stretched. Interview with CNA AA on 4/23/15 at 3:16 p.m. revealed she had not had much experience providing catheter care to residents. The CNA confirmed the catheter tubing was pulled during the catheter care to Resident #2. Review of Resident Care Specialist (CNA) Competency Worksheet for CNA AA revealed on 8/31/14 the CNA demonstrated competence in care of Foley (indwelling) catheters. Review of the facility policy and procedure titled Lippincott Procedures-Indwelling catheter care and management, revised 10/3/2014, revealed: When cleaning the periurethral area, clean the area carefully to prevent catheter movement and urethral traction, which increase the risk of CAUTI (Catheter Acquired Urinary Tract Infection); and Provide enough slack before securing the catheter to prevent tension on the tubing, which could injure the urethral lumen and bladder wall. Review of CMS-672 Resident Census and Condition of Residents, completed by the facility on 4/21/15, revealed 8 residents had indwelling or external catheters. A sheet provided by the facility revealed 18 residents were incontinent on the 100 Hall.
F 0502 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** Based on observation, interview and record review the facility failed to provide quality and timeliness of laboratory services for 2 of 3 hallways (300, 400 Hall), observed for calibration of glucometers in that: 1. LVN P did not place the glucometer in the test mode to calibrate the glucometer. 2. ADON N and LVN R did not place the glucometer in the test mode to calibrate the glucometer. This deficient practice could affect 11 residents on the 300-400 (Rosewood) Halls and could result in inaccurate blood sugar readings. The findings were: 1. Observation on 4/27/15 at 2:30 p.m. revealed LVN P calibrated the glucometer (test done to verify blood sugar machine was working properly). During the calibration LVN P placed a test strip in the slot of the glucometer and then placed a drop of the low control solution on the lid of the test control solution. The test strip was placed into the solution and a reading was obtained that was within range (LVN P did not place the glucometer in the control test mode). The procedure was repeated with the high control solution. After the testing was complete LVN P was asked if the glucometer had a test control mode and LVN P replied no. 2. Observation on 4/27/15 at 2:40 p.m. revealed LVN R was asked to calibrate the glucometer. LVN R stated she was not sure how to do the procedure. LVN R asked ADON N how to calibrate the glucometer. During the calibration ADON N placed a test strip in the slot of the glucometer and then placed a drop of the low control solution on the lid of the test control solution. The test strip was placed into the solution and a reading was obtained that was within normal range. The procedure was repeated with the high control solution by LVN R. After the testing was completed ADON N was asked if the glucometer had a test control mode and ADON N replied no. ADON N was asked for the calibration directions for the glucometer. ADON N reviewed the directions and said I will show you how to do the calibration correctly. Review of the Blood Glucose Monitoring System User's Guide revealed the following directions. 1. Take a test strip and insert the test strip to turn on the meter. 2. Wait until the flashing blood drop and arrow icons appear on the meter display screen. Press the up or down arrow to enter L1 (low) control solution testing. 3. Ctl (Control) Icon will appear next to the test strip icon and L1 will appear on the meter display screen. 4. Squeeze a drop of control solution onto a clean, dry nonabsorbent surface. 5. Gently touch the tip of the test strip to the drop of control solution. 6. The screen will start to count down. After 6 seconds, the control solution test result will appear on the meter display screen. 7. Compare the reading on the screen to the Low range printed on the test strip bottle. Repeat the steps 3 through 8 for the High control solution. Information provided by the facility on a handwritten sheet revealed 11 residents on Rosewood required blood glucose monitoring.
