Parkview Care and Rehabilitation Center, Inc.

Deficiency Details, Certification Survey, April 4, 2014

PFI: 0557
Regional Office: MARO--Long Island sub-office

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F511 483.75(k)(2)(ii): PROMPTLY NOTIFY PHYSICIAN OF RADIOLOGY FINDINGS

Scope: Isolated

Severity: Actual Harm

Corrected Date: June 3, 2014

The facility must promptly notify the attending physician of the findings.

Citation date: April 4, 2014

Based on record review and radiology provider and staff interviews during the recertification survey, the facility did not promptly notify the Attending Physician of the radiological findings. This was evident in 1 of 1 resident reviewed for radiological reporting of results by the radiology provider to the physician in a total of 38 Stage II sampled residents. Specifically, Resident #4 had a Physician Order dated 3/13/14 for a chest x-ray (CXR) to rule out (r/o) Pneumonia. On 3/17/14, the CXR report revealed that the resident had a Left Lung Collapse. There was no documented evidence that the radiology provider promptly notified the Attending Physician of Resident #4's CXR result when the CXR was completed and read by the radiologist on 3/13/14 at 10:13 PM (22:13 hours). This resulted in actual harm for Resident #4 that is not immediate jeopardy.

The finding is:

Resident #4 has diagnoses including Right Hemiplegia, Dysphagia, Depression and Esophageal Reflux. The resident was admitted to the facility on 5/22/13.

The Minimum Data Set (MDS) dated 11/11/13 documented that the resident's Brief Interview for Mental Status (BIMS) score was 15; that indicated that the resident was independent in cognition. The MDS also documented that the resident used wheelchair as mobility device and had impairment on one side of the upper and lower extremities.

The Physician Order dated 2/18/14 documented Albuterol one unit dose via nebulizer every 6 hours PRN for Bronchospasm.

The Medication Administration Record (MAR) for March 2014 documented Albuterol one unit dose via nebulizer every 6 hours PRN for Bronchospasm. The MAR also documented that the resident received Albuterol Nebulizer treatments twice on 3/14/14 through 3/16/14 and once on 3/17/14.

The Physician's Progress Note dated 3/13/14 documented that the resident complained of shortness of breath (SOB). The Note also documented that on auscultation of the chest revealed "good air entry bilaterally."

The Physician Order dated 3/13/14 documented CXR to rule out (r/o) Pneumonia.

The Nurses Note (NNote) dated 3/13/14 (Thursday) documented that the resident was seen by the Physician secondary to shortness of breath (SOB) . The Physician ordered CXR to r/o Pneumonia.

The NNote dated 3/13/14 documented that the chest x-ray was done.

The NNote dated 3/14/14 documented that the chest x-ray was done yesterday to r/o Pneumonia. The NNote also documented that the results were still pending and that the staff will continue to monitor.

The NNote dated 3/15/14 documented that documented that the radiology provider was "contacted at 11:00

AM and stated that the CXR results are still pending."

The NNote, 3 days later on, dated 3/16/14 documented that the CXR completed on 3/13/14 was still pending. The NNote also documented that a message was left with the radiology provider and that the nurse will follow up on 3/17/14 if no responses were to be received from next shift nurse during the tour.

The NNote dated 3/17/14 documented that at 10:00 AM that the facility contacted the radiology department to obtain the 3/13/14 CXR result. The NNote also documented that the Attending Physician read the CXR result with the diagnosis of Left Lung Collapse. The Attending Physician ordered to send the resident to the hospital and that the family was notified of the resident's transfer. In addition, the NNote also documented that the ambulance arrived at the facility at 12:30 PM. The resident's vital signs were: blood pressure of 143/92 (normal is less than 120/80), heart rate/pulse of 130 beats/minute (normal is 60-100 beats/minute), temperature of 98.7 degrees Fahrenheit (normal 98.6) and respiratory rate of 24 breaths/minute (normal 16-25 respirations per minute in a long term care setting).

A review of the NNotes from 3/13/14 through 3/17/14 revealed no documented evidence that the licensed nursing staff assessed the resident's breath sounds or assessed vital signs (v/s) until after the CXR results were known on 3/17/14.

Review of the NNotes from 3/13/14 through 3/17/14 also revealed that there was no documented evidence that the Physician was notified of the resident's CXR status that the result was still pending.

The Physician Progress Note dated 3/17/14 documented decreased air on the left side of the chest and Left Lung Collapse.

The Physician Order dated 3/17/14 documented to transfer the resident to the hospital with Left Lung Collapse.

An interview with the Certified Nursing Assistant (CNA), who worked on 3/17/14 when the resident was sent to the hospital, was conducted on 4/1/14 at 2:40 PM . The CNA stated that the resident had "a little cold, looked fine and regular" and that the resident did not complained of difficulty of breathing.

A confidential interview with a facility visitor was conducted on 3/27/14 at 10:15 AM. The visitor reported to the survey team that, while the visitor was on the unit sometime on 3/17/14, Resident #4 "appeared to be in distress" that the resident had difficulty breathing and was alone in his room. The visitor also stated that this was brought to the facility's attention via a CNA. The visitor stated that there was no staff at the resident's bedside while waiting for the ambulance to transport the resident to the hospital. In addition, the visitor also stated that the CNA reported the nursing staff were attending a meeting at that time.

An interview with the Administrator was conducted on 4/2/14 at 10:21 AM. The Administrator stated that she was not aware nor made aware that the resident's CXR result was pending for 4 days from 3/13/14 through 3/17/14 morning not until 4/2/14 when she was being interviewed by the surveyor.

An interview with radiology provider Operation Manager was conducted on 4/2/14 at 2:10 PM. The Manager stated that per documentation the resident's CXR was done 3/13/14 at around 7:30 PM. The Manager could not say when it was reported to the nursing home facility, to whom and by whom. He said all the records are in the archive and had to be retrieved in a day or two.

On 4/2/14 at 2:30 PM, interview was conducted with the Licensed Practical Nurse (LPN), who was on duty on 3/13/14 when the CXR was ordered and also on 3/17/14 duty when the resident was sent to the hospital. The LPN stated that the resident was noted to be fine, coughing, not cyanotic, and was "normal for the resident to deep breathing" on 3/13/14 and on 3/17/14. The LPN also stated that the resident was administered Albuterol (a bronchodilator inhaler) as needed (PRN) as per the Physician Order and had told the Registered Nurse Supervisor on 3/16/14 to follow-up the still pending CXR result in 24 hours. The LPN could not remember who the RN Supervisor was. In addition, the LPN also stated that the resident had wheezing on both lungs upon auscultation on 3/13/14 and on 3/17/14. However, the LPN could not identify if the wheezing was only on one or on both lungs. The LPN also stated that she did not documented her findings in the medical record.

Review of the medical record revealed that the resident's CXR radiology report on file dated 3/13/14 documented an impression of Left Lung Collapse at 10:13 PM (22:13:25 hours) and was faxed to the facility on 3/17/14 at 8:54 AM.

In an interview with the Director of Nursing Services (DNS) conducted on 4/3/14 at 8:55 AM, the DNS stated that she was "unaware from the get go," but was made aware on 3/17/14 by the Attending Physician/Medical

Director, RN Supervisor and the LPN Charge Nurse that the resident's CXR result was still pending since 3/13/14. The DNS also stated that the Assistant DNS called the radiology provider and spoke with Operations Manager on 3/17/14. The radiology provider sent a fax on 3/13/14 but did not include the resident's CXR report.

The DNS stated that the Nursing Supervisor should be calling the doctors or officer of the day to get the results from the radiology provider. The DNS stated that there is no faxed x-ray log book. The DNS stated that the nursing supervisor on each shift picks up the 24-hour report and should have reviewed that there was a problem of the resident's CXR result. The DNS further added that the nursing staff "dropped the ball" and that the x-ray result should be reported in 4-5 hours time frame from the radiology provider.

In a follow up interview with the radiology provider Operation Manager conducted on 4/3/14 at 11:00 AM. the Manager stated that the provider had transmitted the faxed x-ray reports on the night of 3/13/14 at 10:15 PM (22:15 Hours) containing another resident's x-ray report as page 001 and that of Resident #4's CXR report as page 002. A report was faxed but the report was not correct. However, the Manager could not provide proof of the page 002 x-ray report for Resident #4 that was transmitted to the facility on 3/13/14. The Manager could only provide a copy of the page 001 containing the other resident's report and not Resident #4's CXR result.

An interview with the Attending Physician/Medical Director was conducted on 4/3/14 at 12:43 PM. He stated that he was not made aware by the staff that the x-ray results were still pending. In a follow up interview conducted on 4/3/14 at 1:55 PM, the Physician stated that as "standard of practice, if I order the CXR it is incumbent for the radiology to call the Attending Physician for any abnormality. The radiologist should reach out to the Attending Physician and discuss the x-ray findings". The Physician added that "No, I do not go to check for the results of the x-ray everyday. I can't call for every patient that I have. I did not receive the call from the nursing staff. I called the radiology on the 17th. I sent the resident to the hospital with the panic finding of the CXR." The Physician stated that he expected the nursing staff to monitor the resident's vital signs and respiratory status and document them.

The facility's undated policy and procedure titled Re: Communication and Criteria for Diagnostic X-rays/Diagnostic Tests From Stat Portable (the name of the x-ray company documented "...All notification must be documented in the chart. If results are not received within a timely manner 4-5 hours after completion unless otherwise specified. The Physician/Administration on duty must be notified."

415.21 (b((1)

Citation date: June 3, 2014

Based on record review and radiology provider and staff interviews during the recertification survey, the facility did not promptly notify the Attending Physician of the radiological findings. This was evident in 1 of 1 resident reviewed for radiological reporting of results by the radiology provider to the physician in a total of 38 Stage II sampled residents. Specifically, Resident #4 had a Physician Order dated 3/13/14 for a chest x-ray (CXR) to rule out (r/o) Pneumonia. On 3/17/14, the CXR report revealed that the resident had a Left Lung Collapse. There was no documented evidence that the radiology provider promptly notified the Attending Physician of Resident #4's CXR result when the CXR was completed and read by the radiologist on 3/13/14 at 10:13 PM (22:13 hours). This resulted in actual harm for Resident #4 that is not immediate jeopardy.

The finding is:

Resident #4 has diagnoses including Right Hemiplegia, Dysphagia, Depression and Esophageal Reflux. The resident was admitted to the facility on 5/22/13.

The Minimum Data Set (MDS) dated 11/11/13 documented that the resident's Brief Interview for Mental Status (BIMS) score was 15; that indicated that the resident was independent in cognition. The MDS also documented that the resident used wheelchair as mobility device and had impairment on one side of the upper and lower extremities.

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A confidential interview with a facility visitor was conducted on 3/27/14 at 10:15 AM. The visitor reported to the survey team that, while the visitor was on the unit sometime on 3/17/14, Resident #4 "appeared to be in distress" that the resident had difficulty breathing and was alone in his room. The visitor also stated that this was brought to the facility's attention via a CNA. The visitor stated that there was no staff at the resident's bedside while waiting for the ambulance to transport the resident to the hospital. In addition, the visitor also stated that the CNA reported the nursing staff were attending a meeting at that time.

An interview with the Administrator was conducted on 4/2/14 at 10:21 AM. The Administrator stated that she was not aware nor made aware that the resident's CXR result was pending for 4 days from 3/13/14 through 3/17/14 morning not until 4/2/14 when she was being interviewed by the surveyor.

An interview with radiology provider Operation Manager was conducted on 4/2/14 at 2:10 PM. The Manager stated that per documentation the resident's CXR was done 3/13/14 at around 7:30 PM. The Manager could not say when it was reported to the nursing home facility, to whom and by whom. He said all the records are in the archive and had to be retrieved in a day or two.

On 4/2/14 at 2:30 PM, interview was conducted with the Licensed Practical Nurse (LPN), who was on duty on 3/13/14 when the CXR was ordered and also on 3/17/14 duty when the resident was sent to the hospital. The LPN stated that the resident was noted to be fine, coughing, not cyanotic, and was "normal for the resident to deep breathing" on 3/13/14 and on 3/17/14. The LPN also stated that the resident was administered Albuterol

(a bronchodilator inhaler) as needed (PRN) as per the Physician Order and had told the Registered Nurse Supervisor on 3/16/14 to follow-up the still pending CXR result in 24 hours. The LPN could not remember who the RN Supervisor was. In addition, the LPN also stated that the resident had wheezing on both lungs upon auscultation on 3/13/14 and on 3/17/14. However, the LPN could not identify if the wheezing was only on one or on both lungs. The LPN also stated that she did not documented her findings in the medical record.

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In an interview with the Director of Nursing Services (DNS) conducted on 4/3/14 at 8:55 AM, the DNS stated that she was "unaware from the get go," but was made aware on 3/17/14 by the Attending Physician/Medical Director, RN Supervisor and the LPN Charge Nurse that the resident's CXR result was still pending since 3/13/14. The DNS also stated that the Assistant DNS called the radiology provider and spoke with Operations Manager on 3/17/14. The radiology provider sent a fax on 3/13/14 but did not include the resident's CXR report.

The DNS stated that the Nursing Supervisor should be calling the doctors or officer of the day to get the results from the radiology provider. The DNS stated that there is no faxed x-ray log book. The DNS stated that the nursing supervisor on each shift picks up the 24-hour report and should have reviewed that there was a problem of the resident's CXR result. The DNS further added that the nursing staff "dropped the ball" and that the x-ray result should be reported in 4-5 hours time frame from the radiology provider.

In a follow up interview with the radiology provider Operation Manager conducted on 4/3/14 at 11:00 AM. the Manager stated that the provider had transmitted the faxed x-ray reports on the night of 3/13/14 at 10:15 PM (22:15 Hours) containing another resident's x-ray report as page 001 and that of Resident #4's CXR report as page 002. A report was faxed but the report was not correct. However, the Manager could not provide proof of the page 002 x-ray report for Resident #4 that was transmitted to the facility on 3/13/14. The Manager could only provide a copy of the page 001 containing the other resident's report and not Resident #4's CXR result.

An interview with the Attending Physician/Medical Director was conducted on 4/3/14 at 12:43 PM. He stated that he was not made aware by the staff that the x-ray results were still pending. In a follow up interview conducted on 4/3/14 at 1:55 PM, the Physician stated that as "standard of practice, if I order the CXR it is incumbent for the radiology to call the Attending Physician for any abnormality. The radiologist should reach out to the Attending Physician and discuss the x-ray findings". The Physician added that "No, I do not go to check for the results of the x-ray everyday. I can't call for every patient that I have. I did not receive the call from the nursing staff. I called the radiology on the 17th. I sent the resident to the hospital with the panic finding of the CXR." The Physician stated that he expected the nursing staff to monitor the resident's vital signs and respiratory status and document them.

The facility's undated policy and procedure titled Re: Communication and Criteria for Diagnostic X-rays/Diagnostic Tests From Stat Portable (the name of the x-ray company documented "...All notification must be documented in the chart. If results are not received within a timely manner 4-5 hours after completion unless otherwise specified. The Physician/Administration on duty must be notified."

415.21 (b((1)

F309 483.25: PROVIDE NECESSARY CARE FOR HIGHEST PRACTICABLE WELL BEING

Scope: Isolated

Severity: Actual Harm

Corrected Date: June 18, 2014

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Citation date: April 4, 2014

Based on record review, and an annonymous visitor and staff interviews during the recertification survey, the facility did not 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 that

each resident must receive. This was evident in 2 of 4 residents reviewed for hospitalization in a total of 38 Stage II sampled residents (Residents #4 and 22) and one of six residents reviewed for unnecessary medications (Resident # 18). Specifically, 1) Resident #4 had a Physician Order dated 3/13/14 for a chest x-ray (CXR) to rule out (r/o) Pneumonia. On 3/17/14, the CXR report revealed that the resident had a Left Lung Collapse. There was no documented evidence in the medical record that the nursing staff had notified the Physician that the CXR still had no results from 3/13/14 through 3/17/14; 2) Resident # 22, with a known history of Diarrhea, was not treated for episodes of loose watery stools in a timely manner and recommended standing orders for a medication to treat the loose stools documented on an Oncology Consult were not implemented in a timely manner and 3) Resident # 18 did not receive treatment in a timely manner to a rash on the gluteal folds.
This resulted in actual harm for Resident # 4 and no actual harm with potential for more than minimal harm which is not Immediate Jeopardy for Residents # 22 and # 18.

The findings are:

1) Resident #4 has diagnoses including Right Hemiplegia, Dysphagia, Depression and Esophageal Reflux. The resident was admitted to the facility on 5/22/13.

The Minimum Data Set (MDS) dated 11/11/13 documented that the resident's Brief Interview for Mental Status (BIMS) score was 15; that indicated that the resident was independent in cognition. The MDS also documented that the resident used wheelchair as mobility device and had impairment on one side of the upper and lower extremities.

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The NNote dated 3/17/14 documented that at 10:00 AM the facility contacted the radiology department to obtain the 3/13/14 CXR result. The NNote also documented that the Attending Physician read the CXR result with the diagnosis of Left Lung Collapse. The Attending Physician ordered to send the resident to the hospital and that the family was notified of the resident's transfer. In addition, the NNote also documented that the ambulance arrived at the facility at 12:30 PM. The resident's vital signs were: blood pressure of 143/92 (normal is less than 120/80), heart rate/pulse of 130 beats/minute (normal is 60-100 beats/minute), temperature of 98.7 degrees Fahrenheit (normal 98.6) and respiratory rate of 24 breaths/minute (normal 16-25 respirations per minute in a long term care setting).

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An interview with radiology provider Operation Manager was conducted on 4/2/14 at 2:10 PM. The Manager stated that per documentation the resident's CXR was done 3/13/14 at around 7:30 PM. The Manager could not say when it was reported to the nursing home facility, to whom and by whom. He said all the records are in the archive and had to be retrieved in a day or two.

On 4/2/14 at 2:30 PM, an interview was conducted with the Licensed Practical Nurse (LPN), who was on duty on 3/13/14 when the CXR was ordered and also on 3/17/14 duty when the resident was sent to the hospital. The LPN stated that the resident was noted to be fine, coughing, not cyanotic, and was "normal for the resident to deep breathing" on 3/13/14 and on 3/17/14. The LPN also stated that the resident was administered Albuterol (a bronchodilator inhaler) as needed (PRN) as per the Physician Order and had told the Registered Nurse Supervisor on 3/16/14 to follow-up the still pending CXR result in 24 hours. The LPN could not remember who the RN Supervisor was. In addition, the LPN also stated that the resident had wheezing on both lungs upon auscultation on 3/13/14 and on 3/17/14. However, the LPN could not identify if the wheezing was only on one or on both lungs. The LPN also stated that she did not documented her findings in the medical record.

