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F 000	INITIAL COMMENTS Annual Certification Survey	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to identify and implement appropriate fall interventions for a cognitively impaired resident (R25) and failed to supervise a cognitively impaired resident (R50), both with known histories of multiple falls. R25 and R50 are two of four residents reviewed for falls in the sample list of 17. R50 was admitted to a hospital with acute trauma, scalp laceration and a skull fracture after falling on 10/12/19 at the facility. Findings include: 1. R50's Minimum Data Sheet (MDS) dated 8/12/19 includes the following diagnoses: Seizure Disorder, Alzheimer's Disease, Anxiety and Asthma. This same MDS documents R50 as being severely cognitively impaired, supervision required when ambulating, is to be supervised when up ambulating and has had multiple falls. A facility report titled "Fall Risk Assessment"	F 689	1. For the residents found to have been affected by the alleged deficient practice following corrective actions were implemented: A. Staff in-serviced on fall prevention and following individualized fall interventions. An additional in-service is scheduled for 3/10/19. (Attachment A) B. IDT was in-serviced on developing appropriate interventions based on the root cause of a fall and the comprehensive assessment. (Attachment B) C. R25□s care plan was reviewed and additional fall interventions implemented. (Attachment C) D. R50 is no longer at facility. 2. All residents at risk for falls have the potential for being affected by the alleged deficient practice. However, with the implementation of 1A-C, the alleged deficient practice will not recur.	3/5/20

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

Electronically Signed | 03/05/2020

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F 689	Continued From page 1 dated 8/12/19 documents R50 as being high risk for falls. The facility Fall log dated 1/2019 through 1/2020 documents R50 with the following falls: 2/21/19, 6/15/19, 7/26/19, 8/9/19, 9/9/19, 10/7/19 and 10/12/19. R50's Plan of Care documents that R50 has an identified problem area of Wandering behaviors and to provide supervision and to accompany resident to go where desired. This same Plan of Care identifies R50 with a problem area of falls due to R50 not understanding mobility limits due to cognitive impairment. Interventions of a safety helmet implemented on 7/1/16, keep resident within visuals while ambulating was implemented on 9/21/18. The Plan of Care also documents that R50 was sent to the emergency room on 7/26/19 due to a fall and to continue previous safety interventions. This same intervention of "continue previous safety interventions" are documented in the Plan of Care for falls dated 8/9/19 and 8/18/10. A facility report titled "Final Report" dated 10/18/19 includes the following documentation on R50: "On October 12, 2019 at (9:10pm) (R50) was found lying on the floor in the hallway, (R50) assessed and sent to the Hospital for (Evaluation) and (treatment). (R50 had been walking up and down the hallway as (R50) usually does. Staff stated they went to take a resident to the bathroom and passed (R50) in the hallway walking. Staff heard male resident yelling for help, immediately went to see and observed (R50) lying on the floor with no objects around. Nurse was immediately notified and (R50) assessed, (R50) was sent to the Hospital for (evaluation and treatment)."	F 689	3. The following systematic measures will be followed to ensure the alleged practice has been corrected: A. Management staff will review each fall in the morning QA meeting to ensure that appropriate interventions are in place for resident safety. (Attachment C) B. Administrator or designee will do random observations to ensure interventions are in place. 4. The following Quality Assurance plans have been put into effect to ensure Continued compliance of the alleged deficient practice: A. QA team will review incidents & accidents during morning QA meetings to ensure a new intervention is implemented. B. Recent falls will be reviewed at weekly Fall QA meetings to ensure that facility Policy and Procedure for Fall Prevention is being followed. C. Compliance will be monitored through the internal QA process.	

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Staff Interviews: "(V13, Certified Nursing Assistant) works 10-6-I didn't witness the fall. (R50) was up walking when I passed (R50) in the hallway to take another resident to the restroom. I was in the bathroom with another resident when I heard yelling for help from a male resident. I came out and seen a resident on the floor. I called for help from the nurse immediately. I got vitals and (R50) went out to the hospital."
"V14, Certified Nursing Assistant works 2-10pm-stated I was in the shower room providing ADL (activities of daily living) care to another resident, didn't witness the incident."
"No other staff member witnesses (sic) this incident."
V13, Certified Nursing Assistant documents in a written statement (undated) that V13 did not witness the fall due to toileting another resident and was aware R50 was in the hallway ambulating. This statement is signed by V13. There is no signed statement from V14. Neither Certified Nursing Assistant were available for interview.

