STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146095	A. BUILDING ______ B. WING ______	09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENGLOW LODGE	**215 EAST WASHINGTON PONTIAC, IL 61764**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		9/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
09/23/2015

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

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F 157	Continued From page 1	F 157		

by:
Based on interview and record review the facility failed to notify the physician of a change in condition on six occasions for one of two residents (R10) reviewed for diabetic management in a sample of fourteen.

Findings include:

The facility Admission Record dated 8/19/15 documents R10 with diagnoses to include Diabetes Type II. The Admission Record documents Z1 as R10's physician.

The Protocols for the facility (standing orders) specific to Z1 and for patients treated by Z1, signed by Z1 on 11/15/13 documents, "Diabetic Residents: 1. When Blood Sugar is less than 70 and Symptomatic (cold/clammy skin, sweating, shakiness, confusion, lethargy, loss of consciousness) give one amp (ampule) of Glucagon SQ (subcutaneously)." Additionally documented, "An SBAR (Situation Background Assessment Recommendation) is to be completed and faxed along with the MAR (Medication Administration Record) for all changes in condition."

The facility Protocol for Hypoglycemia (below 70) dated 6/11/14 documents for a blood glucose level below 70 and the resident is symptomatic but still conscious and able to swallow to give 30 grams of glucose or carbohydrates (examples juice and glucose tablets) and recheck blood glucose in 15 minutes, repeat every 15 minutes until blood glucose greater than 100 or until symptoms resolve and notify physician and family.

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F 157	Continued From page 2 Progress Notes on 7/9/15, 8/11/15, 8/16/15, 8/21/15, 8/29/15 and 8/30/15 document R10 as being provided orange juice with 2 packets of sugar due to the results of the 6am blood glucose level. There is no evidence in the Progress Notes or SBAR's on 7/9/15, 8/11/15, 8/16/15, 8/21/15, 8/29/15, or 8/30/15 of notification to Z1 of R10's low blood sugar which were treated with orange juice and sugar. The July MAR document R10's 6am blood glucose at 64 on 7/9/15. Progress Note for R10 dated 7/9/15 at 6:42am documents, "Resident was all sweaty and was slightly glassy-eyed at 5:50am. Still talking, given small glass of orange juice with 2 sugars.....Staff changed her gown and bed linen." There is no documentation in the Progress Notes of physician notification. Progress Note dated 8/29/15 document for R10 "Sugar at 0558 (5:58 a.m.) was 48 given 8 oz (ounces) of OJ (orange juice)....Resident exhibited no signs or symptoms of hypoglycemia except sweaty palms....." There is no documentation in the Progress Notes of physician notification. The Progress Note for R10 dated 9/1/15 at 7:14am documents, "....at 0400 (4:00 a.m.), pt (patient) foaming at the mouth, non-responsive, cold and clammy cbg (blood glucose) was 32. Unable to take anything by mouth. Glucagon given. At 4:25am cbg was 59. Still not able to take fluids. Another (dose) of Glucagon (given)....." The SBAR documents Z1 notified of R10's change in condition at 7:50am. On 9/4/15 at 8:55am, E12 (Nurse) stated E12 stated physicians are to be notified of changes in	F 157		

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F 157	Continued From page 3 condition including use of orange juice for low blood glucose levels. On 9/3/15 at 1:45pm, E2 (Director of Nursing) confirmed Z1 is to be notified of treating blood glucose levels below 70 and for any changes in condition. E2 stated physician notification would be documented in SBAR or Progress Notes. SBAR's are electronically transmitted documents. On 9/4/15 at 10:10am, Z1 stated he could not recall being notified of all of R10's low blood glucose levels. Z1 stated if a resident experiences a trend of a blood glucose below 50 he would expect the facility to contact him so the residents medication could be evaluated for possible adjustment. Z1 stated, "I am not worried about once, maybe not even twice but a trend of blood glucose levels below 50 I would expect notification." The facility policy, Physician and Family Notification, 1/12/2011, documents Physicians and families are to be notified regarding a change in condition (including but not limited to abnormal labs, refusal of medication and/or treatment, falls with or without injury, decline in condition). Doctors can be notified either by telephone or fax.	F 157		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		9/23/15

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F 278	Continued From page 4	F 278		

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on on interview and record review the facility failed to accurately assess one of four residents (R4) reviewed for Minimum Data Set (MDS) assessments in a sample of fourteen.