Review of the medical record revealed that the resident's CXR radiology report on file dated 3/13/14 documented an impression of Left Lung Collapse at 10:13 PM (22:13:25 hours) and was faxed to the facility on 3/17/14 at 8:54 AM.

In an interview with the Director of Nursing Services (DNS) conducted on 4/3/14 at 8:55 AM, the DNS stated that she was "unaware from the get go," but was made aware on 3/17/14 by the Attending Physician/Medical Director, RN Supervisor and the LPN Charge Nurse that the resident's CXR result was still pending since 3/13/14. The DNS also stated that the Assistant DNS called the radiology provider and spoke with Operations Manager on 3/17/14. The radiology provider sent a fax on 3/13/14 but did not include the resident's CXR report.

The DNS went on to say that the Nursing Supervisor should be calling the doctors or officer of the day to get the results from the radiology provider. The DNS stated that there is no faxed x-ray log book. The DNS stated that the nursing supervisor on each shift picks up the 24-hour report and should have reviewed that there was a problem of the resident's CXR result. The DNS further added that the nursing staff "dropped the ball" and that the x-ray result should be reported in 4-5 hours time frame from the radiology provider.

In a follow up interview with the radiology provider Operation Manager conducted on 4/3/14 at 11:00 AM. The Manager stated that the provider had transmitted the faxed x-ray reports on the night of 3/13/14 at 10:15 PM (22:15 Hours) containing another resident's x-ray report as page 001 and that of Resident #4's CXR report as page 002. A report was faxed but the report was not correct. However, the Manager could not provide proof of the page 002 x-ray report for Resident #4 that was transmitted to the facility on 3/13/14. The Manager could only provide a copy of the page 001 containing the other resident's report and not Resident #4's CXR result.

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incumbent for the radiology to call the Attending Physician for any abnormality. The radiologist should reach out to the Attending Physician and discuss the x-ray findings". The Physician added that "No, I do not go to check for the results of the x-ray everyday. I can't call for every patient that I have. I did not receive the call from the nursing staff. I called the radiology on the 17th. I sent the resident to the hospital with the panic finding of the CXR." The Physician stated that he expected the nursing staff to monitor the resident's v/s and respiratory status and document them.

The facility's undated policy and procedure titled Re: Communication and Criteria for Diagnostic X-rays/Diagnostic Tests From Stat Portable (the name of the x-ray company) documented "...All notification must be documented in the chart. If results are not received within a timely manner 4-5 hours after completion unless otherwise specified. The Physician/Administration on duty must be notified."

2) Resident # 22 is a 57 year old male with the following diagnoses: Multiple Myelomas, Status Post Chemotherapy and Radiation Therapy, Diabetes Mellitus; Stage One Pressure Sore (non-blanchable redness to the Gluteal fold).

The Hospital Discharge Summary dated 2/14/14 documented that the resident occasionally has had bowel incontinence secondary to loose stools. The patient states he has had diarrhea for four weeks; watery brown (stools) without blood (or) mucous... . The Hospital Discharge Summary further documented that the diarrhea persisted during the (hospital) admission and that a biopsy pathology was returned and was highly suggestive of amyloid... . In addition, the discharge medications included Lomotil 2.5 mg tablet, one tablet by mouth four times per day as needed.

The resident was admitted to the facility on 2/14/14 and subsequently hospitalized for the evaluation of Hypotension on 2/27/14, thirteen days following admission.

The Admission Minimum Data Set Assessment dated 2/21/14 documented that the resident was cognitively intact with a Brief Interview Mental Score of 15.

The Nursing Admission Assessment dated 2/14/14 documented the date of the residents' last bowel movement on 2/14/14. There was no documented evidence of constipation on the initial nursing assessment nor in the nursing notes reviewed.

A Comprehensive Care Plan (CCP) dated 2/14/14 documented that the resident was incontinent of bowel. The CCP evaluation dated 2/17/14, has the following documentation: On interview with the Certified Nurse Aide (CNA), she states that the resident was having multiple runny stools.

The Nursing Progress notes dated 2/15/14 at 3 PM documented that the resident had loose stools times two. The nursing progress note documented to increase fluids and to monitor (the resident) closely. There was no documented evidence that the resident received medication to address the episodes of loose stools.

The facility's admission Physician's History and Physical dated 2/17/14 documented that the resident's prognosis as good and the resident's Blood Pressure (BP) as 130/80.

The Registered Dietitian (RD) notes on the initial Nutritional Assessment dated 2/19/14 that the resident's bowel function was diarrhea and that he had loose Bowel Movements times two on 2/15/14. In addition, the RD documented that the resident's history includes Multiple Myeloma, weight loss and diarrhea in the past few weeks. She also documented that the resident agreed to extra fluids ; 10 AM 8 ounces diet lemonade, 2 PM diet gingerale and at 8 PM fruit to help meet nutritional needs.

An oncology follow up dated 2/19/14 documented that the recent admission to the hospital was for treatment of Dehydration and Chronic Diarrhea. The current recommendations on the consult were as follows: 1) Treat Diarrhea with a standing dose of Lomotil; one tab twice per day and one tab twice a day as needed with a maximum (dose) of four tablets per day; hold if constipation.

There is a documented telephone order for the standing dose of Lomotil twice per day on 2/21/14 at 2 PM, two days following the Oncology recommendations. The MAR documented that the resident received the first dose, on 2/21/14 at 5 PM.

Despite there being documented evidence by nursing staff, a CNA interview and the RD that the resident had episodes of loose watery stools, the Medication Administration Record (MAR) did not document that Lomotil was ordered timely, given and or offered to the resident until 2/21/14.

In addition, despite documented history of loose stools for weeks, the documented loose stools on both nursing notes, dietary notes and the CCP, the first dose of the Lomotil was not documented as received until

2/21/4 at 5 PM, one week after the residents' admission.

An interview was conducted with the Director of Nursing Services (DNS) on 4/4/14 at 10:45 AM and revealed that the Lomotil should have been given and documented by the nurse who gave the medication when she documented the loose stools (in the nursing progress notes).

The DNS stated that when the resident returned with the consultation from the Oncologist, the Physician should have been contacted sooner (by nursing staff) to change the medication order as recommended and documented by the Oncologist on 2/19/14. She further explained that she would have expected the MD to address the recommendations the next day, 2/20/14.

An interview was conducted with the Registered Nurse (RN) Supervisor on 4/4/14 at 11:00 AM. The RN stated that she found the order (for the standing dose of Lomotil) on the nursing unit signed by the MD on 2/21/14 and realized that the orders had not been picked up. Subsequently, the RN documented the orders on the MAR for the standing dose of Lomotil.

An interview was conducted with the Licensed Practical Nurse (LPN) on 4/4/14 at 12:30 PM who documented the loose stools on 2/15/14 in the nursing progress notes. The LPN explained that she did not know exactly what happened. She did state that in one instance where (the resident) had loose stools, there was no (physician's) order for the Lomotil. The LPN further stated that the order for the Lomotil was received after her shift ended and was picked up by a nurse on a later shift that same day.

An interview was conducted with the Medical Director (MD) on 4/4/14 at 3:10 PM. The Physician stated that he ordered the Lomotil to be discontinued upon the resident's admission. He further explained at the time of admission, the resident was not having loose stools and was now constipated (although there was no documented evidence of constipation). The MD stated that during the admission order confirmation with nursing, it was reported that the resident had not had a Bowel Movement (BM) for a couple of days. The MD stated "I chose to order Dulcolax PRN if he needed it and discontinue the Lomotil." The MD further reported that that he would not have expected the nursing staff to treat two episodes of loose stools with Lomotil. The MD stated, " I would not treat that (two documented episodes of loose stools) until it becomes a bigger problem". The MD stated that the recommendations from the Oncology Consult should have been put into place on 2/20/14.

3) Resident #18, with diagnoses including Diabetes and Myalgia, was admitted to the facility on 3/05/14.

The resident's admission nursing assessment note dated 3/05/14 identified a rash to the gluteal folds.

The Admission physician orders dated 3/05/14 ordered nystatin cream to be applied to the gluteal folds twice a day for seven days to treat the rash.

Review of the Treatment Administration Record (TAR) revealed that the resident received the first application of the Nystatin cream on 3/07/14 on the 7 AM - 3 PM shift.

An interview was held with the Director of Nursing Services (DNS) on 4/02/14 at 2;30 PM. The DNS stated that the the pharmacy received the request for Nystatin on 3/6/14 at 1:30 AM and that the medications and Nystatin cream was delivered to the facility on 3/06/14 at approximately 6:30 AM. The DNS stated that there should have been two applications of the Nystatin cream to the resident's buttocks on 3/06/14, once on the 7 AM -3 PM nursing shift and once on the 3 PM - 11 PM nursing shift.

An interview was held on 4/04/14 at 12:19 PM with the pharmacist. There pharmacist stated that the pharmacy received the order for Nystatin cream on 3/06/14 at 1:45 AM and that the Nystatin cream was delivered to the facility at 6:02 AM on 3/06/14.

A subsequent interview was held with the DNS on 4/04/14 at 4:15 PM with the DNS. The DNS stated that she would expect the nurse to sign for the application of Nystatin cream on the TAR when applied, and the lack of signatures would signify that the cream was not applied. The DNS stated that there would be no excuse not to apply the cream since it was here in the facility. The nurse who worked on 3/06/14 were unavailable for comment.

415.12

Citation date: June 3, 2014

Based on record review, observation, staff and resident interviews during the Post Survey Revisit (PSR) survey, the facility failed to provide the necessary care and services in order to provide the highest, practicable physical, mental and psychosocial well being. This was evident for one resident reviewed for pain management. Specifically, Resident # 246 was admitted on 5/28/14 with orders for Oxycodone and was not provided with the pain medication in a timely manner, nor was there documentation of monitoring for effective pain management. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

This is a REPEAT deficiency from the April 2014 Recertification survey.

The finding is:

Resident # 246 has diagnoses that include difficulty in walking, hypertension, breast cancer with metastasis to the brain.

The Comprehensive Care Plan (CCP) dated 5/29/14 documented that the resident is cognitively intact with a BIMs (able to complete a brief interview for mental status) score of 15. Interventions include pain evaluation as needed. A CCP for pain was initiated on 5/29/14 related to cancer of the brain. Interventions included to observe for signs / symptoms of pain, administer pain medications as ordered and monitor effectiveness of pain management as needed.

The Admission physician orders dated 5/29/14 documented to give Oxycodone 5 milligrams (mg) by mouth (po) every 4 hours as needed for pain. On 6/1/14 at 12 AM, a telephone order was obtained for Tylenol 650 mg every 4 hours as needed for pain. On 6/1/14 at 5:30 PM another telephone order was obtained to give percocet 1 tab from the emergency box every 4 hours as needed until Oxycodone comes from pharmacy.

The medication administration record (MAR) dated 5/28/14 documented to give Oxycodone 5 mg po every 4 hours as needed for pain. On 6/1/14, the MAR was updated to give Tylenol 650 mg every 4 hours as needed for pain and to give percocet 1 tab every 4 hours as needed. On 6/1/14 at 12 AM and at 9 AM, Tylenol was given for pain. At 12 AM the pain level was documented at "6" out of 10 (10 being most severe pain) and the result was an improvement to a "5". At 9 AM, no assessment of pain was documented before and after the administration of the pain medication. On 6/2/14 at 7 am percocet 1 tab was given for leg pain of 7. There was no re-assessment of pain level documented.

A review of the emergency kit controlled drug accountability form documented that at 5:30 PM, 1 tablet of percocet was taken by the nurse. There was no documentation on the MAR that the medication was given at 5:30 PM nor was there documentation of an assessment of the resident's pain level.

On 6/2/14 at 12:00 PM, the resident was interviewed and stated that she has been having pain daily since Saturday 5/31 and she was told that she was being given Oxycodone for pain. She stated normally Oxycodone has relieved her pain and she can't understand why she has not been receiving relief. She stated that the doctor saw her today and ordered another medication, percocet. She reports the pain as a "9 out of 10". The charge nurse Licensed Practical Nurse (LPN) was present when the resident was complaining of level of pain.

An interview with the medication/charge LPN on 6/2/14 at 11:46 AM revealed that the resident's medication Oxycodone was not in stock and that the night nurse gave her the medication at 7 AM on 6/2/14. The medication/charge LPN stated "The physician and myself assessed the resident this morning and the resident had pain when resident's leg was touched." The LPN stated that the physician did not order to give her any more medication for pain at the time of the assessment. The LPN also stated that the resident did not request any pain medication after 11 AM.

On 6/3/14 at 11:00 AM, the resident was re- interviewed and stated that she has been having relief once they give her the Oxycodone pain medication until it starts to wear down. The resident said "Once it wears down I need the pain medication again".

The LPN medication nurse that worked on 6/1/14 from 7 AM to 11 PM was interviewed on 6/3/14 at 12:15 PM and stated that she should have documented an assessment of the resident's pain level before and after the administration of any pain medication. She stated that the resident did report some relief of pain after giving the resident the pain medication percocet on 6/1/14 at 5:30 PM. The LPN further stated that she gave the Tylenol on 6/1/14 at 9 AM and remembered the resident having some relief with Tylenol. She stated she will do a better job to document assessment before and after pain medication administration.

The LPN medication nurse that works 11 PM- 7 AM was not available for interview.

The Nurse Practitioner (NP) made out a triplicate for Oxycodone dated 6/2/14 and documented the triplicate number onto the physician order dated 5/29/14. The NP was interviewed on 6/2/14 at 3:15 PM and stated that he was not aware by the nurse that the resident did not have a script for pharmacy so that pharmacy could dispense the pain medication. "When it was brought to my attention this AM , a script was made out and sent to pharmacy".

The physician was called on 6/2/14 at 12:40 PM and said "On Friday I assessed the resident. The resident was not in pain. I was not aware that the resident's Oxycodone was not in stock until yesterday (on 6/1/14) and I ordered percocet to treat her pain.

The physician was again interviewed on 6/3/14 at 10:00 AM and stated that if the resident was in pain, when he assessed the resident on 5/29/14, a script would have been made out to dispense the narcotic Oxycodone. "We have an emergency box that contains 5 day supply of percocet (which contains the ingredient Oxycodone plus Tylenol) for all residents". He stated that because the resident required the medication on a PRN basis, there would have been no need to send a script because if the resident does not use the medication it would have been wasted. He further stated that on 6/1/14, he received a phone call that the resident was in pain at 5:30 PM. He stated that at that time he gave the nurse an order to take percocet from the narcotic box to address the residents pain. He stated that he would have expected the nurse to administer the medication at that time (5:30 PM) and to document an assessment before and after administering percocet. He also stated that when the resident first complained of pain on 5/31, an order was obtained on 6/1/14 at 12 AM to administer Tylenol 650 mg. every 4 hours as needed for pain. The physician stated that an assessment should have been documented and if there was no improvement in the resident's pain level, he or the NP should have been notified and the stronger pain medication (percocet) would have been ordered.

The pharmacy supervisor was interviewed on 6/2/14 at 2:25 PM. "We first received orders on 5/29 at 5:18 AM. We would not fill the medication if a triplicate was not faxed over with the medication. We did not receive a script from the physician until 6/2/14 at 11:17 AM and that was the reason we could not dispense the Oxycodone".

The Director of Nursing Services (DNS) was interviewed on 6/2/14 at 3:24 PM and stated that if the script was not completed by the physician, the facility would not receive the Oxycodone for the resident. The nurse practitioner should have made out a triplicate script, so pharmacy can dispense the medication. The day nurse is responsible to pick up a missing script to dispense the narcotic. Other shifts would not be responsible. All nurses are responsible to document assessment of pain level prior to and after giving pain medications. She further stated if pain levels were not relieved by ordered mediations, the physician should have been notified promptly to assess the need of giving stronger medications or other interventions that the physician deems necessary.

The facility's Pain management policy dated 11-21-02 documented that assessment should occur after pharmacological intervention and with standardized pain assessment method. Pain scale is to be used from 0-10 with 0= no pain and 10= worst pain. The policy documents that after administration of pain medication, the RN/LPN documents on the MAR, the residents pain scale. The policy further states to re- evaluate resident with chronic pain who are taking medications containing narcotics.

415.12

F241 483.15(a): DIGNITY

Scope: Pattern

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Citation date: April 4, 2014

Based on observations and staff interviews during the recertification survey the facility did not ensure that residents were cared for in an environment that maintains or enhances each resident's dignity and respect. Dignity was not provided on the west nursing unit to multiple residents during toileting. Throughout the survey residents were observed utilizing two hallway toilets on the west unit near the nursing station. This included 4 out of sample residents and 3 of 28 residents observed for Stage 2 (Residents #196, # 177, #59).

Specifically, 1) the privacy curtain was not pulled properly to afford residents privacy while meeting their toileting needs. Additionally, 2) during the first day of the survey, multiple residents in the main dining room were eating their breakfast meal with plastic utensil due to unavailability of metal flatware. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1) An observation was made of the bathroom in the hallway adjacent to the west nursing station on 3/27/14 at 9:10 AM. An out of sample female resident was sitting on the toilet unattended. The privacy curtain was not pulled to provide the resident privacy from the hallway. Three staff members walked by the bathroom without stopping to pull the curtain to provide privacy.

An observation was made of the bathroom in the hallway bathrooms adjacent to the west nursing station on 3/27/14 at 1:15 PM. An out of sample male resident was sitting on the toilet in the bathroom closest to the nursing station. The male resident was attended by a staff member. The curtain was not pulled to provide adequate privacy to the resident.

An observation was made on 3/28/14 at 9:06 AM of the bathrooms adjacent to the west nursing station. Resident # 196 was sitting on the toilet with a staff member present in the bathroom. The privacy curtain was not properly pulled to afford privacy.

An observation of Resident # 59 was made on 3/28/14 at 1:15 PM. Resident # 59 was sitting on the toilet in the hallway bathroom adjacent to the west nursing unit. The resident was attended by a staff member. Resident # 59 was wearing no clothing while sitting on the toilet. The privacy curtain was not pulled properly to afford privacy to the resident. Four residents ambulated or self propelled their wheelchair passed the hallway bathroom where Resident # 59 was sitting on the toilet naked.

On 3/31/14 at 9:20 AM Resident # 177 was observed sitting unattended on the toilet with the privacy curtain not properly closed.

An observation was made on 4/01/14 at 12:50 PM of an out of sample female resident sitting on the toilet in the hallway bathroom on the west unit. A staff member was present in the bathroom with the resident. The privacy curtain was not pulled properly to afford privacy.

An observation was made on 4/02/14 at 8:25 AM of the bathrooms adjacent to the west nursing station. An out of sample male was in one bathroom and an out of sample female resident was in the other bathroom. Neither resident had a staff member attending to them. Neither privacy curtain was pulled to provide privacy. Three staff members walked by the bathrooms and did not pull the curtains to afford privacy. These employees included a housekeeper and two Certified Nursing Assistants (CNA).