Hospital records dated 10/13/19 at 1:06 am document the following on R50: "(R50 is a 71 year old female that presents as a transfer after a fall. The patient has a history of dementia and non-verbal at baseline. History obtained from (R50's) son. (R50) reportedly stood up to ambulate without assistance at her (facility) and fell. She has had recurrent falls for which she wears a helmet." Electronically signed by V16, Hospital Admitting Physician

"CT (Computed Tomography) Brain (10/13/19): Indication : Acute Trauma; Impression: 1. Small hemorrhagic contusions along the floor and anterior aspect of the right frontal lobe. 2. Left

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occipital skull fracture which is minimally displaced 3. Cerebral and cerebellar atrophy 4. Small vessel ischemic/degenerative changes 5. Posterior scalp hematoma.; Active Hospital Problem: Diagnoses; Principal Problem Fall; Scalp Laceration, posterior; Occipital fracture; Brain contusion with no loss of consciousness; Trauma - Plan: Admit to surgical floor"

"CT Brain without contrast (10/14/19)" Findings: "There is redemonstration of trace scattered subarachnoid hemorrhage, which is most pronounced in the right inferior frontal region. This is slightly less conspicuous from prior CT. Trace intraventricular hemorrhage within the occipital horns is more pronounced, which may be related to redistribution. There is redemonstration of bilateral subdural collections, which are increased in size from the prior exam. For reference, the left convexity subdural collection measures 1.5 cm (centimeters in thickness in the right convexity subdural collection measures up to 0.9 cm in thickness (series 2 image 19. On prior CT these collections measured 1.0 and 0.7 cm respectively. The subdural collections are predominately hypodense; although, there is hyperdensity posteriorly on the right (series 2 image 17). There is redemonstration of a non-displaced left occipital calvarial fracture. The middle ear cavities and mastoid air cells reveal no significant opacity." Impression: 1. Increased size of subdural collections along the bilateral cerebral convexities, left greater than right. 2. Slight improvement of trace subarachnoid hemorrhage and increased prominence of trace intraventricular hemorrhage. 3. Non-displaced left occipital calvarial fracture" Electronically signed by V15, Radiologist

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On 2/5/20 at 1:55 pm, V2 Director of Nursing defined and stated supervision of a resident meant that the resident is within visuals of staff at all times. V2 confirmed that R50 was in the hallway ambulating without supervision, fell and was sent to the hospital on 10/12/19. V2 stated R50 had a soft helmet on, but could not say whether the helmet had been removed prior to the fall.
2. R25's Physician's Order Sheet dated February 2020 documents the following diagnoses: Cervical Spine Fracture C2, C3, C4, Chronic Kidney Disease Stage 4, Chronic Obstructive Pulmonary Disease, Hypertension, Neurodegenerative Cognitive Impairment and Toxic Encephalopathy and Fracture Right Hip.

The Minimum Data Sheet (MDS) dated 11/29/19 documents R25 as being severely cognitively impaired. The MDS also documents R25 requires one person physical assist for transfers, walking in the room, walking in the corridor and requires two person physical assist for toileting.

The facility form titled "Fall Risk Assessment" dated 9/27/10 for R25 documents Fall Risk scores for 8/7/19, 9/20/19 and 11/29/19 at high risk. The form documents R25 to have Occasional Confusion, and Loss of Balance with standing and walking.

R25's Care Plan dated 11/22/2019 documents R25 is to have one assist and gait belt for all ambulation. Use additional assist as needed. Personal alarm on while in bed and while up in chair. Check position with cares and functions each shift. R25 is known to unplug and shut off alarm. On 11/8/19 this same Care Plan

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documents R25 is frequently non-compliant with waiting for staff assistance with ambulation.