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 reviews and interviews, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete, accurately documented, and systematically organized for 2 of 23 residents (Resident #16 and #22) whose clinical records were reviewed in that: 1. Resident #16's closed clinical record: a. included another resident's wound treatment sheets and wound treatment care plan; and b. had a note written by the dietitian that was not signed or dated. 2. Resident #22 had an order for [REDACTED]. This deficient practice could affect all 81 residents at the facility with clinical records by contributing to care based on inaccurate documentation. The findings were: 1. Review of Resident #16's closed medical record discharge summary sheet revealed he was admitted to the facility on [DATE] and discharged on [DATE] with final [DIAGNOSES REDACTED]. Resident #16's closed medical record contained a yellow Dietary Progress Note. Hand written on the Dietary Progress Note was the first initial of the resident's name and his last name, which were underlined. Underneath the resident's name was hand written [MEDICATION NAME] 1.5 at 60 cc/hr x 20 hrs (hours) to = 1800 kcal (calories) in 1200 cc Flush w/ 50 cc ac (before) & p (after) meds + 200 cc QS (every shift). The hand written note did not have a signature or a date. The closed medical record for Resident #16 contained wound treatment sheets and a wound treatment care plan for another resident that were behind treatment sheets for Resident #16. Interview with the DON on 4/23/15 at 2:40 p.m. confirmed Resident #16's closed medical record contained wound treatment sheets and a wound treatment care plan for another resident that were behind treatment sheets for Resident #16. The DON looked at the yellow Dietary Progress Note and compared the handwriting to handwriting on the Nutrition Assessment sheet and reported the hand written Dietary Progress Note was by the dietitian. The DON confirmed the note was not signed or dated. 2. Review of Resident #22's face sheet, dated 10/14/14, revealed he was admitted to the facility on [DATE] with [DIAGNOSES

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F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) REDACTED]. Review of Resident #22's telephone orders revealed an order dated 4/3/15 to discontinue [MEDICATION NAME] 5 mg-325 mg (a pain medication) and to start Tylenol #3 two tabs by mouth every 6 hours as needed for pain. Review of Resident #22's April 2015 MARs revealed next to [MEDICATION NAME] 5 mg-325 mg was hand written D/C'd 4/3/15. Further review of the MARs revealed no order for Tylenol #3. Interview with LVN E on 4/27/15 at 3:05 p.m. confirmed Tylenol #3 was not listed on the April MARs. LVN E looked through the physician's telephone orders and confirmed a telephone order had been written on 4/3/15 for Tylenol #3. LVN E stated Resident #22 had not complained of any pain in the last month. Review of the American Health Information Management Association Long Term Care Health Information Practice and Documentation Guidelines, dated September 2001, revealed on p. 26: HIM (Health Information Management) STANDARD: The healthcare organization has a policy that requires a separate, unique health record for each resident. In the same document on p. 34 and 37, it revealed: Order are transcribed accurately to Medication Administration Record [REDACTED]. Review of the CMS-672, Resident Census and Conditions of Residents, completed by the facility on 4/21/15 revealed 81 residents were in the facility.
F 0518 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Train all employees on what to do in an emergency, and carry out announced staff drills.** Based on observation and interview, the facility failed to train all employees in emergency procedures when they begin to work in the facility and periodically review the procedures with existing staff for 3 of 11 staff interviewed (LVN E, LVN R, and CNA AA) in that: 1. LVN E was not aware there were red plugs or the purpose of the red plugs (emergency power). 2. LVN R did not know the appropriate use of emergency electric outlets. 3. CNA AA did not know the appropriate use of emergency electric outlets. This deficient practice of could affect 81 resident and put them at risk of harm in the event of an emergency disaster. The findings were: 1. Interview on 4/22/15 at 10:15 a.m. with LVN E revealed she did not know what to do if the electrical power went off. LVN E was unaware of the red plugs used for electricity during a power outage. 2. Interview on 4/22/15 at 11:15 a.m. with LVN R revealed she was not aware what the red plugs were used for in the facility, responding, Not Really know what they are for. 3. Interview with CNA AA on 4/22/15 at 11:45 a.m. revealed when asked to locate the red plug on the 300 Hall, she was observed searching the length of the hall trying to locate the red plug which had been hidden behind a laundry cart. When questioned what it was used for, CNA AA replied, I am not sure. The CMS Form 672, completed by the facility and dated 4/21/15, revealed there were 81 residents in the facility.