Resident # 196 was observed being toileted by a staff member on 4/2/14 at 11:51 AM. The privacy curtain was not pulled to afford privacy to the resident. Four staff members passed by the bathroom, including one housekeeper, 2 CNAs and one Licensed Practical Nurse (LPN).

An interview was held with a CNA on 4/04/14 at 11:00 AM. The CNA stated that the privacy curtain could be wider to make sure the whole doorway to the bathroom is covered. The CNA stated that maybe two curtains would be better for each bathroom.

An interview was held with a LPN charge nurse on 4/04/14 at 11:15 AM. The LPN stated that the residents should have privacy when being toileted in the hallway bathrooms. The LPN stated that the facility has utilized these curtains for a long time.

An interview was held with the Director of Maintenance on 4/04/14 at 11:30 AM. The Director of Maintenance Services stated that at one time the bathroom had a door, however, the door swung in towards the bathroom. A person in a wheelchair would not be able to close the door once in the bathroom to afford privacy. The Director of Maintenance Services stated that the door could not be hinged to allow the door to swing in the opposite direction because it would become a safety concern for residents in the hallway.

2) During a breakfast observation in the main dining room on 3/27/14 at 8:30 AM, there were multiple out of sample residents, at least six residents, observed to be using plastic utensils while eating. The other residents observed in the dining room were using metal flatware while eating their breakfast.

An interview with the Registered Dietitian on 3/27/14 at 8:40 AM revealed that the kitchen probably ran out of the metal utensils.

An interview with the Dietary Aide on 3/27/14 at 8:45 AM revealed that the reason some residents had been given the plastic utensils is that there were not enough metal utensils in the kitchen. In addition, the Dietary Aide reported that the dietitian had ordered additional metal spoons on 3/26/14 and that the fork and knives were on back order.

415.5 (a)

Citation date: June 3, 2014

Based on observations and staff interviews during the recertification survey the facility did not ensure that residents were cared for in an environment that maintains or enhances each resident's dignity and respect. Dignity was not provided on the west nursing unit to multiple residents during toileting. Throughout the survey residents were observed utilizing two hallway toilets on the west unit near the nursing station. This included 4 out of sample residents and 3 of 28 residents observed for Stage 2 (Residents #196, # 177, #59). Specifically, 1) the privacy curtain was not pulled properly to afford residents privacy while meeting their toileting needs. Additionally, 2) during the first day of the survey, multiple residents in the main dining room were eating their breakfast meal with plastic utensil due to unavailability of metal flatware. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1) An observation was made of the bathroom in the hallway adjacent to the west nursing station on 3/27/14 at 9:10 AM. An out of sample female resident was sitting on the toilet unattended. The privacy curtain was not pulled to provide the resident privacy from the hallway. Three staff members walked by the bathroom without stopping to pull the curtain to provide privacy.

An observation was made of the bathroom in the hallway bathrooms adjacent to the west nursing station on 3/27/14 at 1:15 PM. An out of sample male resident was sitting on the toilet in the bathroom closest to the nursing station. The male resident was attended by a staff member. The curtain was not pulled to provide adequate privacy to the resident.

An observation was made on 3/28/14 at 9:06 AM of the bathrooms adjacent to the west nursing station. Resident # 196 was sitting on the toilet with a staff member present in the bathroom. The privacy curtain was not properly pulled to afford privacy.

An observation of Resident # 59 was made on 3/28/14 at 1:15 PM. Resident # 59 was sitting on the toilet in the hallway bathroom adjacent to the west nursing unit. The resident was attended by a staff member. Resident # 59 was wearing no clothing while sitting on the toilet. The privacy curtain was not pulled properly to afford privacy to the resident. Four residents ambulated or self propelled their wheelchair passed the hallway bathroom where Resident # 59 was sitting on the toilet naked.

On 3/31/14 at 9:20 AM Resident # 177 was observed sitting unattended on the toilet with the privacy curtain not properly closed.

An observation was made on 4/01/14 at 12:50 PM of an out of sample female resident sitting on the toilet in the hallway bathroom on the west unit. A staff member was present in the bathroom with the resident. The privacy curtain was not pulled properly to afford privacy.

An observation was made on 4/02/14 at 8:25 AM of the bathrooms adjacent to the west nursing station. An out of sample male was in one bathroom and an out of sample female resident was in the other bathroom. Neither resident had a staff member attending to them. Neither privacy curtain was pulled to provide privacy. Three staff members walked by the bathrooms and did not pull the curtains to afford privacy. These employees included a housekeeper and two Certified Nursing Assistants (CNA).

Resident # 196 was observed being toileted by a staff member on 4/2/14 at 11:51 AM. The privacy curtain was not pulled to afford privacy to the resident. Four staff members passed by the bathroom, including one housekeeper, 2 CNAs and one Licensed Practical Nurse (LPN).

An interview was held with a CNA on 4/04/14 at 11:00 AM. The CNA stated that the privacy curtain could be wider to make sure the whole doorway to the bathroom is covered. The CNA stated that maybe two curtains would be better for each bathroom.

An interview was held with a LPN charge nurse on 4/04/14 at 11:15 AM. The LPN stated that the residents should have privacy when being toileted in the hallway bathrooms. The LPN stated that the facility has utilized these curtains for a long time.

An interview was held with the Director of Maintenance on 4/04/14 at 11:30 AM. The Director of Maintenance Services stated that at one time the bathroom had a door, however, the door swung in towards the bathroom. A person in a wheelchair would not be able to close the door once in the bathroom to afford privacy. The Director of Maintenance Services stated that the door could not be hinged to allow the door to swing in the opposite direction because it would become a safety concern for residents in the hallway.

2) During a breakfast observation in the main dining room on 3/27/14 at 8:30 AM, there were multiple out of sample residents, at least six residents, observed to be using plastic utensils while eating. The other residents observed in the dining room were using metal flatware while eating their breakfast.

An interview with the Registered Dietitian on 3/27/14 at 8:40 AM revealed that the kitchen probably ran out of the metal utensils.

An interview with the Dietary Aide on 3/27/14 at 8:45 AM revealed that the reason some residents had been given the plastic utensils is that there were not enough metal utensils in the kitchen. In addition, the Dietary Aide reported that the dietitian had ordered additional metal spoons on 3/26/14 and that the fork and knives were on back order.

415.5 (a)

F323 483.25(h): FACILITY IS FREE OF ACCIDENT HAZARDS

Scope: Pattern

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Citation date: April 4, 2014

Based on observations and staff interview during the recertification survey the facility did not ensure that the resident's environment remained free from accident hazards and that each resident received adequate supervision to prevent accidents. Specifically, three of four shower rooms contained large sharps containers with a large opening with a resident could potentially place their hand into. These sharps containers were not secured to the wall and were accessible to residents.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

During tour of the facility on 3/28/14 unsecured sharps containers were identified in three of four shower rooms. At 10:28 AM the sharps container was observed unsecured on the floor in the west nursing unit. At 10:35 AM the sharps container was observed unsecured on a shelf in the shower room the east nursing unit. At 10:37 AM the sharps container was observed unsecured on a shelf in the center nursing unit shower room. All of the sharps containers were large and had an opening that resident's potentially could place their hand into. A resident who independently showered could potentially remove the sharps container from the shower rooms.

An interview was held a Licensed Practical Nurse (LPN) on 3/28/14 at 10:42 AM. The LPN stated that resident's disposable razors are stored in the sharps containers in the shower rooms and that some residents do take showers independently.

An interview was held with the Director of Housekeeping Services on 3/28/14 at 11:15 AM. The Director of Housekeeping Services stated that razors are placed in the sharps containers in the shower room and that the sharps containers are removed and replaced once a month by the housekeeping staff. The Director of Housekeeping stated that he will order brackets to secure the sharps container to the walls immediately, to prevent the residents from having access to the containers.

An observation was made on 3/31/14 at 8:30 AM with the Director of Housekeeping present. The shower room on the west unit now had a sharps containers attached to the wall and the opening of the sharps containers was smaller, prohibiting the access.

415.12(h)(2)

Citation date: June 3, 2014

Based on observations and staff interview during the recertification survey the facility did not ensure that the resident's environment remained free from accident hazards and that each resident received adequate supervision to prevent accidents. Specifically, three of four shower rooms contained large sharps containers with a large opening with a resident could potentially place their hand into. These sharps containers were not secured to the wall and were accessible to residents.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

During tour of the facility on 3/28/14 unsecured sharps containers were identified in three of four shower rooms. At 10:28 AM the sharps container was observed unsecured on the floor in the west nursing unit. At 10:35 AM the sharps container was observed unsecured on a shelf in the shower room the east nursing unit. At 10:37 AM the sharps container was observed unsecured on a shelf in the center nursing unit shower room. All of the sharps containers were large and had an opening that resident's potentially could place their hand into. A resident who independently showered could potentially remove the sharps container from the shower rooms.

An interview was held a Licensed Practical Nurse (LPN) on 3/28/14 at 10:42 AM. The LPN stated that resident's disposable razors are stored in the sharps containers in the shower rooms and that some residents do take showers independently.

An interview was held with the Director of Housekeeping Services on 3/28/14 at 11:15 AM. The Director of Housekeeping Services stated that razors are placed in the sharps containers in the shower room and that the sharps containers are removed and replaced once a month by the housekeeping staff. The Director of Housekeeping stated that he will order brackets to secure the sharps container to the walls immediately, to prevent the residents from having access to the containers.

An observation was made on 3/31/14 at 8:30 AM with the Director of Housekeeping present. The shower room on the west unit now had a sharps containers attached to the wall and the opening of the sharps containers was smaller, prohibiting the access.

415.12(h)(2)

F253 483.15(h)(2): HOUSEKEEPING AND MAINTENANCE SERVICES

Scope: Pattern

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

Citation date: April 4, 2014

Based on observations, and staff, resident, and visitor interviews during the recertification survey the facility did not ensure that necessary housekeeping and maintenance services were provided to maintain a sanitary, orderly, and comfortable interior. Specifically, 1) observations were made of pails collecting dripping water on 1 of 4 nursing units (west nursing unit hallway) due to a leaking roof 2) strong urine odors were noted throughout the survey in three shared male bathrooms on two of four units (east unit and Central unit; 3) on one of four units, cold air draft around the window for Resident # 60; 4) for one resident on one of four units, a dirty Gastrostomy Tube (GT) pole base was noted, Resident # 96 ; 5) on one of four nursing units, two broken wood door frames with jagged splintered edges were observed (West unit).

This resulted in actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings include but are not limited to:

1) During an observation on 3/31/14 from 7:45 AM through 3:00 PM on the west nursing unit two garbage pails were observed in the middle of the hallway under the heating and air conditioning supply unit. Water was observed throughout the day dripping into the garbage pail.

An interview was held with an anonymous visitor on 3/27/14 at 11:15 AM. The visitor stated that the roof in the dining room has been leaking for several months, going back to approximately November 2013. The staff place garbage pails under the dripping water in the main dining room and residents continue to eat in the dining room in close proximity to the pails.

An interview was held with a representative from the resident council on 3/31/15 at 10:15 AM. The representative stated that the roof has been leaking for several months and confirmed that the staff place garbage pails under the leaking ceiling tiles in the main dining room when it rains.

An interview was held with the Director of Maintenance Services on 4/04/14 at 11:30 AM. The Director of Maintenance Services stated that the roof has had minor leaks for a while and that this winter did a lot of damage to the roof. The Director of Maintenance Services stated that the roof is very old. The facility is in the process of obtaining bids to replace the roof.

2) Three shared male bathrooms on the east nursing unit were observed with strong urine odors throughout the survey. Strong urine odors were observed in the following bathrooms at the following dates and times:

Room shared bathroom for rooms 477 and 479 (2 two-bedded male rooms): 3/27/14 at 1 PM, 3/31/14 at 9:35 AM, 4/01/14 at 8:25 AM, 4/02/14 at 2:00 PM, 4/03/14 at 9:00 AM, and 4/04/14 at 8:18 AM. The Director of Housekeeping Services was present during the observation on 4/04/14.

Room 487 (1 four-bedded male room): 3/28/14 at 11:50 AM, 3/31/14 at 8:43 AM, 4/01/14 at 8:26 AM, 4/02/14 at 2:03 PM, 4/03/14 at 9:02 AM, and 4/04/14 at 8:20 AM. The Director of Housekeeping Services was present during the observation on 4/04/14.

Room 491 (1 four-bedded male room): 3/28/14 at 11:35 AM and 12:03 PM, 3/31/14 at 8:45 AM, 4/01/14 at 8:27 AM, 4/02/14 at 2:01 PM, 4/03/14 at 9:01 AM, and 4/04/14 at 8:19 AM. The Director of Housekeeping Services was present during the observation on 4/04/14.

An interview was held with the Director of Housekeeping Services on 4/4/14 at 8:21 AM. The Housekeeping Director stated that the three bathrooms on the east unit have been identified as problems bathrooms. The housekeeping staff cleans and deodorizes these bathrooms twice a day on the day shift. The facility also has a porter available until 10 PM. The Housekeeping Director stated that the urine odor is embedded in the tile and grout around and under the commode. The deodorizer "Gold" is a urine counter-actant that has been used for over a year. The Housekeeping Director stated that the Administrator is aware of the concern with urine odors in some of the resident rooms and bathrooms. The male residents using each of these bathrooms may toilet themselves. The Housekeeping Director stated that the maintenance log book is utilized only for maintenance problems, that if urine odors are identified by staff they should verbally report the urine odor to the housekeeping staff.

During the initial tour of the central unit on 3/27/14 at 8:20 AM Room 371 was observed with a strong urine odor. Two empty urinals were observed hanging over the elevated siderail on the right side of the bed. A strong urine odor was noted in room 371 on 3/28/14 at 12:00 PM. A subsequent observation of a strong urine odor emitting form room 371 was made on 4/04/14 at 9:00 AM with the Director of Housekeeping present.

An interview was held immediately with the Director of Housekeeping Services on 4/04/14 at 9:00 AM. The Director of housekeeping Services stated that the room 371 has been a problem room for quite a while. The resident uses the urinal to self toilet and has had the mattress replaced due to the resident's incontinence. The Director of Housekeeping stated that this room is also one of the rooms that is cleaned twice a day, however, the strong urine odor remains.

3) During a stage one interview with an alert lucid resident (Resident # 60), the resident complained that during the winter months, it was cold in her room and the building. She explained that although she would complain and staff would turn up the heat, it was still cold. The staff would say to her that this is the way it is.

In addition, the alert lucid resident complained that there are (water) leaks in the building in the hallway and dining room. She further explained that the staff places pails on the floor where the water is coming through the ceiling to catch the leaking water.

Observation of the window in the resident's room (110) on 3/27/14 at 11:00 AM revealed that there is a

constant draft of cold air coming from the window even though the window was fully closed.

An air temperature log sheet from the Park Unit was reviewed and showed that not all daily air temperatures were recorded for the month of January 2014.

During an interview with the Director of Maintenance on 4/4/14/at 11:30 AM, the Director stated that attempts are made to maintain the air temperature between 72 and 76 degrees Fahrenheit. The Director explained that the reason that not all temperatures were recorded on the log sheet is due to call outs on the weekends and if there was an emergency, then temperatures may not be recorded. He also stated that during normal conditions, it is not a problem maintaining the temperature. He also stated that when there is an extended period of below normal temperatures, it gets to be a challenge. He further explained it has to do with the age of the building and that the administration is looking into new windows. In addition, the new roof (still getting bids for the new roof) will also help the building be better insulated.

4) During the initial observational tour of Central Unit with the Licensed Practical Nurse (LPN) conducted on 3/27/14 at 10:40 AM and subsequent tour on 3/28/14 at 7:20 AM, the following was observed:
- the base of the gastrostomy tube (GT) feeding pole dedicated for Resident #96 was dirty and coated with brownish creamy dried materials.

An interview with the LPN was conducted on 3/28/14 at 7:20 AM. The LPN stated that the base of the GT feeding pole should be cleaned and that she will notify the housekeeping department to clean it.

An interview with the Housekeeping Staff was conducted on 3/28/14 at 7:30 AM. The Housekeeping Staff stated that it was her department's job to clean the GT poles and that she was not aware that the GT pole was dirty but she would get to clean it.

5) An observation was made on 3/28/14 at 10:45 AM on the west unit of two broken and splintered wooden door frames. Resident room 223 and the shower room door frame next to room 223 had broken wooden molding around the door frames. The edges were jagged with splintered wood.

Subsequent observations were made on 3/31/14 at 9:00 AM and 10:40 AM. The wood door frames around room 223 and the shower room next to room 223 remained broken with jagged edges exposed.

An interview was held with the Director of Housekeeping Services on 3/31/14 at 10:40 AM. The Director of Housekeeping Services stated that the broken door frames should be removed and the Director of Maintenance Services will be informed.

The Director of Maintenance Services was observed removing the broken wooden door frames surrounding room 223 and the shower room on 3/31/14 at 11:20 AM.

An interview was held with the Director of Maintenance Services on 4/02/14 at 8:25 AM. The Director of Maintenance Services stated that he removed the broken door frames and replaced the door frame with plastic molding. The Director of Maintenance Services stated that 3/31/14 was the first time he was made aware of the broken door frames. He reviewed the maintenance log book for the last three months and found no entries related to the broken door frames. He stated that any staff member who identifies a maintenance issue should report the concern in the maintenance log book or verbally tell him of the issue.

415.(h)(2)

Citation date: June 3, 2014

Based on observations, and staff, resident, and visitor interviews during the recertification survey the facility did not ensure that necessary housekeeping and maintenance services were provided to maintain a sanitary, orderly, and comfortable interior. Specifically, 1) observations were made of pails collecting dripping water on 1 of 4 nursing units (west nursing unit hallway) due to a leaking roof 2) strong urine odors were noted throughout the survey in three shared male bathrooms on two of four units (east unit and Central unit; 3) on one of four units, cold air draft around the window for Resident # 60; 4) for one resident on one of four units, a dirty Gastrostomy Tube (GT) pole base was noted, Resident # 96 ; 5) on one of four nursing units, two broken wood door frames with jagged splintered edges were observed (West unit).

This resulted in actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings include but are not limited to:

1) During an observation on 3/31/14 from 7:45 AM through 3:00 PM on the west nursing unit two garbage pails were observed in the middle of the hallway under the heating and air conditioning supply unit. Water was observed throughout the day dripping into the garbage pail.

An interview was held with an anonymous visitor on 3/27/14 at 11:15 AM. The visitor stated that the roof in the dining room has been leaking for several months, going back to approximately November 2013. The staff place garbage pails under the dripping water in the main dining room and residents continue to eat in the dining room in close proximity to the pails.