A facility report titled "Final Report" dated 1/10/20 documents R25 falling on 1/4/2020 and being admitted to the hospital with a Right Intertrochanteric Femur Fracture. The report documents R25 was yelling and the CNA (Certified Nursing Assistant) hearing her yell went into the room and found both R25 and her room mate on the floor.

The facility report titled "AIM for Wellness" dated 1/4/20 documents under "Nursing Notes "R25 complaining of right hip pain, unable to move (R25's) right leg. Shortening noted. Orders received from Nurse Practitioner (V12) to send (R25) to emergency room for evaluation and treatment.

Hospital records titled "Emergency Department Note Physician Final Report" dated 1/4/2020 documents the following for R25: "Chief Complaint - (R25) in ED (Emergency Department) following fall. (R25) has shortening of the right leg. This patient (R25) is an (sic) 95-year old female presented to the emergency department by EMS (Emergency Medical Service) from (facility) for an evaluation from a fall. From what can be gathered, (R25) was found on the floor and nursing staff observed shortened right lower extremity. (R25) is complaining of right hip pain and there is obvious shortening of the right lower extremity. " X-Ray of the right hip: Impression: "Right Intertrochanteric Femur Fracture."

On 2/5/20 at 2:05 pm, V2 Director of Nursing confirmed that on 1/4/20, R25 had gotten up from

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F 689	Continued From page 6 the recliner in the room to help R25's roommate. V2, also confirmed R25's Plan of Care for fall interventions prior to 1/4/20 included pressure alarms while in recliner and bed, with frequent checks. V2 stated R25 has previously had therapy and was instructed to use the call light and wait for assistance. V2 confirmed there were no alarms being used for R25 the night she fell 1/4/2020. The facility policy titled "Fall Prevention" dated 11/10/18 documents the following: "1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 2. All staff must observe residents for safety. If a residents (sic) with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident. 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in morning Quality Assurance meeting and any new interventions will be written on the Care Plan." Fall Prevention Interventions: "Keep in visual when out of bed." "Instructions for resident not cognitively impaired to use call light and wait for assistance."	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes,	F 693		3/5/20

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F 693	Continued From page 7 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to perform hand hygiene, change contaminated gloves, failed to prevent potential cross contamination by using contaminated undated disposable equipment, failed to check residual of stomach content to verify gastrostomy (surgical, abdominal access for nutrition and medication administration) tube (G-tube) placement according to facility policy, and failed to fully prepare medications to avoid obstruction of G-tube. These failures have the potential to affect one of one resident (R27) reviewed for G-tube medication administration on the sample list of 17. Findings include:	F 693	1. For R27□s the following corrective action for the alleged deficient practice has been achieved by the following: A. Nurses were in-serviced on enteral feedings, changing/labeling of syringe, rinsing graduate, proper protocol for providing g/tube medications and clearing a clogged feeding tube. An additional in-service will be conducted on 3/10/20. (Attachment A) 2. All residents requiring enteral feedings have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1 A, the alleged deficient practice will not recur.	