An interview was held with a representative from the resident council on 3/31/15 at 10:15 AM. The representative stated that the roof has been leaking for several months and confirmed that the staff place garbage pails under the leaking ceiling tiles in the main dining room when it rains.

An interview was held with the Director of Maintenance Services on 4/04/14 at 11:30 AM. The Director of Maintenance Services stated that the roof has had minor leaks for a while and that this winter did a lot of damage to the roof. The Director of Maintenance Services stated that the roof is very old. The facility is in the process of obtaining bids to replace the roof.

2) Three shared male bathrooms on the east nursing unit were observed with strong urine odors throughout the survey. Strong urine odors were observed in the following bathrooms at the following dates and times:

Room shared bathroom for rooms 477 and 479 (2 two-bedded male rooms): 3/27/14 at 1 PM, 3/31/14 at 9:35 AM, 4/01/14 at 8:25 AM, 4/02/14 at 2:00 PM, 4/03/14 at 9:00 AM, and 4/04/14 at 8:18 AM. The Director of Housekeeping Services was present during the observation on 4/04/14.

Room 487 (1 four-bedded male room): 3/28/14 at 11:50 AM, 3/31/14 at 8:43 AM, 4/01/14 at 8:26 AM, 4/02/14 at 2:03 PM, 4/03/14 at 9:02 AM, and 4/04/14 at 8:20 AM. The Director of Housekeeping Services was present during the observation on 4/04/14.

Room 491 (1 four-bedded male room): 3/28/14 at 11:35 AM and 12:03 PM, 3/31/14 at 8:45 AM, 4/01/14 at 8:27 AM, 4/02/14 at 2:01 PM, 4/03/14 at 9:01 AM, and 4/04/14 at 8:19 AM. The Director of Housekeeping Services was present during the observation on 4/04/14.

An interview was held with the Director of Housekeeping Services on 4/4/14 at 8:21 AM. The Housekeeping Director stated that the three bathrooms on the east unit have been identified as problems bathrooms. The housekeeping staff cleans and deodorizes these bathrooms twice a day on the day shift. The facility also has a porter available until 10 PM. The Housekeeping Director stated that the urine odor is embedded in the tile and grout around and under the commode. The deodorizer "Gold" is a urine counter-actant that has been used for over a year. The Housekeeping Director stated that the Administrator is aware of the concern with urine odors in some of the resident rooms and bathrooms. The male residents using each of these bathrooms may toilet themselves. The Housekeeping Director stated that the maintenance log book is utilized only for maintenance problems, that if urine odors are identified by staff they should verbally report the urine odor to the housekeeping staff.

During the initial tour of the central unit on 3/27/14 at 8:20 AM Room 371 was observed with a strong urine odor. Two empty urinals were observed hanging over the elevated siderail on the right side of the bed. A strong urine odor was noted in room 371 on 3/28/14 at 12:00 PM. A subsequent observation of a strong urine odor emitting form room 371 was made on 4/04/14 at 9:00 AM with the Director of Housekeeping present.

An interview was held immediately with the Director of Housekeeping Services on 4/04/14 at 9:00 AM. The Director of housekeeping Services stated that the room 371 has been a problem room for quite a while. The resident uses the urinal to self toilet and has had the mattress replaced due to the resident's incontinence. The Director of Housekeeping stated that this room is also one of the rooms that is cleaned twice a day, however, the strong urine odor remains.

3) During a stage one interview with an alert lucid resident (Resident # 60), the resident complained that during the winter months, it was cold in her room and the building. She explained that although she would complain and staff would turn up the heat, it was still cold. The staff would say to her that this is the way it is.

In addition, the alert lucid resident complained that there are (water) leaks in the building in the hallway and dining room. She further explained that the staff places pails on the floor where the water is coming through the ceiling to catch the leaking water.

Observation of the window in the resident's room (110) on 3/27/14 at 11:00 AM revealed that there is a

constant draft of cold air coming from the window even though the window was fully closed.

An air temperature log sheet from the Park Unit was reviewed and showed that not all daily air temperatures were recorded for the month of January 2014.

During an interview with the Director of Maintenance on 4/4/14/at 11:30 AM, the Director stated that attempts are made to maintain the air temperature between 72 and 76 degrees Fahrenheit. The Director explained that the reason that not all temperatures were recorded on the log sheet is due to call outs on the weekends and if there was an emergency, then temperatures may not be recorded. He also stated that during normal conditions, it is not a problem maintaining the temperature. He also stated that when there is an extended period of below normal temperatures, it gets to be a challenge. He further explained it has to do with the age of the building and that the administration is looking into new windows. In addition, the new roof (still getting bids for the new roof) will also help the building be better insulated.

4) During the initial observational tour of Central Unit with the Licensed Practical Nurse (LPN) conducted on 3/27/14 at 10:40 AM and subsequent tour on 3/28/14 at 7:20 AM, the following was observed:
- the base of the gastrostomy tube (GT) feeding pole dedicated for Resident #96 was dirty and coated with brownish creamy dried materials.

An interview with the LPN was conducted on 3/28/14 at 7:20 AM. The LPN stated that the base of the GT feeding pole should be cleaned and that she will notify the housekeeping department to clean it.

An interview with the Housekeeping Staff was conducted on 3/28/14 at 7:30 AM. The Housekeeping Staff stated that it was her department's job to clean the GT poles and that she was not aware that the GT pole was dirty but she would get to clean it.

5) An observation was made on 3/28/14 at 10:45 AM on the west unit of two broken and splintered wooden door frames. Resident room 223 and the shower room door frame next to room 223 had broken wooden molding around the door frames. The edges were jagged with splintered wood.

Subsequent observations were made on 3/31/14 at 9:00 AM and 10:40 AM. The wood door frames around room 223 and the shower room next to room 223 remained broken with jagged edges exposed.

An interview was held with the Director of Housekeeping Services on 3/31/14 at 10:40 AM. The Director of Housekeeping Services stated that the broken door frames should be removed and the Director of Maintenance Services will be informed.

The Director of Maintenance Services was observed removing the broken wooden door frames surrounding room 223 and the shower room on 3/31/14 at 11:20 AM.

An interview was held with the Director of Maintenance Services on 4/02/14 at 8:25 AM. The Director of Maintenance Services stated that he removed the broken door frames and replaced the door frame with plastic molding. The Director of Maintenance Services stated that 3/31/14 was the first time he was made aware of the broken door frames. He reviewed the maintenance log book for the last three months and found no entries related to the broken door frames. He stated that any staff member who identifies a maintenance issue should report the concern in the maintenance log book or verbally tell him of the issue.

415.(h)(2)

F469 483.70(h)(4): MAINTAINS EFFECTIVE PEST CONTROL PROGRAM

Scope: Pattern

Severity: Potential for more than Minimal Harm

Corrected Date: June 18, 2014

The facility must maintain an effective pest control program so that the facility is free of pests and rodents.

Citation date: April 4, 2014

Based on several observations, staff interview and record review during the recertification survey, the facility did not ensure that all resident and food areas were pest free. Specifically, during multiple days of survey,

there were live insects noted in resident areas near nursing units and in the main kitchen during the initial tour.

This resulted in no actual harm with the potential for more than minimal harm.

The findings are:

During the initial tour of the main kitchen on 3/27/14 at 9:15 AM, there were multiple live flies identified as drain flies in the dishwasher area.

In addition, insect glue cardboard traps were placed in the corner of electrical receptacles approximately 3 feet off the floor. In at least two instances, the glue traps were adjacent to the food preparation and or cooking areas in the main kitchen.

During an interview with the First Cook on 4/3/14 at 10:00 AM, he reported that the pest control company is contracted to come to the facility on a weekly basis. In addition, he reported that the pest control company placed the glue traps high up off the floor in the main kitchen.

A statement from the pest control company dated 4/4/14 documented that a very long time ago the facility had a slight rodent problem and the bait stations placed in the kitchen are part of the precautionary monitoring system set up to ensure that there is no reoccurrence of rodent activity.

During an observation on 4/3/14 at 11:30 AM revealed that there were live flies in the hallway on the Park Unit.

During an observation on 4/4/14 at 6:24 AM there was a small live insect flying near to the nursing station on the Central Unit.

During an observation on 4/4/14 at 7:33 AM there was a small live flying insect near the East nursing station.

During an interview with the pest control company representative on 4/4/14/at 11:00 AM, he confirmed that the representative from pest control comes into the facility on a weekly basis. He also stated that the glue traps placed on the walls in the main kitchen do not attract insects to that area but catch anything walking and that he can have the traps relocated nearer to the floor.

415.29 (j) (5)

Citation date: June 3, 2014

Based on multiple observations, staff interview and record review during the Post Survey Revisit (PSR), the facility did not ensure that all resident and food preparation areas were pest-free. Specifically, multiple observations on two of two days of survey and on two of four nursing units were made of live and dead insects; while touring the main kitchen, during interviews in multiple bedded rooms, in the conference area and in the Director of Nursing Services (DNS) office.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

This is a REPEAT deficiency from the April 2014 Recertification survey.

The findings are:

During the initial tour of the main kitchen on 6/2/14 at 8:30 AM revealed the following observations:

1) A large ceiling light fixture located near to the exterior door of the kitchen and approximately 3 feet in length was covered with what appeared to be small black insects, i.e., gnats. These black insects covered a large section of the fixture and appeared to be on the outside of the fixture cover and appeared dead as the insects were not moving.

2) In addition, there were multiple citings of black flying insects approximately one quarter of an inch in size near the preparation sink. These flying insects appeared to be Drain flies and were identified by the Sanitarian Surveyor on the most recent Recertification Survey, two months ago, and were found within the main kitchen.

Resident Room observations:

3) An Observation on 6/2/14 at 2:30 PM revealed that the Resident # 114 was lying in bed and was awake. On the resident's night stand was an uneaten wrapped sandwich. The resident reported to the surveyor at

that time that the observed uneaten sandwich was from his morning breakfast tray. There were multiple live black flies circling the night stand. In addition, there were black flies on the sandwich bag and on the wall behind the night stand. These black flies were approximately a quarter inch in size and appeared to be Drain flies.

An interview with a nearby Housekeeper who observed the insects in Resident # 114's room on 6/2/14 at 2:35 PM revealed that he would address the problem and have the area cleaned up.

4) An observation on 6/3/14 at 2:00 PM during an interview with the alert and lucid resident in room # 368 (Unit C) revealed that there were several live flying insects in the room which appeared to be Drain flies.

5) During an interview with the Director of Nursing Services (DNS) on 6/3/14 at 3:00 PM revealed that there was what appeared to be a black flying insect; i.e., Drain fly, within her office located on the West Unit hallway. Resident rooms are located directly across from the DNS's office.

6) During the two days of the PSR, citings of the black flying insects were made within the conference room area located on the West Unit where residents reside.

7) An interview was conducted with the Director of Maintenance on 6/3/14 at 3:30 PM and he said that he is not able to put a screen door in the kitchen and that in the past he has tried a screen sliding door which was not effective. He also stated that he has not seen the flies that the surveyor has been seeing during the past two days.

415.29(j)(5)

F282 483.20(k)(3)(ii): SERVICES BY QUALIFIED PERSONS IN ACCORDANCE WITH CARE PLAN

Scope: Pattern

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

Citation date: April 4, 2014

Based on observation, record review, resident and staff interview during the recertification survey, the facility did not provide all care in accordance with the comprehensive Care Plan for 3 of 38 Stage two residents reviewed. Specifically, 1) For Resident # 114, there were Physician's orders for removal of a dressing to the AV shunt site 24 hours following dialysis. There was no documented evidence that the physician's orders were consistently being followed by facility staff. 2) Resident # 192 did not have a HgbA1c laboratory test (blood test to assess the blood sugar over the past 3 months) performed as ordered by the physician. 3) Resident #71 had a Physician order to have the Groshong catheter flushed daily. This was not followed as per the plan of care. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1) Resident # 114 with diagnoses that includes End Stage Renal Disease receives Dialysis three times per week.

The recent Minimum Data Set Assessment dated 1/07/14 documented the resident's cognition as being intact with a Brief Interview Mental Status (BIMS) score of 15.

The current Physician Orders documented on the Treatment Administration Record (TAR) include: Removal of the dressing on the left arm antecubital 24 hours after dialysis... Tuesday, Thursday and Saturday.

There was no documented evidence on the current TAR started on 3/22/14 that the nurses were removing the dressing to the left arm as ordered by the Physician.

An interview with the alert and lucid resident on 4/2/14 at 10:00 AM revealed that the facility nurses do not

always take the dressing off the resident's left arm and that sometimes the dressing is taken off at the Dialysis Center.

An interview with the Assistant Director of Nursing Services (ADNS) on 4/2/14 at 11:20 AM revealed that the nurses should have been documenting the removal of the dressing on the TAR.

A phone interview was conducted with the LPN on 4/2/14 at 12:00 PM revealed that the LPN reported that he was removing the dressing and signing for the removal on the TAR.

A second interview with the ADNS on 4/4/14 at 11:00 AM could not explain the discrepancy.

2) Resident # 192, with diagnoses including Diabetes, Polyneuropathy secondary to Diabetes, and Dementia, was admitted to the facility on 10/25/13.

The admission Minimum Data Set (MDS) assessment dated 11/01/13 documented that the resident's brief interview for mental status (BIMS) score of 3 indicated that the resident had severely impaired cognitive skills. The resident was identified as having daily wandering behavior and trouble concentrating 7-11 days in the past 2 weeks.

The admission physician's orders dated 10/25/13 documented medications including but not limited to: Glipizide ER 2.5 milligrams by mouth 30 minutes before breakfast.

A physician's order dated 11/04/13 requested a Complete Blood Count (CBC), Basal Metabolic Panel (BMP) and a Hemoglobin test (HgbA1c) to assess the resident's blood sugar concentration over a three month period.

The Comprehensive Care Plan (CCP) dated 10/25/13 for alteration in blood glucose level related to Non Insulin Dependent Diabetes Mellitus documented an intervention including but not limited to: monitor the resident's blood glucose levels as ordered and notify physician of changes.

A nurse's note dated 11/05/13 at 7:15 PM documented that the CBC was unable to be completed due to the "tube clotted" The physician was made aware. The CBC was to be obtained on 11/06/13. The physician was to evaluate the BMP, glucose of 165 and Blood Urea Nitrogen (BUN) level of 33.

The laboratory report dated 11/05/13 dated documented "tube clotted". The glucose level was 165 milligrams per deciliter (mg/dL) and the BUN was 33. There was no HgbA1c result on the laboratory report.

The laboratory report dated 11/06/13 did not contain the results of the HgbA1c.

An interview was held with the physician on 4/02/14 at 9:45 AM. The physician stated that he was not made aware that the HgbA1c test that he ordered had not been completed.

An interview was held with the Director of Nursing Services (DNS) on 4.02/14 at 10:16 AM. The DNS stated that the laboratory was called today. The laboratory had no record that the HgbA1c had been completed as ordered by the physician on 11/05/13. The tube was clotted on 11/05/13 and blood was then re-drawn on 11/06/13. The 11/06/13 bloodwork included a CBC, however no assessment of the resident's HgbA1c was performed.

3) Resident #71 has diagnoses including Depression, Neuropathy, Anxiety, and Atrial Fibrillation. The resident is a dialysis patient.

A Physician's Order dated 3/24/14 documented the following: Flush Groshong Catheter with 10 milliliters (ml) of Normal Saline daily.

The Treatment Administration Record (TAR) for January 3-30 2014 documented to flush Groshong Catheter with 10 ml of Normal Saline daily. Review of the TAR revealed that 12 out of the 28 days had signatures from the nursing staff.

The TAR for February 1-23, 2014 documented that 23 of the 23 days had no signatures of the nursing staff to indicate that the Groshong catheter was flushed with Normal Saline.

The TAR for February 24, 2014 - March 31, 2014 documented to flush Groshong Catheter with 10 ml of Normal Saline daily. The TAR also documented licensed staff signatures on the following dates: 2/28/14, 3/4/14, 3/5/14, 3/6/14, 3/11/13 through 3/13/14, and 3/18/14 to indicate that flushing of the Groshong catheter was flushed with Normal Saline. Review of the TAR revealed that there were 23 out of 39 days that

the Groshong catheter was not flushed as per the missing licensed nursing staff signatures.

An interview with Resident #71, alert and oriented as to person, time, and place, was conducted on 3/31/14 at 10:00 AM. The resident stated that her Groshong catheter is only flushed by the licensed nursing staff once a week.

An interview with the Attending Physician/Medical Director was conducted on 4/2/14 at 10:06 AM. The Physician stated that the Groshong catheter should be flushed daily as per the Physician's Order and should be followed.

The facility's undated policy and procedure titled Groshong Catheter documented that it should be flushed with Normal Saline to keep the site patent.

415.11(c)(3)(ii)

Citation date: June 3, 2014

Based on observation, record review, resident and staff interview during the recertification survey, the facility did not provide all care in accordance with the comprehensive Care Plan for 3 of 38 Stage two residents reviewed. Specifically, 1) For Resident # 114, there were Physician's orders for removal of a dressing to the AV shunt site 24 hours following dialysis. There was no documented evidence that the physician's orders were consistently being followed by facility staff. 2) Resident # 192 did not have a HgbA1c laboratory test (blood test to assess the blood sugar over the past 3 months) performed as ordered by the physician. 3) Resident #71 had a Physician order to have the Groshong catheter flushed daily. This was not followed as per the plan of care. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1) Resident # 114 with diagnoses that includes End Stage Renal Disease receives Dialysis three times per week.

The recent Minimum Data Set Assessment dated 1/07/14 documented the resident's cognition as being intact with a Brief Interview Mental Status (BIMS) score of 15.

The current Physician Orders documented on the Treatment Administration Record (TAR) include: Removal of the dressing on the left arm antecubital 24 hours after dialysis... Tuesday, Thursday and Saturday.

There was no documented evidence on the current TAR started on 3/22/14 that the nurses were removing the dressing to the left arm as ordered by the Physician.

An interview with the alert and lucid resident on 4/2/14 at 10:00 AM revealed that the facility nurses do not always take the dressing off the resident's left arm and that sometimes the dressing is taken off at the Dialysis Center.

An interview with the Assistant Director of Nursing Services (ADNS) on 4/2/14 at 11:20 AM revealed that the nurses should have been documenting the removal of the dressing on the TAR.

A phone interview was conducted with the LPN on 4/2/14 at 12:00 PM revealed that the LPN reported that he was removing the dressing and signing for the removal on the TAR.

A second interview with the ADNS on 4/4/14 at 11:00 AM could not explain the discrepancy.

2) Resident # 192, with diagnoses including Diabetes, Polyneuropathy secondary to Diabetes, and Dementia, was admitted to the facility on 10/25/13.

The admission Minimum Data Set (MDS) assessment dated 11/01/13 documented that the resident's brief interview for mental status (BIMS) score of 3 indicated that the resident had severely impaired cognitive skills. The resident was identified as having daily wandering behavior and trouble concentrating 7-11 days in the past 2 weeks.

The admission physician's orders dated 10/25/13 documented medications including but not limited to: Glipizide ER 2.5 milligrams by mouth 30 minutes before breakfast.

A physician's order dated 11/04/13 requested a Complete Blood Count (CBC), Basal Metabolic Panel (BMP)

and a Hemoglobin test (HgbA1c) to assess the resident's blood sugar concentration over a three month period.

The Comprehensive Care Plan (CCP) dated 10/25/13 for alteration in blood glucose level related to Non Insulin Dependent Diabetes Mellitus documented an intervention including but not limited to: monitor the resident's blood glucose levels as ordered and notify physician of changes.

A nurse's note dated 11/05/13 at 7:15 PM documented that the CBC was unable to be completed due to the "tube clotted" The physician was made aware. The CBC was to be obtained on 11/06/13. The physician was to evaluate the BMP, glucose of 165 and Blood Urea Nitrogen (BUN) level of 33.

The laboratory report dated 11/05/13 dated documented "tube clotted". The glucose level was 165 milligrams per deciliter (mg/dL) and the BUN was 33. There was no HgbA1c result on the laboratory report.

The laboratory report dated 11/06/13 did not contain the results of the HgbA1c.

An interview was held with the physician on 4/02/14 at 9:45 AM. The physician stated that he was not made aware that the HgbA1c test that he ordered had not been completed.

An interview was held with the Director of Nursing Services (DNS) on 4.02/14 at 10:16 AM. The DNS stated that the laboratory was called today. The laboratory had no record that the HgbA1c had been completed as ordered by the physician on 11/05/13. The tube was clotted on 11/05/13 and blood was then re-drawn on 11/06/13. The 11/06/13 bloodwork included a CBC, however no assessment of the resident's HgbA1c was performed.

3) Resident #71 has diagnoses including Depression, Neuropathy, Anxiety, and Atrial Fibrillation. The resident is a dialysis patient.

A Physician's Order dated 3/24/14 documented the following: Flush Groshong Catheter with 10 milliliters (ml) of Normal Saline daily.

The Treatment Administration Record (TAR) for January 3-30 2014 documented to flush Groshong Catheter with 10 ml of Normal Saline daily. Review of the TAR revealed that 12 out of the 28 days had signatures from the nursing staff.

The TAR for February 1-23, 2014 documented that 23 of the 23 days had no signatures of the nursing staff to indicate that the Groshong catheter was flushed with Normal Saline.

The TAR for February 24, 2014 - March 31, 2014 documented to flush Groshong Catheter with 10 ml of Normal Saline daily. The TAR also documented licensed staff signatures on the following dates: 2/28/14, 3/4/14, 3/5/14, 3/6/14, 3/11/13 through 3/13/14, and 3/18/14 to indicate that flushing of the Groshong catheter was flushed with Normal Saline. Review of the TAR revealed that there were 23 out of 39 days that the Groshong catheter was not flushed as per the missing licensed nursing staff signatures.

An interview with Resident #71, alert and oriented as to person, time, and place, was conducted on 3/31/14 at 10:00 AM. The resident stated that her Groshong catheter is only flushed by the licensed nursing staff once a week.

An interview with the Attending Physician/Medical Director was conducted on 4/2/14 at 10:06 AM. The Physician stated that the Groshong catheter should be flushed daily as per the Physician's Order and should be followed.

The facility's undated policy and procedure titled Groshong Catheter documented that it should be flushed with Normal Saline to keep the site patent.

415.11(c)(3)(ii)

F371 483.35(i): STORE/PREPARE/DISTRIBUTE FOOD UNDER SANITARY CONDITIONS

Scope: Pattern

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions

Citation date: April 4, 2014

Based on multiple observations, staff interviews and record reviews during the Recertification survey, the facility did not ensure that sanitary conditions were being maintained in the kitchen area. Specifically, the initial tour of the main kitchen on 3/27/14 revealed the following: 1) The dishwashing machine final rinse temperature was below 180 degrees Fahrenheit (F) without a sanitizing chemical agent in place; 2) Incomplete sanitizing log sheet for the three compartment pot washing sink; 3) a Registered Dietitian observed without a hair restraint, and 4) The kitchen was in poor repair and in need of cleaning; preparation sink with a leaky faucet, food service equipment not thoroughly cleaned i.e., a roof vent reported to have precipitation (snow) which leaked into the kitchen, observed cob webs, and a generally unkept appearance.

This resulted in a pattern of no actual harm with the potential for more than minimal harm this is not immediate jeopardy.

In addition, this is a REPEAT deficiency from the 2013 Recertification Survey.

The findings are:

Observation during the initial tour on 3/27/14 at 9:15 AM of the main kitchen revealed the following:

The dishwashing machine was being operated with storage racks running through the machine being cleaned. The final rinse water temperature was observed at 160 degrees Fahrenheit (F). The operating temperature for the final rinse should be at 180 degrees (F). The dietary employee operating the dish machine stated that there is a chemical sanitizer back up in place. Observation at that time revealed that the chemical sanitizer was in the off position and when the dietary employee saw the chemical sanitizer in the off position, he then switched it to on.

The recorded sanitizer log sheet for the three compartment sink was not consistently being recorded three times per day. There were some days left completely blank and some days had only partial information with regard to the sanitizer concentration level.

The faucet of the sink adjacent to the dry goods storeroom was observed to be dripping heavily.

On 3/27/14 at 9:00 AM, the Registered Dietitian (RD) was observed in the kitchen preparing a snack cart with her long hair unrestrained. She explained that the reason she was not wearing a hair net was that she was leaving from the kitchen very shortly.

There was a large black rubber floor mat hung over a railing adjacent to the food preparation area.

An interview with the first cook at that time revealed that the rug was being cleaned and should not have been hung in that location.

A rolling storage and serving cart filled with individual boxes of cereals was visibly soiled with dust and was in need of cleaning.

Cobb webs were observed attached to the kitchen exit sign.

The exit door was visibly soiled with dirt and dried on splashes an was in need of cleaning.

The first cook reported that it had "snowed" inside the kitchen when it snowed outdoors. He further stated that the snow must be coming through a roof vent and that should not be.

An interview with the Director of Maintenance on 4/4/14 at 11:30 AM revealed that although precipitation should not be coming through the roof vent, the snow could possibly blow in.

415.14 (h)

Citation date: June 3, 2014

Based on multiple observations, staff interviews and record reviews during the Recertification survey, the facility did not ensure that sanitary conditions were being maintained in the kitchen area. Specifically, the initial tour of the main kitchen on 3/27/14 revealed the following: 1) The dishwashing machine final rinse

temperature was below 180 degrees Fahrenheit (F) without a sanitizing chemical agent in place; 2) Incomplete sanitizing log sheet for the three compartment pot washing sink; 3) a Registered Dietitian observed without a hair restraint, and 4) The kitchen was in poor repair and in need of cleaning; preparation sink with a leaky faucet, food service equipment not thoroughly cleaned i.e., a roof vent reported to have precipitation (snow) which leaked into the kitchen, observed cob webs, and a generally unkept appearance.

This resulted in a pattern of no actual harm with the potential for more than minimal harm this is not immediate jeopardy.

In addition, this is a REPEAT deficiency from the 2013 Recertification Survey.

The findings are:

Observation during the initial tour on 3/27/14 at 9:15 AM of the main kitchen revealed the following:

The dishwashing machine was being operated with storage racks running through the machine being cleaned. The final rinse water temperature was observed at 160 degrees Fahrenheit (F). The operating temperature for the final rinse should be at 180 degrees (F). The dietary employee operating the dish machine stated that there is a chemical sanitizer back up in place. Observation at that time revealed that the chemical sanitizer was in the off position and when the dietary employee saw the chemical sanitizer in the off position, he then switched it to on.

The recorded sanitizer log sheet for the three compartment sink was not consistently being recorded three times per day. There were some days left completely blank and some days had only partial information with regard to the sanitizer concentration level.

The faucet of the sink adjacent to the dry goods storeroom was observed to be dripping heavily.

On 3/27/14 at 9:00 AM, the Registered Dietitian (RD) was observed in the kitchen preparing a snack cart with her long hair unrestrained. She explained that the reason she was not wearing a hair net was that she was leaving from the kitchen very shortly.

There was a large black rubber floor mat hung over a railing adjacent to the food preparation area.

An interview with the first cook at that time revealed that the rug was being cleaned and should not have been hung in that location.

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An interview with the Director of Maintenance on 4/4/14 at 11:30 AM revealed that although precipitation should not be coming through the roof vent, the snow could possibly blow in.

415.14 (h)

F312 483.25(a)(3): ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Citation date: April 4, 2014

Based on observation, record reviews and staff interviews during the recertification survey, the facility did not ensure that a resident who is unable to carry out activities of daily living (ADL)receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This was evident in 2 of 2 residents reviewed for ADLs in a total of 38 Stage II sampled resident. Specifically, 1) Resident #5 was observed in bed with mouth full of froth on two separate occasions. The resident is a quadriplegic. 2) Resident #216 was observed in bed with a thick coated tongue on two separate occasions. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1) Resident #5 has diagnoses including Neurogenic Bladder, Quadriplegia, Multiple Sclerosis, and Salivary Secretions.

The Minimum Data Set (MDS) Quarterly Assessment dated 2/18/14 documented BIMS=15, personal hygiene total dependence of one person assist with both upper and lower extremities impairment on both sides.

The resident was observed in bed with her mouth full of froth and dripping saliva on both sides of the mouth on the following dates:
3/27/14 at 10:45 AM
3/28/14 at 7:20 AM

An interview with the Licensed Practical Nurse (LPN) was conducted on 3/27/14 at 10:50 AM. The LPN stated that the resident always froth with saliva and had medication for the increased salivary secretions.

An interview with the Registered Nurse (RN) Infection Control Nurse was conducted on 3/28/14 at 7:25 AM. The RN stated that she reminds the nursing staff to monitor the resident's increased salivary secretions to make sure the resident is always clean and comfortable.

2) Resident #216 has diagnoses of Intellectual Disability and Dysphagia.

The Minimum Data Set (MDS) dated 3/11/14 documented severely impaired in cognition, personal hygiene extensive assistance of one-person. The MDS also documented under Section H listed ostomy as appliance used and under Section L (oral/Dental Status) that nothing was checked or that no entry was made.

On 3/27/14 at 10:30 AM, the resident was observed in bed with his tongue coated with thickened dried creamy- greenish debris.

The LPN Charge Nurse was interviewed and stated that the Certified Nursing Assistant (CNA) always cleans the resident's mouth with a swab.

On the 3/28/14 at 10:04 AM, the resident was again observed with the same but less thickened debris coated tongue.

The CNA interviewed on 3/28/14 at 10:10 AM . The CNA stated that the nursing staff cleans his mouth and that she was not aware of the debris on the resident's tongue.

The facility's undated policy and procedure titled Oral Care documented "...The responsibility of each individual within the nursing department is to ensure good oral care for each resident...".

415.12(a)(3)

Citation date: June 3, 2014

Based on observation, record reviews and staff interviews during the recertification survey, the facility did not ensure that a resident who is unable to carry out activities of daily living (ADL)receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This was evident in 2 of 2 residents reviewed for ADLs in a total of 38 Stage II sampled resident. Specifically, 1) Resident #5 was observed in bed with mouth full of froth on two separate occasions. The resident is a quadriplegic. 2) Resident #216 was observed in bed with a thick coated tongue on two separate occasions. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1) Resident #5 has diagnoses including Neurogenic Bladder, Quadriplegia, Multiple Sclerosis, and Salivary Secretions.

The Minimum Data Set (MDS) Quarterly Assessment dated 2/18/14 documented BIMS=15, personal hygiene total dependence of one person assist with both upper and lower extremities impairment on both sides.

The resident was observed in bed with her mouth full of froth and dripping saliva on both sides of the mouth on the following dates:
3/27/14 at 10:45 AM
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An interview with the Licensed Practical Nurse (LPN) was conducted on 3/27/14 at 10:50 AM. The LPN stated that the resident always froth with saliva and had medication for the increased salivary secretions.

An interview with the Registered Nurse (RN) Infection Control Nurse was conducted on 3/28/14 at 7:25 AM. The RN stated that she reminds the nursing staff to monitor the resident's increased salivary secretions to make sure the resident is always clean and comfortable.

2) Resident #216 has diagnoses of Intellectual Disability and Dysphagia.

The Minimum Data Set (MDS) dated 3/11/14 documented severely impaired in cognition, personal hygiene extensive assistance of one-person. The MDS also documented under Section H listed ostomy as appliance used and under Section L (oral/Dental Status) that nothing was checked or that no entry was made.

On 3/27/14 at 10:30 AM, the resident was observed in bed with his tongue coated with thickened dried creamy- greenish debris.

The LPN Charge Nurse was interviewed and stated that the Certified Nursing Assistant (CNA) always cleans the resident's mouth with a swab.

On the 3/28/14 at 10:04 AM, the resident was again observed with the same but less thickened debris coated tongue.

The CNA interviewed on 3/28/14 at 10:10 AM . The CNA stated that the nursing staff cleans his mouth and that she was not aware of the debris on the resident's tongue.

The facility's undated policy and procedure titled Oral Care documented "...The responsibility of each individual within the nursing department is to ensure good oral care for each resident...".

415.12(a)(3)

F514 483.75(l)(1): CLINICAL RECORDS MEET PROFESSIONAL STANDARDS

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 18, 2014

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

Citation date: April 4, 2014

Based on record review and staff interviews during the recertification survey the facility did not ensure that clinical records were complete and accurately documented. This was evident for three of 38 Stage 2 sampled residents. Specifically, 1) Resident # 175's Medication Administration Record (MAR) did not accurately reflect the administration of three medications and fingerstick blood sugar results on 3/25/14; 2) Resident # 71 did not have accurate physician's progress notes related to a Stage IV pressure ulcer; and 3) Resident # 91 did not have accurate physician progress notes related to skin breakdown on the resident's bilateral great toes. Additionally, Resident # 91 was admitted to the facility on 12/5/13 and was reviewed in the Stage 1 for Pressure Ulcers. Review of the closed record revealed that there was no December 2013 Treatment Administration Record (TAR) found despite having physician orders for treatment to a Pressure Sore; and Resident # 91 was a dialysis patient and had a Physician Order to listen to the bruit and feel the thrill of the

arteriovenous (AV) fistula (a connection between a vein and artery for hemodialysis access) site to the left arm every shift. The December 2013 TAR could not be located in the medical record to verify if the order was followed through by the nursing staff. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

This is a REPEAT deficiency from the 2013 and 2012 Recertification Surveys.

The findings are:

1) Resident # 175, with diagnoses including Hypertension, Diabetes and Hyperlipidemia, was admitted to the facility on 3/21/14.

The 5-day Minimum Data Set (MDS) assessment dated 3/28/14 documented that Resident # 175 had clear speech, was sometimes understood and sometimes understands. No mood or behavioral problems were identified. The resident's medications included antibiotics and duiretics.

The admission physician orders dated 3/21/14 prescribed medications including but not limited to: Enalapril 10 milligrams (mg) tab by mouth daily for Hypertension, Lasix 40 mg tab by mouth daily as a diuretic, and Metformin 500 mg tablet by mouth twice a day for Diabetes Mellitus. Additionally, the physician order fingersticks twice a day with coverage of Humalog R insulin based on the results.

Review of the Medication Administration Record (MAR) on 4/04/14 at 11:10 AM revealed that there were no signatures for 3/25/14 for Enalapril, Lasix, Metformin and the fingerstick results.

An interview was held with the Licensed Practical Nurse (LPN) on 4/04/14 at 11:18 AM. The LPN identified herself as being the medication nurse working on 3/25/14.

The Director of Nursing Services (DNS) arrived on the east unit at 11:20 AM. The MAR was reviewed with the LPN with the DNS standing behind and to the left of the LPN. When the blank spaces were brought to the LPN's attention the LPN started to sign her initials in those blank (3/25/14) spaces.

An interview was held at that time with the LPN. The LPN stated that she checked the resident's fingerstick that morning (3/25/14) and did administer the medications but forgot to sign for the medications and forgot to document the resident's fingerstick reading.

An interview was held with the DNS on 4/04/14 at 11:35 AM. The DNS stated that the medications should have been signed for when administered.

2) Resident #71 has diagnoses including Neuropathy, Anxiety, Atrial Fibrillation and Stage IV Sacral Pressure Ulcer (P/U). The resident was admitted to the facility on 10/10/13.

The Minimum Data Set (MDS) Admission Assessment dated 10/17/13 documented the resident was at risk for developing P/U, had one unhealed P/U, two Stage II P/Us present on admission, and one Stage IV P/U present on admission with the dimensions of 1 centimeter (cm) x 1.4 cm x 3.5 cm with granulation tissue.

The MDS Quarterly Assessment dated 1/30/14 also documented that the resident had one Stage IV present since admission with the dimensions of 1 cm x 1.4 cm x 3.5 cm with granulation tissue.

The Treatment Administration Record (TAR) for March 2014 documented to cleanse coccyx and sacrum with Normal Saline (NS), apply Gentamycin cream packing daily, cover with Dry Protective Dressing (DPD) daily and as needed (PRN).

The five Physician's Monthly Progress Notes dated 12/5/13, 1/2/14,1/30//14, 2/25/14 and 3/24/4 documented under number 14 "Skin integrity: Decubitus/Stasis ulcer, other: Yes or No. If Yes state site, evaluation and plan". The Physician documented "No."

An interview with the Attending Physician/Medical Director conducted on 4/4/14 at 9:00 AM. The Physician stated that the statement in the Physician's Monthly Progress Notes concerning the skin integrity was meant to be if there was any skin integrity changes. The Physician also stated that he will have the form corrected to state "change".

3) Resident #91 has diagnoses including Transient Ischemic Attack (TIA), Uncontrolled Diabetes Mellitus (DM), and Metabolic Encephalopathy. The resident is legally blind. The resident was admitted to the facility on 12/5/13.

The Minimum Data Set (MDS) Admission Assessment dated 12/12/13 documented the resident was independent in cognition, had no pressure ulcers, and received dialysis treatment during the review period.

The Nurses Note dated 12/26/13 documented that the resident had a skin breakdown on the resident's bilateral great toes approximately 0.3 cm x 0.4 cm over the right great toe and 1.3 cm x 1.5 cm over the left great toe. The Note also documented that the Physician was made aware.

The Comprehensive Care Plan (CCP) developed for Alteration in Skin Integrity dated 12/26/13 documented bilateral great toe with skin breakdown and that treatments were in place.