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F 693	Continued From page 8 R27's "Cumulative Diagnoses Log" dated 10/1/2015 documents the following diagnoses: Cerebral Palsy, Seizure Disorder, Dysphagia, Profound Mental Retardation, Hypertension, Anemia, Hormone Depletion, Anxiety and Constipation. R27's Physician Order Sheet (POS) dated 2/1-2/29/2020 documents the following: Jevity 1.2 calorie at (infuse) 46 milliter (ml) per hour through G-tube times 18 hours, Flush with 30 ml water before am after med (medication) pass. Flush G-tube with 100 ml four times daily. Cocktail (crushed and mixed together, dissolved in water) meds (medication) may be given through G-tube. The same POS documents the following medications: Clonazepam one mg (milligram) tablet per G-tube twice a day, Docusate Sodium 100 mg tab one per G-tube twice a day, Multivitamin /Minerals one per G-tube every day, Metoprolol 25 mg one per G-tube twice daily, Primidone 250 mg one per G-tube twice a day, Ferrex 150 mg one capsule per G-tube twice daily, Lactulose 10 gram /15 ml solution take 15 ml (10 gram) per G-tube once a day, Levetiracetam 100 mg/ml take 7.5 ml (750 mg) per G-tube twice a day, and Phenytoin 125 mg / 5ml suspension give 4 ml (100mg) per G-tube twice daily (at 9:00 am and 6:00 pm) and 2 ml (50mg) at bedtime. R27's Care Plan dated 11/25/19 documents the following: "Category: Feeding Tubes Resident receives Nutritional Support. Related diagnosis Malnutrition. PO (by mouth) Status NPO (nothing by mouth). Goal: Will tolerate tube feeding as evidenced by no diarrhea, vomiting or abdominal distention. Approach/Intervention: Check proper placement of the tube (G-Tube) by aspirating	F 693	3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: A. DON will do random observations to ensure resident who receive enteral feedings for proper procedures to prevent cross contamination, administration of medications, labeling of syringe and cleaning the graduate. (Attachment B) B. Additional education will be provided as needed and all new hires will be educated on enteral feedings. 4. The following Quality Assurance programs have been implemented to ensure continued compliance: A. Nursing Administration will bring any concerns for residents with enteral feedings to morning QA meeting and provide 1:1 education as indicated and/or disciplinary action for failure to comply with facility policy. B. Quality Assurance Committee will monitor for compliance through the internal QA process.	

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(residual) and auscultating (inject air and listen via stethoscope) prior to every feeding, every shift and prn (as needed)."

On 2/5/2020 at 9:05 am V10, Licensed Practical Nurse (LPN) cocktailed the above medications, without using hand sanitizer or washing V10's hands. V10, LPN enters R27's room and set the cocktailed medication cup on R27's soiled bedside dresser. V10, LPN dons gloves and turned the manual crank device at the foot of R27's bed, to raise R27's head of bed to a 45 degree elevation. V10, LPN, wearing the same contaminated gloves, used a stethoscope to auscultate (listen to air injected through the G-tube into R27's stomach) verification of R27's G-tube placement in the stomach, prior to administration of G-tube medication. V10, LPN did not verify R27's G-tube placement by aspirating stomach content residual. Wearing the same contaminated gloves, V10, LPN picked up an undated measuring graduate container from R27's dresser. R27's dresser top had a large amount of a thick liquid type, opaque white, sticky substance adhering to the surface top. R27's G-tube 60 ml syringe and separate syringe plunger also laid on the soiled dresser top. V10, LPN left R27's room with the same contaminated gloves and graduate. V10, entered a shared resident hall bathroom. V10, LPN continued with the same contaminated gloves and touched the bathroom door, and sink faucets.V10, LPN returned to R27's room, retrieved the contaminated syringe and syringe plunger, and continued with the same contaminated gloves. V10, LPN, administered R27's 30 milliter G-tube water flush. V10, LPN continued with the same contaminated gloves, poured the cocktailed medication into the open ended syringe for bolus

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(gravity) administration. R27's medication had visible fragments of undissolved medication present. R27's medication did not flow by gravity. R27's medication was retained in the syringe body which was attached to R27's G-tube port. V10, LPN inserted the plunger of the syringe into the medication filled syringe and attempted to force the plunger down to inject R27's medication into R27's stomach. The medication in the syringe did not move. When V10, LPN stopped forcing the plunger, the plunger popped backwards out the end of the syringe and made a popping sound as the the force of air ejected the syringe plunger. V10, LPN acknowledged R27's G-tube was clogged. V10, LPN stated "it (medication) still isn't going in (to the stomach via G-tube)." V10, LPN manipulated the G-tube tubing below the syringe, with V10's fingers. R27's cocktailed meds did not move down into the G-tube tubing, from the syringe. V10, LPN reinserted the syringe plunger and pushed with force until the cocktailed medication moved by a rapid surge into R27's G-tube. V10, did not wash V10's hands, use hand sanitizer or changed V10's gloves after contamination, before during or after administering R27's G-tube medication. V10, LPN laid the contaminated equipment back on R27's contaminated dresser removed contaminated gloves and returned to the medication cart.