The Physician's Monthly Progress Notes dated 1/2/14 documented under number 14 "Skin Integrity: decubitus/stasis ulcer, other: Yes or No. If Yes , state site, evaluation and plan". The Physician checked "no".

An interview with the Attending Physician/Medical Director was conducted on 4/4/14 at 9:10 AM. The Physician stated that the "no" answer under the Skin Integrity question number 14, he meant that there was no change in skin integrity.

MD treatment orders dated 12/26/13 at 8 PM documented as follows: Cleanse bilateral Great toe opened area with normal saline. Pat dry. apply bacitracin and a clean dry dressing every day times seven days or until healed.

The closed medical record was reviewed during the Stage one process.

There was no Treatment Administration Record (TAR) sheet record dated December 2013 found in the closed medical record.

An interview with the Director of Nursing Services on 4/4/14 at 9:28 AM revealed that although the treatment record could not be found, the treatment Registered Nurse was interviewed and could ensure that the treatment was completed on a daily basis as ordered by the physician.

The Minimum Data Set (MDS) Admission Assessment dated 12/12/13 documented the resident's Brief Interview for Mental Status (BIMS) was 15 that indicated the resident was independent in cognition. The MDS also documented that the resident had no pressure ulcers and received dialysis treatment during the review period.

The Physician Order dated 12/6/13 documented to listen to the bruit and feel the thrill to the AV fistula site to the left arm every (q) shift. Remove dressing to left arm AV fistula 24 hours site after dialysis on Tuesday-Thursday-Saturday (T-Th-Sat). The dialysis day is on Monday-Wednesday-Friday (M-W-F).

The December 2013 TAR could not be located in the medical record to verify if the order was followed through by the nursing staff.

The Nurses Notes reviewed dated 12/5/13 through 12/31/13 did not contain documented evidence that the resident's AV fistula was being monitored every shift.

415.22(a)(1-4)

Citation date: June 3, 2014

Based on observation, record review and interviews during the Post Survey Revisit (PSR) survey the facility did not ensure that clinical records were maintained in accordance to accepted professional standards and practices, including that clinical records being complete and accurately documented. This was evident for three of seventeen resident's clinical records (Resident # 175, #13 and # 5). Specifically; 1) Resident # 175 was missing documentation related to fingerstick blood sugar monitoring and whether insulin was administered; 2) Resident # 13 had a interim physician's order which did not clearly address what medication was to be given to the resident; 3) Resident # 5 had a physician's order to provide oral care every two hours during 7 AM - 11 PM when the resident was awake. The May 2014 and June 2014 Certified Nursing Assistant Accountability Record (CNAAR) did not have consistent documented evidence that oral care was being signed for on every shift.

This resulted in no actual harm with potential for minimum harm.

This is a REPEAT deficiency from the April 2014 Recertification survey.

The findings are:

1) Resident # 175 has diagnoses including Diabetes Mellitus and Hypertension.

The most recent physician's orders documented to monitor the resident's blood sugar twice a day at 7:30 AM and 5:30 PM and to administer Humalog insulin, based on a sliding scale, of the resident's blood sugar results.

The most recent Medication Administration Record (MAR) dated 5/13/14 - 6/03/14 was reviewed. There was no recording on May 20, 2014 of the 5:30 PM fingerstick blood sugar result nor if insulin was administered to the resident.

An interview was held with the Director of Nursing Services (DNS) on 6/03/14 at 11:50 AM. The DNS stated that the medication nurse should have documented the resident's blood sugar results on the MAR and if insulin was administered. The DNS stated that the 11 PM - 7 AM Licensed Practical Nurse (LPN) is responsible to audit the MAR's to ensure that the MAR is complete.

An interview was held with the DNS on 6/03/14 at 2:10 PM. The DNS stated that the 3 PM - 11 PM LPN will be counseled regarding not recording the resident's blood sugar result and the 11 PM - 7 AM LPN will be counseled regarding not identifying the missing fingerstick blood sugar results on the MAR.

An interview was held on 6/03/14 at 3:20 PM with the 11 PM - 7 AM LPN who worked on 5/20/2014. The LPN stated that he does review the MAR's and that he would document any missing information on the audit tool and report the missing information to the Registered Nurse (RN) Supervisor.

A call was placed to the LPN identified by the facility as working on 5/20/14 on the 3 PM - 11 PM nursing shift, however, no return call was received.

2) Resident #13 has diagnoses including Coagulation Defect, Sleep Apnea and Acute Respiratory Failure. The resident was re-admitted to the facility on 10/11/12.

The Minimum Data Set (MDS) Annual Assessment dated 9/16/13 documented that the resident was independent in cognition and for decision-making with a score of 15 on the Brief Interview for Mental Status (BIMS). The MDS documented active diagnoses that include Atrial Fibrillation.

The Comprehensive Care Plan (CCP) developed for at risk for bleeding secondary to anticoagulant use for diagnosis of Atrial Fibrillation dated 3/25/14 documented to monitor signs of bleeding and to report to the Physician.

The Physician's order dated 5/27/14 documented to "give dose 2 milligrams (mg) and to call the Physician in AM for direction."

The Physician's order did not have documented evidence that indicated the right medication, the right form of medication, and the right time the medication was to be given.

The nurse, who transcribed the order, was not available for interview.

An interview with the Medical Director/Attending Physician was conducted on 6/03/14 at 10:04 AM. The physician stated that it was "an error on the part of the nurse who transcribed the order and that the order needed to be clarified" as to what medication was ordered to be given.

An interview with the Director of Nursing Services (DNS) was conducted on 6/03/14 at 10:11 AM. The DNS stated that the nurse, who transcribed the order, should have completed the order.

3) Resident # 5 has diagnoses that include Multiple Sclerosis and Spastic Paraplegia and is fed via a Gastrostomy tube.

The Minimum Data Set (MDS) assessment dated 5/21/14 documented that the resident is totally dependent on staff for all Activities of Daily Living and her Brief Interview Mental Score (BIMS) is 14 of 15 indicating that her cognition is intact.

Multiple observations during the two days of the survey, 6/2/14 and 6/3/14 during the morning and afternoon revealed that the resident was lying in bed with her mouth full of froth, sometimes dripping down her chin.

Current Physician's orders dated 5/16/14 documented that the resident is to receive oral care every two hours during waking hours between 7 AM - 11 PM.

Review of the Certified Nurse Aide Accountability Records dated April and May 2014 revealed that not all the

nursing shifts were signing for the mouth care as ordered by the Physician.

The May 2014 accountability record documented as follows: The 3 PM to 11 PM shift did not sign the Accountability Record from 5/26/14 through 5/30/14. The June 2014 Accountability Record did not show any specific mouth care directions when reviewed by the surveyor on 6/2/14. On 6/3/14, however, the same June 2014 Accountability Record had hand written directions for the mouth care every two hours during waking hours. There were no documented signatures on the June accountability record from any of the nursing shifts on June 1 through June 2, 2014.

An interview with the Charge Licensed Practical Nurse (LPN) on 6/3/14 at 2:15 PM revealed that the 11 PM to 7 AM Nurse documents (the direction) on the accountability record. The LPN further stated that all the staff wipe the resident's mouth when they are in the residents room.

An interview with the 3 PM to 11 PM Certified Nurse Aide on 6/3/14 at 3:40 PM revealed that she did not sign the Accountability Record on 6/2/14 because she was waiting for an inservice to see whether she needed to sign the accountability record.

An interview with the alert and lucid Resident # 5 on 6/3/14 at 3:00 PM revealed that she does not always receive the mouth care that she needs.

415.22 (a) (1- 4)

F279 483.20(d), 483.20(k)(1): DEVELOP COMPREHENSIVE CARE PLANS

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 18, 2014

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under ¾483.25; and any services that would otherwise be required under ¾483.25 but are not provided due to the resident's exercise of rights under ¾483.10, including the right to refuse treatment under ¾483.10(b)(4).

Citation date: June 3, 2014

Based on observation, staff interview and record review during the Recertification Post Survey Revisit, the facility did not develop a Comprehensive Care Plan for one of seventeen residents reviewed for Comprehensive Care Plans. Specifically, Resident # 232 was recently admitted to the locked Dementia Unit. When angry, the resident had threatened to kill her self on multiple occasions. There was no documented complete Comprehensive Care Plan developed to address the residents' repeated threats of self-injurious behavior.

This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The finding is:

Resident # 232 has diagnoses that included Cerebral Vascular Accident and Vascular Dementia.

The resident was admitted to the facility on 5/9/14. The transferring Patient Review Instrument (PRI) dated 5/2/14 documented that the patient requires Long Term Care on a locked Dementia Unit. The most recent Screen (DOH-695) dated 5/9/14 documented that the resident has a history of unpredictable behaviors and may injure self or others and that the condition is not temporary.

Nursing Progress Note dated 5/9/14 documented that the resident does not like this place and that she feels like a prisoner...

Nursing Progress Note dated 5/19/14 at 2:45 PM documented as follows: Resident stated I am going to kill myself if I stay here...

Social Work Progress Notes dated 5/19/14 documented that the resident stated that she wants to return home and will kill herself. The progress note documented that the resident will find (medication pills) from the cart (to kill herself with).

Review of the Comprehensive Care Plan for Resident # 232 did not reveal a complete Comprehensive Care Plan to address the resident's repeated threats of self-injurious behaviors.

An interview with the Supervising Registered Nurse (RN) on 6/3/14 at 11:00 AM revealed that a comprehensive care plan for the potential self- injurious threatening behavior had not been developed or found in the medical record at that time.

An interview with the Director of Nursing Services on 6/3/14 at 1:00 PM revealed that either of the RNs would be responsible for developing the care plan for the resident's threatening self-injurious behavior.

415.11(c)(1)

F280 483.20(d)(3), 483.10(k)(2): DEVELOPMENT/PREPARE/REVIEW OF COMPREHENSIVE CARE PLAN

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

Citation date: April 4, 2014

Based on record review and staff interviews during the recertification survey, the facility did not revise the care plan for changes in care and treatment. This was evident in 1 of 3 residents reviewed for Purified Protein Derivative (PPD) screen test in a total of 38 Stage II sampled residents. Specifically, Resident #197 had a PPD test completed on 12/9/13 with a positive result at 40 millimeter (mm) induration. There was no change in the care or treatment to address the positive result of the PPD. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The finding is:

Resident #197 has diagnoses including Hypertension, Osteoarthritis, Mild Dementia and Seizure. The resident was admitted to the facility on 12/10/13 and subsequently expired on 1/10/14.

The Minimum Data Set (MDS) Admission Assessment dated 12/16/13 documented the resident was moderately impaired in cognition and no active disease under pulmonary diagnoses.

The Physician order dated 12/9/13 documented PPD 0.1 ml intradermally, if negative repeat in 7-21 days of negative reading.

The Immunization record revealed PPD was administered on 12/9/13 with 40 mm reading result.

The Laboratory Test dated 12/11/13 documented Quantiferon-TB Gold report was out of range with indeterminate results (Reference range=negative).

The Physician Progress Note dated 12/12/13 documented to do a Quantiferon TB testing.

The Physician Order dated 12/16/13 documented chest x-ray (CXR) secondary to PPD positive and Pulmonary Consult.

The CXR Report dated 12/16/13 revealed no evidence of of an acute pneumonia or evidence of active TB.

The Physician Order dated 12/18/13 documented to discontinue pulmonary consult.

An interview with Attending Physician/Medical Director was conducted on on 4/2/14 at 10/05 AM. The Physician stated that "when PPD is not conclusive, all of this is just suspecting. On the indeterminate result on Quantiferon TB test, I called the hospital and the Hospital Infection Control Nurse and she stated that TB was ruled out." The Physician added that "extrapulmonary TB is an aberration".

An interview with the New York State Department of Health Regional Tuberculosis Program Supervisor was conducted on 4/2/14 at 10:40 AM. The Supervisor stated that the facility should take the 40 mm result of PPD at "face value" and should have started preventive/prophylactic treatment of Izoniazid (INH) medication for 9 months to treat Latent Tuberculosis Infection (LTBI) and not the active TB which the resident did not have as per the CXR result of 12/16/13.

The facility's undated policy and procedure titled Infection Control Manual - General Policies documented "... 1. To provide a safe environment within the facility for the protection of residents, employees, physicians and visitors...".

The facility's undated policy and procedure titled Screening Procedures and Treatment documented "... 5. Residents who develop positive reactions, but who do not have evidence of TB, should be evaluated for preventive therapy according to current guidelines...".

The New York State Department of Health (NYDOH) DAL/DQS:#06-03 dated 2/16/06 documented "... All residents should be screened for latent TB infection and active TB disease upon admission... baseline screening for latent TB infection should be performed with either Tuberculin Skin Test or Quantiferon Test...".

415.11 (c)(2)(i-iii)

F456 483.70(c)(2): ESSENTIAL EQUIPMENT IN SAFE OPERATING CONDITION

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 18, 2014

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

Citation date: April 4, 2014

Based on observations, record reviews, and staff interviews during the recertification survey. the facility did not ensure that all essential mechanical, electrical, and patient care equipment are maintain in safe operating condition. This was evident in 3 of 4 nursing units toured on the initial day of the survey period. Specifically, 1) During the tour of the Central Unit, the suction machine dedicated for Resident #5 was not equipped with the necessary suction catheter kit ready for use in case of an emergency. 2) During the initial observational tour of West Unit, the medication refrigerator thermometer read 18 degrees Fahrenheit (F) approximately 18 degrees below the recommended temperature range. 3) During the initial observational tour of Park Unit, the unit's glucometer was not properly calibrated to reflect the correct dates that the fingersticks were done. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1) During the initial observation tour of Central Unit with the Licensed Practical Nurse (LPN) conducted on 3/27/14 at 10:45 AM, the following was observed:
-the suction machine dedicated for Resident #5 was not equipped with suction catheter kit ready for use in case of an emergency
-the suction machine was located the resident's bedside
- the resident has diagnoses including Quadriplegia and Salivary Secretions.

2) During the initial observational tour of West Unit with the LPN Charge Nurse conducted on 3/27/14 at 9:52 AM, the following was observed:
-the medication refrigerator thermometer read at 18 degrees Fahrenheit (F).

An interview with the LPN was conducted on 3/27/14 at 10:10 AM. The LPN stated that she could not locate the unit's temperature log for the medication refrigerator. The LPN also stated that the temperature should be maintained between 36-46 degrees F, but she was not sure if it was the night shift who monitors the medication refrigerator's temperature and document it daily.

An interview with the Director of Nursing Services (DNS) was conducted on 3/27/14 at 10:16 AM. The DNS stated that each unit has the log paper and will try to locate the West Unit temperature log book. The DNS also stated that the AM shift nurse monitors and documents the medication refrigerator temperature daily.

An interview with the Maintenance Director on 3/27/14 at 11:00 AM. The Director stated that there is no temperature log for the medication refrigerator. The temperature log is only for the dietary refrigerator. The Director also stated that the thermometer was broken and will replace it.

3) During the initial observational tour of Park Unit with the Registered Nurse (RN) Infection Control Coordinator conducted on 3/27/14 at 9:27 AM, the following was observed:
- the unit's glucometer (pvnh 2060) recorded the date as 5/19.

An interview with the RN was immediately done. The RN stated that she was not aware that the glucometer's date was not calibrated to reflect the current date.

The LPN Medication Nurse was also interviewed at the same time and stated that she does not calibrate the glucometer's date. When asked who is responsible to calibrate the glucometers, the LPN responded that she does not know.

415.29

Citation date: June 3, 2014

Based on observations, record reviews, and staff interviews during the recertification survey. the facility did not ensure that all essential mechanical, electrical, and patient care equipment are maintain in safe operating condition. This was evident on 1 of 4 nursing units. During the an observational tour of West Unit, the unit's glucometer was not properly calibrated to reflect the correct dates that the fingersticks were done. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

This is a REPEAT deficiency from the April 2014 Recertification survey.

The finding is:

During the initial observational tour of west unit with the Licensed Practical Nurse (LPN) and the Director of Nursing Services (DNS) on 6/3/14 at 12:00 PM, the following was observed:

- the unit's glucometer - Assure platinum was checked on west unit reflected the date 2-16.

An interview with the DNS was immediately done. The DNS stated that the glucometer should be re-calibrated to reflect the correct days.

The LPN Medication Nurse was also interviewed at the same time and stated that she does not calibrate the glucometer's date. When asked who is responsible to calibrate the glucometers, the LPN responded that she does not know.

415.29

F441 483.65: FACILITY ESTABLISHES INFECTION CONTROL PROGRAM

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions

related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

Citation date: April 4, 2014

Based on record review and staff interviews during the recertification survey, the facility did not maintain the Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This was evident in 2 of 5 residents reviewed for Infection Control in a total of 38 Stage II sampled residents. Specifically, 1) Resident #197 had a Purified Protein Derivative (PPD) test completed on 12/9/13 with a positive result at 40 millimeter (mm) induration. There was prophylactic treatment with Isoniazid (INH) to address the positivity result of the PPD to treat latent Tuberculosis Infection (LTBI). 2) Resident #71 was observed that the Gentamycin packing touched the resident's buttock during the sacral pressure ulcer dressing change done by the Licensed Practical Nurse (LPN) Treatment Nurse. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The findings include:

1) Resident #197 has diagnoses including Hypertension, Osteoarthritis, Mild Dementia and Seizure. The resident was admitted to the facility on 12/10/13 and subsequently expired on 1/10/14.

The Minimum Data Set (MDS) Admission Assessment dated 12/16/13 documented the resident was moderately impaired in cognition and no active disease under pulmonary diagnoses.

The Physician order dated 12/9/13 documented PPD 0.1 ml intradermally, if negative repeat in 7-21 days of negative reading.

The Immunization record revealed PPD was administered on 12/9/13 with 40 mm reading result.

The Laboratory Test dated 12/11/13 documented Quantiferon-TB Gold report was out of range with indeterminate results (Reference range=negative).

The Physician Progress Note dated 12/12/13 documented to do a Quantiferon TB testing.

The Physician Order dated 12/16/13 documented chest x-ray (CXR) secondary to PPD positive and Pulmonary Consult.

The CXR Report dated 12/16/13 revealed no evidence of an acute pneumonia or evidence of active TB.

The Physician Order dated 12/18/13 documented to discontinue pulmonary consult.

An interview with Attending Physician/Medical Director was conducted on on 4/2/14 at 10/05 AM. The Physician stated that "when PPD is not conclusive, all of this is just suspecting. On the indeterminate result on Quantiferon TB test, I called the hospital and the Hospital Infection Control Nurse and she stated that TB was ruled out." The Physician added that "extrapulmonary TB is an aberration".