On 2/5/2020 at 9:30 am V10, Licensed Practical Nurse stated the following:"I don't know why I didn't wash my hands or use hand sanitizer. I guess I'm just nervous. I guess I shouldn't have went into get the water in the bathroom and use the same gloves to do (R27's) meds." V10 also stated: "I think our policy says we only have to check G-tube placement with air, not residual

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F 693	Continued From page 11	F 693		

checks, as far as I know." V10 also stated "I didn't notice the sticky dresser in (R27's) room. I should have used a new syringe anyway. We are suppose to change the syringe (G-tube) every day. The graduate should be dated last Friday, they (unidentified staff)change those (graduate measuring container) on nights, every Friday. Without dates I (V10, LPN) have no way of knowing for sure when either (graduate container and syringe) of them were changed." V10 also stated: "No excuses, I (V10, LPN) should not have forced the meds in (through) the syringe, I (V10, LPN) couldn't get the G-tube unclogged. I don't usually do it that way."

On 2/5/2020 at 11:40 am V 2, Director of Nursing (DON) stated V 2's expectation if G-tube is clogged:"The nurse would milk the tubing, and put warm water in." V 2, DON also stated: "I wouldn't say force the water but maybe (gives a visual display) bumping with the piston (syringe plunger) but definitely not by forcing."

The facility policy "Administration of Medication Via a Feeding Tube" dated 11/06/18 documents the following: "Policy: Is is the policy of (Company) that when feeding is provided via Nasogastric or Gastrostomy tubes, the resident may receive ingestible medication via the feeding tube when the oral route cannot be used and an order for such exists. 3. Unless cotraindicated, medications may be crushed and combined for dissolution/ in water prior to instillation." The same policy documents the following: "Procedure: 10. Wash your hands. 11. Put gloves on. 12. Check placement by checking for residual (aspirate for stomach content). If no residual is aspirated, verify placement by placing a stethoscope over the stomach and instilling

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CASEY HEALTHCARE CENTER	100 N.E. 15TH CASEY, IL 62420

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F 693	Continued From page 12 approximately 30 cc (cubic centimeters) of air. Auscultate for air instillation, proceed if heard." The same policy documents the following: "19. Rinse syringe and store unassembled in plastic when dry. 20. Replace syringe daily and prn (as needed). 21. Dispose of used equipment/supplies or return to appropriate setting. 22. Remove gloves. 23. Wash hands."	F 693		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		3/5/20

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F 758	Continued From page 13 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to limit PRN (as-needed) Haldol (anti-psychotic) medication use to 14 days, failed to identify specific behaviors necessitating Haldol use, failed to complete a psychotropic medication assessment for Haldol, and failed to develop and implement care planning for anti-psychotic medication use. These failures affect one resident (R15) of five reviewed for unnecessary medications on the sample list of 17. Findings include: R15's Physician Orders (December 2019-February 2010) document R15 has an order for the anti-psychotic medication Haldol 5mg/mL (five milligrams per milliliter), inject one milliliter intramuscularly every six hours as needed for	F 758	1 For the residents found to have been potentially affected by the alleged deficient practice, the corrective action is as follows: A. R15□s PRN Haldol was discontinued. B. R15□s Behavioral Tracking forms were updated on 02/15/2020 to reflect behaviors r/t her Dementia w/ Psychosis diagnosis. (Attachment A) C. Problem, goal, and interventions added to R15□s Care Plan r/t behaviors and psychotropic medication use. (Attachment B) D. Nursing staff in-serviced on Psychotropic Medication Policy. (Attachment C) E. IDT in-serviced on behavior monitoring and developing a behavior	

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F 758	Continued From page 14 agitation/anxiety. The start date for the medication is 12/6/2019 and no end date is documented. R15's medication administration record documents R15 received Haldol injections in the months of December 2019 and January 2020. R15's medical record (undated) does not document any assessment for R15's Haldol use or any medical provider re-evaluation for R15's continued PRN (as-needed) use of Haldol after the initial order date of 12/6/2019. R15's Behavior Tracking Records (December 2019-January 2020) do not document R15's Haldol use. R15's care plan (2/3/2020) does not document R15's use of of Haldol, fails to identify specific targeted behaviors necessitating use of the drug, and does not limit the use of the anti-psychotic medication to a maximum of 14 days, as required, without provider re-evaluation for continued need. On 2/7/2020 at 3:05PM, V2 (Director of Nursing) stated "Yes" (R15's Haldol order was not limited to 14 days, R15 did not have any behaviors specifically identified as requiring Haldol, did not have a psychotropic medication assessment for Haldol, and did not have any care planning for Haldol use.) The facility Psychotropic Medication Policy (11/28/2017) documents psychotropic medications will not be prescribed prior to attempting non-pharmacological interventions to decrease behavior, a pre-psychotropic	F 758	care plan. (Attachment D) 2 All residents who currently receive or may be prescribed Psychotropic Medications have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1A-C, the alleged deficient practice will not recur. 3 The following systemic measures have been implemented to ensure the alleged deficient practice does not recur: A. IDT will review resident□s receiving Psychotropic Medications weekly during weekly Psychotropic/Behavior QA Committee meeting to ensure: accurate evaluation, assessment, diagnosis and identification of targeted behaviors are addressed on the Quarterly Psychotropic Assessment, Care Plan and Behavior Monitoring Forms. (Attachment E) 4 To ensure all corrections are achieved the following Quality Assurance measures have been implemented: A. Weekly Psychotropic QA Meeting will be conducted to ensure compliance. B. Compliance will be monitored through the internal QA process.	

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F 758	Continued From page 15 medication assessment will be completed prior to administration of a new psychotropic medication, any resident receiving as-needed (PRN) psychotropic medications will have the prescriber document the diagnosed specific condition and indication for the medication in the resident's medical record, and the facility will limit the use of as-needed anti-psychotic medications to a duration of 14 days unless the presciber re-evaluates the resident to determine if the anti-psychotic is appropriate.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer physician ordered medication according to pharmacy recommendations for two of seven residents (R22 and R28) observed for medication administration. The facility had two medication errors out of 25 opportunities for error, resulting in a medication error rate of 8.0 percent. Findings include: 1. R22's "Cumulative Diagnosis Log" dated 10/1/2015 documents the following diagnoses: Coronary Artery Disease, Hypertension, Seizure Disorder Post Stroke (Cerebral Vascular Accident), Dementia and a History of Falls.	F 759	1. For the residents identified to potentially be affected by the alleged deficient practice, the following corrective actions were taken: A. Nurses in-serviced regarding policy & procedure for Medication Administration, inhalers (specifically Breo Ellipta) and following pharmaceutical recommendations. An additional in-service will be conducted on 3/10/20. (Attachment A) B. Pharmacy review requested on R22□s medication for alternative r/t Dysphagia diagnosis. (Attachment B) 2. All residents, who receive medication, have the potential to be affected by the	3/5/20