An interview with the New York State Department of Health Regional Tuberculosis Program Supervisor was conducted on 4/2/14 at 10:40 AM. The Coordinator stated that the facility should take the 40 mm result of PPD as "face value" and should have started preventive/prophylactic treatment of Izoniazid (INH) medication for 9 months to treat Latent Tuberculosis Infection (LTBI) and not the active TB which the resident did not have as per the CXR result of 12/16/13.

The facility's undated policy and procedure titled Screening Procedures and Treatment documented "... 5. Residents who develop positive reactions, but who do not have evidence of TB, should be evaluated for preventive therapy according to current guidelines...".

The New York State Department of Health (NYDOH) DAL/DQS:#06-03 dated 2/16/06 documented "... All residents should be screened for latent TB infection and active TB disease upon admission... baseline screening for latent TB infection should be performed with either Tuberculin Skin Test or Quantiferon Test...".

2) Resident #71 has diagnoses including Depression, Hiatal Hernia, Neuropathy, Anxiety, GERD, and Atrial Fibrillation. The resident was admitted to the facility on 10/10/13.

The MDS Quarterly Assessment dated 1/30/14 documented documented the resident was independent in cognition with the BIMS score of 15, used walker and wheelchair as mobility devices, with upper extremity impairment on one side, with lower extremities impairment on both sides. The resident was at risk for pressure ulcer (P/U), with one unhealed P/U, no Stage II P/U, one Stage 4 P/U present on admission with dimensions of 1 centimeter (cm) x 1.4 cm x 3.5 cm with granulation tissue, two Stage II P/U that were noted on the prior assessment that have completely closed an one venous /arterial ulcer present.

The Treatment Administration Record (TAR) for March 2014 documented cleanse coccyx and sacrum with Normal Saline (NS) apply Gentamycin cream packing daily cover with Dry Protective Dressing (DPD) daily and as needed (PRN).

During the sacral pressure ulcer dressing change with the LPN Treatment Nurse conducted on 4/3/14 at 10:54 AM. the following was observed:
-the sacral P/U was a Stage IV
-when the LPN was packing the Gentamycin cream with the packing strip, the packing strip dangled and touched the resident's buttock.

The LPN was immediately interviewed and stated that the Gentamycin packing should not have touched the resident's buttock while she was packing the strip into the wound base.

The RN Wound Care Nurse was also interviewed and stated that the packing strip should not touch the resident's buttock. The RN added that the LPN should have held the packing strip with her gloved-hand while the other gloved-hand guides the packing into the wound base.

415.19(a)(1-3)

Citation date: June 3, 2014

Based on record review and staff interviews during the recertification survey, the facility did not maintain the Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This was evident in 2 of 5 residents reviewed for Infection Control in a total of 38 Stage II sampled residents. Specifically, 1) Resident #197 had a Purified Protein Derivative (PPD) test completed on 12/9/13 with a positive result at 40 millimeter (mm) induration. There was prophylactic treatment with Isoniazid (INH) to address the positivity result of the PPD to treat latent Tuberculosis Infection (LTBI). 2) Resident #71 was observed that the Gentamycin packing touched the resident's buttock during the sacral pressure ulcer dressing change done by the Licensed Practical Nurse (LPN) Treatment Nurse. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The findings include:

1) Resident #197 has diagnoses including Hypertension, Osteoarthritis, Mild Dementia and Seizure. The resident was admitted to the facility on 12/10/13 and subsequently expired on 1/10/14.

The Minimum Data Set (MDS) Admission Assessment dated 12/16/13 documented the resident was moderately impaired in cognition and no active disease under pulmonary diagnoses.

The Physician order dated 12/9/13 documented PPD 0.1 ml intradermally, if negative repeat in 7-21 days of negative reading.

The Immunization record revealed PPD was administered on 12/9/13 with 40 mm reading result.

The Laboratory Test dated 12/11/13 documented Quantiferon-TB Gold report was out of range with indeterminate results (Reference range=negative).

The Physician Progress Note dated 12/12/13 documented to do a Quantiferon TB testing.

The Physician Order dated 12/16/13 documented chest x-ray (CXR) secondary to PPD positive and Pulmonary Consult.

The CXR Report dated 12/16/13 revealed no evidence of an acute pneumonia or evidence of active TB.

The Physician Order dated 12/18/13 documented to discontinue pulmonary consult.

An interview with Attending Physician/Medical Director was conducted on on 4/2/14 at 10/05 AM. The Physician stated that "when PPD is not conclusive, all of this is just suspecting. On the indeterminate result on Quantiferon TB test, I called the hospital and the Hospital Infection Control Nurse and she stated that TB was ruled out." The Physician added that "extrapulmonary TB is an aberration".

An interview with the New York State Department of Health Regional Tuberculosis Program Supervisor was conducted on 4/2/14 at 10:40 AM. The Coordinator stated that the facility should take the 40 mm result of PPD as "face value" and should have started preventive/prophylactic treatment of Izoniazid (INH) medication for 9 months to treat Latent Tuberculosis Infection (LTBI) and not the active TB which the resident did not have as per the CXR result of 12/16/13.

The facility's undated policy and procedure titled Screening Procedures and Treatment documented "... 5. Residents who develop positive reactions, but who do not have evidence of TB, should be evaluated for preventive therapy according to current guidelines...".

The New York State Department of Health (NYDOH) DAL/DQS:#06-03 dated 2/16/06 documented "... All residents should be screened for latent TB infection and active TB disease upon admission... baseline screening for latent TB infection should be performed with either Tuberculin Skin Test or Quantiferon Test...".

2) Resident #71 has diagnoses including Depression, Hiatal Hernia, Neuropathy, Anxiety, GERD, and Atrial Fibrillation. The resident was admitted to the facility on 10/10/13.

The MDS Quarterly Assessment dated 1/30/14 documented documented the resident was independent in cognition with the BIMS score of 15, used walker and wheelchair as mobility devices, with upper extremity impairment on one side, with lower extremities impairment on both sides. The resident was at risk for pressure ulcer (P/U), with one unhealed P/U, no Stage II P/U, one Stage 4 P/U present on admission with dimensions of 1 centimeter (cm) x 1.4 cm x 3.5 cm with granulation tissue, two Stage II P/U that were noted on the prior assessment that have completely closed an one venous /arterial ulcer present.

The Treatment Administration Record (TAR) for March 2014 documented cleanse coccyx and sacrum with Normal Saline (NS) apply Gentamycin cream packing daily cover with Dry Protective Dressing (DPD) daily and as needed (PRN).

During the sacral pressure ulcer dressing change with the LPN Treatment Nurse conducted on 4/3/14 at 10:54 AM. the following was observed:
-the sacral P/U was a Stage IV
-when the LPN was packing the Gentamycin cream with the packing strip, the packing strip dangled and touched the resident's buttock.

The LPN was immediately interviewed and stated that the Gentamycin packing should not have touched the resident's buttock while she was packing the strip into the wound base.

The RN Wound Care Nurse was also interviewed and stated that the packing strip should not touch the resident's buttock. The RN added that the LPN should have held the packing strip with her gloved-hand while the other gloved-hand guides the packing into the wound base.

415.19(a)(1-3)

F425 483.60(a),(b): FACILITY PROVIDES DRUGS AND BIOLOGICALS

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in ¾483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the

provision of pharmacy services in the facility.

Citation date: April 4, 2014

Based on record review and staff interviews during the recertification survey the facility did not ensure that one of six residents reviewed for unnecessary medications, from a total of thirty eight Stage 2 sampled residents, received a medicated cream in a timely manner. Specifically,
Resident # 18 had a physician's order dated 3/06/14 for Monistat cream to be administered at bedtime for 7 days. This medicated cream was not available until 3/07/14 due to the pharmacy not having the medicated cream in stock. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The finding is:

Resident #18, with diagnoses including Diabetes, Fibromyalgia and unstageable wound to the left heel, was admitted to the facility on 3/05/14.

The resident's admission nursing assessment note dated 3/05/14 identified a rash to the gluteal folds.

The initial body diagram dated 3/05/14 documented that the resident had redness to the sacral area and a rash to the groin area bilaterally.

A nurse's note dated 3/06/14 at 6 AM documented that the resident complained of vaginal itching.

A physician's order dated 3/06/14 documented an order for Monistat 7 one application vaginally at bedtime for 7 days.

A nurse's note dated 3/07/14 at 10 PM documented that Monistat is to start tonight as ordered by the physician for discharge and painful urination.

Review of the Treatment Administration Record (TAR) revealed Monistat was signed for as administered on 4/08/14 at 10 PM.

An interview was held on 4/02/14 at 2:30 PM with the Director of Nursing Services (DNS). The DNS stated that Monistat was ordered on 3/06/14 around 6 PM and that the Monistat cream was not delivered to the facility until 3/07/14 around 9:30 PM. The DNS stated that the LPN administered the Monistat on 3/07/14 on the 11 PM - 7 AM shift after the Monistat was available in the facility, however the LPN forgot to sign the TAR.

A written statement was provided by the LPN who administered Monistat on the evening of 3/07/14 into the morning of 3/08/14. The LPN documented that she was asked by the nurse on the 3 PM - 11 PM shift to administer Monistat, which she did. The LPN decremented that she forgot to sign the TAR.

An interview was held with the pharmacist on 4/04/14 at 12:49 AM. The pharmacist stated that the pharmacy received the order for Monistat on 3/06/14 at 3:14 PM and that the cream was delivered on 3/07/14 at 10:10 PM. There was a delivery to the facility on 3/06/14 however the Monistat was not available at that time because the pharmacy did not have Monistat in stock. The pharmacist stated that Monistat was delivered as soon as it was available, that usually the pharmacy has Monist in stock but ran out.

415.18(a)

F431 483.60(b), (d), (e): PROPER LABELING OF DRUGS AND BIOLOGICALS

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 18, 2014

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs

and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Citation date: April 4, 2014

Based on observation, record review and staff interviews during the recertification survey, the facility did not ensure that drugs in the facility were labeled in accordance with currently accepted professional principles and that expired medications are disposed. This was evident in 1 of 4 nursing units toured on the first day of the survey period. Specifically, during an observational tour of Park Unit, there were opened and undated insulin vials stored inside the unit's medicine refrigerator. In addition, there was one Saline Enema bottle that expired 10/2013. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The finding is:

During an observational tour of Park Unit with the Registered Nurse (RN) and Licensed Practical Nurse (LPN) Charge Nurse conducted on 3/27/14 at 9:27 AM, the following was observed inside the medicine refrigerator:
-one opened and undated vial of Humalog Insulin
-one opened and undated vial of Lantus Insulin
-one opened and undated vial of Humulin Insulin.
In addition, one Saline Enema bottle, that expired 10/2013, was stored inside the medicine cabinet.

The LPN was immediately interviewed and stated that all the three opened and undated Insulin vials were currently in use. The LPN also added that the nursing staff would use the Saline Enema bottle if the resident was ordered for it by the Physician.

The RN was also interviewed at that time and stated that the Insulin vials should be dated once opened. The RN also stated that she will have the expired Saline Enema bottle discarded.

415.18(d)

Citation date: June 3, 2014

Based on observation and staff interviews during the revisit survey the facility did not ensure that all medication was stored in accordance with currently accepted professional principles, including dating insulin vials when opened. This was evident on one of four nursing units. Specifically, six of nine residents insulin vials were observed opened and undated on the center nursing unit. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

This is a REPEAT deficiency from the April 2014 Recertification survey.

The finding is:

During initial tour of the facility for the revisit survey on 6/02/14 at 8:56 AM six of nine insulin vials were opened and undated on the center nursing unit medication cart. The medication Licensed Practical Nurse (LPN) was present during the observation and confirmed the missing dates on the opened insulin vials.

An interview was held with the Director of Nursing Services (DNS) on 6/02/14 at 11:15 AM. The DNS stated that the 11-7 Registered Nurse (RN) Supervisor checked the medication storage room, including the insulin bottles and documented on the audit tool that all open insulin bottles were dated. The DNS stated that the 11 PM -7 AM LPN must have opened the vials and will be counseled.

An interview was held with the DNS on 6/03/14 at 9:00 AM. The DNS stated that the 11 PM - 7 AM LPN was counseled, although the 11 PM - 7 AM LPN stated that she did not open the insulin vials.

An interview was held on 6/03/14 at 11:42 AM with the same 11 PM - 7 AM LPN that worked on the evening of 6/01/14 leading into the morning of 6/02/14. The LPN stated that she did not open any insulin bottles that evening. The LPN stated that the insulin vials were in the refrigerator at the end of her shift. The LPN stated that she knows she is responsible to date insulin vials when they are first opened and she reiterated that she did not open any insulin vials on the 11 PM - 7 AM shift. The LPN further stated that the insulin vials were in the refrigerator at the end of her shift.

An interview was held on 6/03/14 at 11:56 AM with the 11 PM -7 AM shift RN supervisor. The RN stated that she checked all of the insulin vials in the center unit on her shift starting 6/01/14 at 11 PM and ending on 6/02/14 at 7 AM. There were a few open and dated insulin vials and that there were several unopened vials of insulin in the medication refrigerator.

415.18(d)

F314 483.25(c): PROPER TREATMENT TO PREVENT/HEAL PRESSURE SORES

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

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

Citation date: April 4, 2014

Based on observation, resident and staff interviews during the recertification survey, the facility did not ensure that a resident with a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This was evident in 1 of 1 resident reviewed for pressure ulcer in a total of 38 Stage II sampled residents. Specifically, Resident #71 had a Stage IV Sacral Pressure Ulcer. The Physician ordered to have the wound dressing treatment daily. The TAR revealed that there was a weekend that the dressing changes were not done by the licensed nursing staff. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The finding is:

Resident #71 has diagnoses including Neuropathy, Atrial Fibrillation and Stage IV Sacral Pressure Ulcer. The resident was admitted to the facility on 10/10/13.

The Minimum Data Set (MDS) Admission Assessment dated 10/17/13 documented the resident was independent in cognition and had impairment of the upper extremity on one side and an impairment to the lower extremities on both sides. The MDS also documented that the resident was at risk of developing pressure ulcer. The MDS also documented that the resident had one unhealed pressure ulcer, two Stage II pressure ulcers and one Stage IV pressure ulcer all were present on admission with the dimensions of 1 centimeter (cm) x 1.4 cm x 3.5 cm with granulation tissue.

The MDS Quarterly Assessment dated 1/30/14 documented the same Stage IV sacral pressure ulcer present since admission.

The Braden Scale for Predicting Pressure Sore Risk dated 10/10/13 documented that the resident scored 15 (moderate risk) and on 1/30/14 the resident scored 17 (low risk).

The Comprehensive Care Plan (CCP) developed for Alteration in Skin Integrity documented sacral pressure ulcer Stage IV.

The Physician Order dated 2/24/14 documented to cleanse sacrum Stage IV with Normal saline then pat dry and apply Sivercel rope daily and cover with Dry Protective Dressing.

The TAR for February- March 2014 documented to cleanse sacrum Stage IV with Normal saline then pat dry and apply Sivercel rope daily and cover with Dry Protective Dressing. Review of the TAR revealed that on 3/1/14 through 3/3/14 there were missing licensed nursing staff signatures that indicated the sacral treatments were not done.

An interview with the alert and oriented Resident #71 was conducted on 4/1/14 at 11:25 AM. The resident stated that on weekends there is only one nurse to do the medication and treatment/wound dressing. There were weekends that her wounds were not dressed. She could not remember the dates.

The RN Supervisor was interviewed on 4/4/14 at 10:30 AM. The RN stated that there are weekends that there

was no treatment nurse when the nurse called in sick. However, the other nursing staff should have covered the the unit to do the dressing changes.

415.12(c)(2)

Citation date: June 3, 2014

Based on observation, resident and staff interviews during the recertification survey, the facility did not ensure that a resident with a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This was evident in 1 of 1 resident reviewed for pressure ulcer in a total of 38 Stage II sampled residents. Specifically, Resident #71 had a Stage IV Sacral Pressure Ulcer. The Physician ordered to have the wound dressing treatment daily. The TAR revealed that there was a weekend that the dressing changes were not done by the licensed nursing staff. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The finding is:

Resident #71 has diagnoses including Neuropathy, Atrial Fibrillation and Stage IV Sacral Pressure Ulcer. The resident was admitted to the facility on 10/10/13.

The Minimum Data Set (MDS) Admission Assessment dated 10/17/13 documented the resident was independent in cognition and had impairment of the upper extremity on one side and an impairment to the lower extremities on both sides. The MDS also documented that the resident was at risk of developing pressure ulcer. The MDS also documented that the resident had one unhealed pressure ulcer, two Stage II pressure ulcers and one Stage IV pressure ulcer all were present on admission with the dimensions of 1 centimeter (cm) x 1.4 cm x 3.5 cm with granulation tissue.

The MDS Quarterly Assessment dated 1/30/14 documented the same Stage IV sacral pressure ulcer present since admission.

The Braden Scale for Predicting Pressure Sore Risk dated 10/10/13 documented that the resident scored 15 (moderate risk) and on 1/30/14 the resident scored 17 (low risk).

The Comprehensive Care Plan (CCP) developed for Alteration in Skin Integrity documented sacral pressure ulcer Stage IV.

The Physician Order dated 2/24/14 documented to cleanse sacrum Stage IV with Normal saline then pat dry and apply Sivercel rope daily and cover with Dry Protective Dressing.

The TAR for February- March 2014 documented to cleanse sacrum Stage IV with Normal saline then pat dry and apply Sivercel rope daily and cover with Dry Protective Dressing. Review of the TAR revealed that on 3/1/14 through 3/3/14 there were missing licensed nursing staff signatures that indicated the sacral treatments were not done.

An interview with the alert and oriented Resident #71 was conducted on 4/1/14 at 11:25 AM. The resident stated that on weekends there is only one nurse to do the medication and treatment/wound dressing. There were weekends that her wounds were not dressed. She could not remember the dates.

The RN Supervisor was interviewed on 4/4/14 at 10:30 AM. The RN stated that there are weekends that there was no treatment nurse when the nurse called in sick. However, the other nursing staff should have covered the the unit to do the dressing changes.

415.12(c)(2)

F333 483.25(m)(2): RESIDENTS FREE FROM SIGNIFICANT MEDICATION ERRORS

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 18, 2014

The facility must ensure that residents are free of any significant medication errors.

Citation date: April 4, 2014

Based on 1 of 4 closed record reviews and staff interview the facility did not ensure that all necessary medications were documented and given as ordered by the Physician. Specifically, there was documented evidence that Coumadin (an anticoagulant medication) was not given to Resident # 22 for 3 days.

This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The finding is:

Resident # 22 has diagnoses that includes Paroxysmal Atrial Fibrillation.

An interim physician's order dated 12/20/13 documented that the Coumadin was to be increased to 3.0 milligrams and that the PT /INR was to be repeated on 12/24/13.