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F 759	Continued From page 16 R22's Physician Order Sheet (POS) dated 2/1-2/29/2020 documents the following medication order: Diltiazem 30 milligrams (mg), take one tablet by mouth four times daily. R22's Medication Administration Record (MAR) dated 2/1-2/29/2020 documents the following Diltiazem pharmacy directive: "Label Warnings: Swallow whole-don't chew /crush; pulse suggested, may cause dizziness." On 2/5/2020 at 12:15 pm V11, Licensed Practical Nurse (LPN) administered R22's Diltiazem 30 mg tablet by mouth, crushed in pudding. R22's medication pharmacy label warnings reiterated the medication precaution: "Swallow whole-don't chew /crush; pulse suggested, may cause dizziness." On 2/5/2020 at 12:20 pm V11, LPN stated the following:"I didn't know I wasn't suppose to crush (R22's) Diltiazem." The facility pharmacy "Drug Information" sheet for Diltiazem dated 2/2013 documents the following: "Take this medication by mouth before meals and at bedtime as directed by your doctor, usually three or four times a day. Swallow the tablet whole. Do not split, crush or chew the tablets. Doing so can release all the drug at once increasing the risk of side effects." The same "Drug Information"sheet document side effects: Dizziness, light headedness, weakness, nausea, flushing, constipation, and headache may occur." 2. R28's Cumulative Diagnosis Log dated 10/1/2015 documents the following diagnoses: Chronic Obstructive Pulmonary Disease, Hypoxia, Congestive Heart Failure and Dementia with Behaviors.	F 759	alleged deficient practice. However, due to the implantation of 1-A-C, the alleged deficient practice will not recur. 3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: A. Nursing Management will do random observations of medication administration to ensure proper medication procedures are being followed and that medication ordered are available. (Attachment C) B. The Pharmacy Consultant will observed Med Pass at least annually, to ensure that proper medication administration procedures are being followed. C. All new nurses will be in-serviced on medication administration and procedures for administering all types of medications and obtaining medications from the pharmacy or back up pharmacy. (on-going) 4. The following Quality Assurance programs have been implemented to ensure continued compliance: A. Any and all medication administration errors will be discussed at during daily QA meetings and additional training and/or disciplinary action will be implemented B. Compliance will be monitored through the internal QA process.	

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F 759	Continued From page 17 R28's POS dated 2/1-2/29/20 documents the following medication orders: "Breo Ellipta 100-25 mcg (microgram), inhale one puff po (by mouth) daily (label directs to rinse and spit) and Ferrous Sulfate 220 mg/5 milliliter (ml) Elixir, take 5 ml by mouth three times daily, with meals in two to four ounces of orange juice." R28's MAR dated 2/1-2/29/2020 documents the following Breo Ellipta pharmacy directive: "Label Warnings:"Wait one minute between inhaled meds (medication); After use; Rinse and spit discard as label instructs; store in cool, dry place." On 2/5/2020 at 11:52 am V10, LPN administered R28's Breo Ellipta 100-25 mcg. R28 inhaled one puff. V10 did not offer or provide water for R28 to rinse and spit. V10 administered R28's Ferrous Sulfate by mouth, mixed with orange juice. On 2/5/20 at 11:57 am V10, LPN stated "I did not know the Breo inhaler had those instructions to rinse and spit. I guess I haven't read the label." The facility pharmacy "Drug Information" for Breo Ellipta dated 8//2013 documents the following: "To prevent dry mouth, hoarseness, and oral yeast infections from developing, gargle and rinse your mouth with water after each use. Do not swallow the rinse water."	F 759		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		3/5/20

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F 880	Continued From page 18	F 880		

development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 19 (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a water management plan that included the required risk assessment and testing protocols to reduce the risk of grown of Legionella and other pathogens in the facility's water system. This failure has the potential to affect all 48 residents in the facility. Findings include: On 2/6/2020 at 2:30PM, the facility water management plan (8/2/2019) did not include the required risk assessment to determine where waterborne pathogens could grow and spread in the facility water system. The same record did not document the required consideration of the ASHRAE (American Society of Heating,	F 880	1. For the Residents found to have been potentially affected by the alleged deficient practice, the following corrective action was implemented: A. Maintenance completed Risk Assessment. (Attachment A) B. Maintenance Director is completing testing protocols (Attachment B) 2 All residents in the facility have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1 A-B, the alleged deficient practice will not recur. 3. The following systemic measure has	

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F 880	Continued From page 20 Refrigerating and Air-Conditioning Engineers) standard or the (CDC) Centers for Disease Control and Prevention Water Management Program toolkit. The plan did not identify any specific testing protocols or acceptable ranges for control measures, or any corrective actions when control limits are not maintained. On 2/6/2020 at 2:35PM V1 (Administrator) was present and stated "Yes" the above document was the entire facility plan. The Resident Census and Conditions of Residents report (2/4/2020) documents 48 residents reside in the facility.	F 880	been implemented to insure the alleged deficient practice does not recur. A. Administrator will monitor Water Management Program to ensure monitoring is completed as indicated. 4. The following Quality Assurance Programs have been implemented to ensure continued compliance. A. Compliance will be monitored through the internal QA process.	