The Medication Administration Record (MAR) documented the order for Coumadin; 3.0 milligrams on 12/20/13. There was no documented evidence on the MAR that the Coumadin had been given to the resident on the following three days: 12/20/13, 12/21/13, and 12/22/13.

Review of the Emergency box reorder sheet stored in the Supervisors office had no documented evidence that Coumadin was removed from the supply box in December of 2013 for Resident # 22.

There was no documented information on the 24 hour report from 12/20/13 through 12/23/13 for Resident # 22.

An interview was conducted with the Pharmacy on 4/2/14 at 2:00 PM. The Registered Pharmacist Director of Compliance stated that the Coumadin 3.0 mg left the pharmacy on 12/23/13 at 7 PM and the facility (staff) signed for the Coumadin 3.0 mg on 12/23/13 at 9 PM.

An interview with the Licensed Practical Nurse (LPN) on 4/3/14 at 12:15 PM revealed that the LPN had no recollection of Resident # 22 not receiving the Coumadin and did not remember back to December 2013. She further stated that the blanks on the MAR (where signatures were missing) may just be human error.

An interview was conducted with the Registered Nurse (RN) Supervisor on 4/3/14 at 12:00 PM. The RN could not remember giving any medications from the emergency box to Resident #22.
She further explained had she been made aware of a missing medication, she would take the medication form the emergency box and then refax the order to the pharmacy. She also stated that if she had taken the Coumadin from the emergency box she would have documented on the reorder sheet (stored in the emergency box itself).

An interview was conducted with the Medical Director (MD) on 4/3/14 at 1:50 PM. The Medical Director could not say whether he had been contacted by the nursing staff that the Coumadin had not been given to Resident # 22 for three days. The MD stated that he would still have increased the Coumadin on 12/24/13 to the 4 milligram dose since that was based on the INR value. He further explained that the INR value had decreased to 1.1 (12/25/13 lab value) and this could be due to dark green vegetables (in the resident's diet).

A second interview with the RPH on 4/3/14 at 2:20 PM revealed that normally once an emergency box is opened for medication use, the form inside the box would be filled in by the nurse documenting the resident's name, the date, the quantity of the medication used. In addition, the RPH stated that there were no reports generated in December of 2013 for Resident #22 and the use of Coumadin from the Emergency Box.

415.12(m)(2)

Citation date: June 3, 2014

Based on record review and staff interviews during the revisit investigation, the facility did not ensure that residents are free of any significant medication errors. This was evident in 1 of 3 residents reviewed for medication error in a total of 17 sampled residents during the post survey revisit (PSR) survey. Specifically, Resident #244 has a Physician's Order to administer Ativan and Keflex. Ativan was not administered for 3 doses. Keflex was not administered until it was brought to the medication nurse's attention. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

This is a REPEAT deficiency from the April 2014 Recertification survey.

The finding is:

Resident #244 has diagnoses including Benign Neoplasm of the Brain, Difficulty of Walking, Cerebral Edema, Hypertension (HTN), Hypothyroidism, Atypical Meningioma, and Agitation. The resident was admitted to the facility on 5/21/14.

The Physician's Admission Order dated 5/21/14 documented Ativan 0.25 milligram (mg) by mouth (PO) 3 times a day for Agitation.

The Physician's Order dated 5/27/14 documented Keflex 500 mg PO every (q) 12 hours (h) x 7 days for Right Leg Cellulitis.

The Nurse's Note dated 5/21/14 at 4:40 PM documented that the medication orders were faxed to the pharmacy.

The Medication Administration Record (MAR) for May 2014 documented no licensed staff signatures to indicate that the medications were administered on the following dates:
-Ativan 0.25 mg tablet -on 5/21/14 at 10:00 PM, 5/22/14 at 6:00 AM and 2:00 PM
-Keflex 500 mg capsule-on 6/3/14 at 9:00 AM.

An interview with Director of Nursing Services (DNS) and Licensed Practical Nurse Medication/Charge Nurse was conducted on 6/3/14 at 12:25 PM. Both stated that Keflex should have been administered to the resident within the prescribed time frame. The DNS stated that the Ativan was ordered held by the Physician. The LPN stated that she was not able to give the resident's Keflex since the resident was still attending the Rehabilitation Unit.

Review of the Physician's Order dated 5/22/14 at 6:00 PM documented to hold Ativan until the stock arrives from the pharmacy. The order was written 20.5 hours after the resident had already missed 3 Ativan doses.

An interview with the Director of the Rehabilitation Unit was conducted on 6/3/14 at 1:22 PM. The Director stated that the resident attended the Rehabilitation Unit between 9:30 AM through 10:30 AM. This was almost 2 hours passed that the resident had already returned to the floor and 2.20 hours passed the time frame to administer Keflex.

415.12(m)(2)

F281 483.20(k)(3)(i): SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 18, 2014

The services provided or arranged by the facility must meet professional standards of quality.

Citation date: April 4, 2014

Based on observations, record review and staff interviews the facility did not ensure that professional standards of practice were met. Specifically, on 4/04/14 a Licensed Practical Nurse (LPN) was observed altering a Medication Administration Record (MAR) by signing for the administration of medications of eight days prior on 3/25/14. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The finding is:

Resident # 175, with diagnoses including Hypertension, Diabetes and Hyperlipidemia, was admitted to the facility on 3/21/14.

The admission physician orders dated 3/21/14 prescribed medications including but not limited to: Enalapril 10 milligrams (mg) tab by mouth daily for Hypertension, Lasix 40 mg tab by mouth daily as a diuretic, and Metformin 500 mg tablet by mouth twice a day for diabetes Mellitus. Additionally, the physician order fingersticks twice a day with coverage of Humalog R insulin based on the results.

Review of the Medication Administration Record (MAR) on 4/04/14 at 11:10 AM revealed that there were no signatures for 3/25/14 for Enalapril, Lasix, Metformin and the fingerstick results.

An interview was held with the Licensed Practical Nurse (LPN) on 4/04/14 at 11:18 AM. The LPN checked the staffing log book on the nursing unit and identified herself as being the medication nurse working on 3/25/14.

The Director of Nursing Services (DNS) arrived on the east unit at 11:20 AM. The MAR was reviewed with the LPN with the DNS standing behind and to the left of the LPN. The
LPN was observed signing her initials for Enalapril and started to sign for Lasix.

An interview was held at that time with the LPN. The LPN stated that on 3/25/14 she checked the residents fingerstick that morning and did administer the medications but forgot to sign for the medications and forgot to documented the resident fingerstick reading.

An interview was held with the DNS on 4/04/14 at 11:35 AM. The DNS stated that the medications should have been signed for when administered.

515.11(c)(3)(i)

Citation date: June 3, 2014

Based on record review, observation, staff and resident interviews during the revisit survey, the facility did not ensure one of seventeen residents had services provided that met professional standards of quality (Resident # 246). Specifically, Resident # 246, who was admitted on 5/29/14 had complained of pain. There was no documented assessment of the resident's pain level after the administration of pain medications on two occasions.
This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

This is a REPEAT deficiency from the April 2014 Recertification survey.

The finding is:

Resident # 246 has diagnoses that include difficulty in walking, hypertension, breast cancer with metastasis to the brain.

The Comprehensive Care Plan (CCP) dated 5/29/14 documented that the resident is cognitively intact with a BIMs (able to complete a brief interview for mental status) score of 15. Interventions include pain evaluation as needed. A CCP for pain was initiated on 5/29/14 related to cancer of the brain. Interventions included to observe for signs/symptoms of pain, administer pain medications as ordered and monitor effectiveness of pain management as needed.

The Admission physician orders dated 5/29/14 documented to give Oxycodone 5 milligrams (mg) by mouth (po) every 4 hours as needed for pain. On 6/1/14 at 12 AM, a telephone order was obtained for Tylenol 650 mg every 4 hours as needed for pain. On 6/1/14 at 5:30 PM another telephone order was obtained to give percocet 1 tab from the emergency box every 4 hours as needed until Oxycodone comes from pharmacy.

The Medication Administration Record (MAR) dated 5/28/14 documented to give Oxycodone 5 mg po every 4 hours as needed for pain. On 6/1/14, the MAR was updated to give Tylenol 650 mg every 4 hours as needed for pain and to give percocet 1 tab every 4 hours as needed. On 6/1/14 at 12 AM and at 9 AM, Tylenol was given for pain. At 9 AM, no assessment of pain was documented before and after the administration of the pain medication. On 6/2/14 at 7 am percocet 1 tab was given for leg pain of 7. No documented re-assessment of pain level was documented.

A review of the emergency kit controlled drug accountability form documented that at 5:30 PM, 1 tablet of percocet was taken by the nurse. There was no documentation on the MAR that the medication was given at 5:30 PM nor was there documentation of an assessment of the residents pain level.

On 6/2/14 at 12:00 PM, the resident was interviewed and stated that she has been having pain daily since Saturday 5/31 and she was told that she was being given Oxycodone for pain. She stated normally Oxycodone has relieved her pain and she can't understand why she has not been receiving relief. She stated that the doctor saw her today and ordered another medication, percocet. She reports the pain as a "9 out of 10."

The Licensed Practical Nurse (LPN) medication nurse that worked on 6/1/14 from 7 AM to 11 PM was interviewed on 6/3/14 at 12:15 PM and stated that she should have documented an assessment of the residents pain level before and after the administration of any pain medication. She also stated that she should have documented the percocet that was given on 6/1/14 on the MAR. She stated she will do a better job to document assessment before and after pain medication administration.

The LPN medication nurse that works 11 PM- 7 AM was not available for interview.

The Director of Nursing Services (DNS) was interviewed on 6/2/14 at 3:24 PM and stated that all nurses are responsible to document assessment of pain level prior to and after giving pain medications. She further stated if pain levels were not relieved by ordered medications, the physician should have been notified promptly to assess the need of giving stronger medications or other interventions that the physician deems necessary.

415.11(c)(3)(i)

K147 NFPA 101: EMERGENCY PLAN

Scope: Pattern

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

Citation date: April 4, 2014

1999 NFPA 70 Article 305-2. All Wiring Installations
(a) Other Articles. Except as specifically modified in this article, all other requirements of this Code for permanent wiring shall apply to temporary wiring installations.
(b) Approval. Temporary wiring methods shall be acceptable only if approved based on the conditions of use and any special requirements of the temporary installation.

1999 NFPA 70 Article 305-3. Time Constraints
(a) During the Period of Construction. Temporary electrical power and lighting installations shall be permitted during the period of construction, remodeling, maintenance, repair, or demolition of buildings, structures, equipment, or similar activities.
(b) 90 Days. Temporary electrical power and lighting installations shall be permitted for a period not to exceed 90 days for Christmas decorative lighting and similar purposes.
(c) Emergencies and Tests. Temporary electrical power and lighting installations shall be permitted during emergencies and for tests, experiments, and developmental work.
(d) Removal. Temporary wiring shall be removed immediately upon completion of construction or purpose for which the wiring was installed.

1999 NFPA 70 Article 400-8. Uses Not Permitted
Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:
1. As a substitute for the fixed wiring of a structure
2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors
3. Where run through doorways, windows, or similar openings
4. Where attached to building surfaces
5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors
6. Where installed in raceways, except as otherwise permitted in this Code

Based on observation and staff interview, extension cords were noted in use and plugged into outlets in the East Dining Room and the Dietary Office in the Main Dining Room.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

On 3/28/14 between 9:00am- 11:00am during the recertification survey, extension cords were noted in use and plugged into outlets in the East Dining Room and the Dietary Office in the Main Dining Room.

In an interview on 3/28/14 at approximately 9:25am, the Director of Maintenance stated that he would remove the extension cords immediately.

1999 NFPA 70
10NYCRR 711.2(a)(1)

K62 NFPA 101: SPRINKLER SYSTEM MAINTENANCE

Scope: Pattern

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

Citation date: April 4, 2014

Based on observation and staff interview during the recertification survey the facility did not ensure that sprinkler spray patterns were not obstructed, sprinkler piping was free from external loads, sprinkler was properly installed, and did not maintain spare sprinklers on premise.
This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy:
The findings are:
During the Life Safety survey conducted on 03/28/14 between 8:30am and 1:30pm the following was noted:
1. Sprinkler spray patterns were obstructed by the solid stall partition walls from providing full coverage in the shower stalls (alcove spaces) of the male and female restrooms in the basement.
2. Two pipes were noted strapped onto the sprinkler piping in the boiler room in the basement.
3. A recessed/concealed type sprinkler head was noted without a sprinkler cap, and was not installed flush with the ceiling level in the Rehab. Room.
4. There was no spare sprinklers of the concealed pendent type used in the facility.
In an interview on the same day at approximately 10:45am, the Director of Maintenance stated that he would order the spare sprinkler heads, and he earlier stated that the other identified issues with the sprinkler system would be addressed.
10 NYCRR 711.2
NYCRR 415.29

K56 NFPA 101: AUTOMATIC SPRINKLER SYSTEM

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

Citation date: April 4, 2014

Based on observation and staff interview during the recertification survey, the facility was not protected throughout by an approved, supervised automatic sprinkler system. Reference is made to the lack of sprinkler protection for a wooden deck and a combustible walk-in cooler that are situated within 10 feet of unprotected window and door openings into the facility.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

During the Life Safety Code survey conducted on 03/11/14 between 9:00am and 2:00pm it was noted that sprinkler protection was not provided for all parts of the facility. Examples included the following:

1. An approximately 19 -foot wide by 32-foot long wooden deck that has been constructed immediately adjacent to unprotected windows into the East Wing of the facility (i.e., resident sleeping and activity rooms).

2. An approximately 8-foot wide by 12-foot long walk-in cooler of Type V(000) Unprotected, Combustible

construction that is 28-inches from unprotected window openings into the health care facility.

A review the NYDOH records revealed that the facility was previously granted a time limited waiver for the issues under a K-12 deficiency. However, the time limited waiver expired on 8/13/13 and the facility has not addressed the issues. The facility is now required to meet the requirement of CMS mandates(S&C-09-04, S&C-13-55-LSC) requiring all Nursing Homes to be fully sprinkled effective August 13, 2013. The deficiency now requires a Plan of Correction.

10 NYCRR 711.2
NYCRR 415.29

K64 NFPA 101: PORTABLE FIRE EXTINGUISHERS

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10

Citation date: April 4, 2014

1998 NFPA 10 Chapter 5-2 Frequency.
At intervals not exceeding those specified in Table 5-2, fire extinguishers shall be hydrostatically retested. The hydrostatic retest shall be conducted within the calendar year of the specified test interval. In no case shall an extinguisher be recharged if it is beyond its specified retest date. (For nonrechargeable fire extinguishers, see the exception to 4-4.3.)

Table 5-2 Hydrostatic Test Interval for Extinguishers

Extinguisher Type Test Interval
(Years)
Stored-pressure water, loaded stream, and/or
antifreeze 5
Wetting agent 5
AFFF (aqueous film-forming foam) 5
FFFP (film-forming fluoroprotein foam) 5
Dry chemical with stainless steel shells 5
Carbon dioxide 5
Wet chemical 5
Dry chemical, stored-pressure, with mild steel shells, brazed brass shells, or aluminum shells 12
Dry chemical, cartridge- or cylinder-operated, with mild steel shells 12
Halogenated agents 12
Dry powder, stored-pressure, cartridge- or cylinder-operated, with mild steel shells 12
Note: Stored-pressure water extinguishers with fiberglass shells (pre-1976) are prohibited from hydrostatic testing due to manufacturer's recall.

Based on observation, staff interview and record review, the facility did not ensure that all fire extinguishers were hydrostatically tested within the 5 year requirement. This was noted in the Main Dining Room.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

On 3/28/14 at approximately 9:55am during the recertification survey, two water type fire extinguishers in the Main Dining Room were noted with manufactured dates of 2008. There was no documentation provided of the most recent hydrostatic testing within the last 5 years.

In an interview on 3/28/14 at approximately 10:00am, the Director of Maintenance stated that he will have the fire extinguishers hydrostatically tested.

1998 NFPA 10: 5-2

10NYCRR 711.2(a)(1)

K25 NFPA 101: SMOKE PARTITION CONSTRUCTION

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

Citation date: April 4, 2014

Based on observation and staff interview during the recertification survey, the facility did not ensure that smoke barriers were constructed to provide at least a one half-hour fire resistance rating. Reference is made to the lack of an automatic/self-closing door that is incorporated into a smoke barrier.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

During the Life Safety Code survey conducted on 03/11/14 between 9:00am and 2:00pm, the following was noted:

The door to the activities room that is incorporated into the smoke barrier was not self-closing or automatic closing.

The facility's application for a permanent waiver for this finding from the 09/28/09 recertification survey is disapproved by the regional office.

10 NYCRR 711.2
NYCRR 415.29

K67 NFPA 101: VENTILATING EQUIPMENT

Scope: Isolated

Severity: Potential for more than Minimal Harm

Corrected Date: June 3, 2014

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

Citation date: April 4, 2014

Based on observation and staff interview during the recertification survey, the facility's air handling units were not installed in accordance with the requirements of NFPA 101 2000: section 9.2.

During the Life Safety Code survey conducted on 03/11/14 between 9:00am and 2:00pm, the following was noted:

The building's mechanical handling air units that has a capacity of 2,000 cubic feet per minute (CFM) or more (e.g., the two rooftop 10-Ton air handling units) and is not provided with smoke detectors located downstream of the air filters and ahead of any branch connections nor provided with any means to automatically shut down in the event of a fire and/or smoke condition within the building.

Interviews with the Director of Maintenance during the survey revealed that the issues with the air handling units were cited during 9/28/09 recertification survey and still exist pending a permanent waiver approval.

The facility's application for a permanent waiver for this finding from the 09/28/09 recertification survey is disapproved by the regional office.

10 NYCRR 711.2
NYCRR 415.29

K146 NFPA 101: ALTERNATE SOURCE OF POWER

Scope: Pattern

Severity: Potential for no more than Minimal Harm

Corrected Date: June 3, 2014

A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1¾ hour after loss of the normal source. NFPA 99, 3.6.3.1.1

Citation date: April 4, 2014

The following requirement of the Life Safety Code has been previously waived. Repeat waivers are granted based on previous justifications by the owner, previous NYSDOH and USDHHS reviews, and certification that the conditions under which the waivers have been granted have not changed.

Please indicate if the facility wishes the waiver to be continued, or provide a plan of correction.

K-146

The facility is not provided with a conforming Type 3 Essential Electrical System. A single automatic transfer switch (ATS) serves both Article 700-Emergency System loads and non-Article 700 loads.

Article 700 - Emergency System wiring is not completely independent of all other wiring and equipment.

10NYCRR, 415.29 (a) (2), 711.2 (a), NFPA 99-1999, NFPA 99-1996, NFPA 70-1999, NFPA 70-1996, NFPA 110-1999 , NFPA 110-1996.