Findings include:

A facility Occurrence Report dated 6/4/15 documents R4 had a fall without injury. A facility Occurrence Report dated 5/30/15 documents R4 had a fall with a skin tear to the right arm requiring steri strip application.

The Minimum Data Set (MDS) dated 7/1/15 documents R4 with one fall without injury in

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F 278	Continued From page 5 section J1900A and section J1900B is documented as zero indicating no fall with injury incurred since the prior assessment. On 9/3/15 at 12:25pm, E11 (MDS Coordinator) confirmed R4 had one fall with injury and one fall without injury between the 4/1/15 and 7/1/15 MDS assessments. E11 confirmed section J1900B on the 7/1/15 MDS should be marked to reflect a fall with injury in section J1900B. E11 stated, "I missed one."	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. This REQUIREMENT is not met as evidenced by:	F 280		9/23/15

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F 280	Continued From page 6	F 280		

Based on interview and record review the facility failed to ensure residents' comprehensive care plans were revised to include recommended post-fall interventions. This applies to two of nine residents (R1, R12) reviewed for falls in the sample of 14.

The findings include:

1) The Occurrence Report states on 1/6/15 at 5:15 AM, R1 was found on the floor of her bedroom. There was no injury sustained. Interventions state to apply bed and chair sensor at full volume. R1's care plan initiated 9/2/14 does not include interventions to keep the bed and chair sensor at full volume.

The Occurrence Report states on 5/19/15 at 10:30 AM, R1 was found on the floor of her bedroom. R1 sustained injury to her left ear and left elbow. Interventions include to keep R1's shoes out of reach of bed. R1's care plan initiated on 9/2/14 does not include interventions to keep R1's shoes out of reach of bed.

2) The Occurrence Report states on 1/11/15 at 8:50 PM, R12 was found on the floor of her bedroom. There was no injury sustained. Interventions state to utilize a scoop mattress. R12's care plan initiated on 1/7/15 does not include use of a scoop mattress.

The Occurrence Report states on 1/14/15 at 8:50 PM, R12 fell in her bedroom. There was no injury sustained. Interventions state to not leave R12 unattended in the recliner in her room. R12's care plan initiated on 1/7/15 does not include interventions to not leave her unattended in the recliner of her room.

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F 280	Continued From page 7 The Occurrence Report states on 1/16/15 at 4:10 PM, R12 was found on the floor of her bedroom. There was no injury sustained. Interventions stated to pin laptop cushion to personal safety alarm. R12's care plan initiated on 1/7/15 was not updated until 8/10/15, to include pinning the laptop cushion to personal safety alarm. The Occurrence Report states on 8/6/15 at 10:00PM, R12 was found on the floor of her bathroom. There was no injury sustained. Interventions state to keep R12 at the nurses' station or in the living room until put to bed. R12's care plan initiated on 1/7/15 does not include interventions to keep R12 at the nurses' station or living room until put to bed. On 9/3/15 at 1:50 PM, E11 (Care Plan Coordinator) stated post-fall interventions should be immediately added to the residents' care plans. The facility's Procedure for Resident Falls & Incidents, dated 11/19/07, states staff will determine the root cause of falls and implement interventions. The residents' plan of care will reflect the new interventions implemented. The facility's Care Plans policy, revised 2/2000, states as issues arise with a resident, problem statements goals and interventions should be added to the residents care plan in a timely fashion.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		9/23/15

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F 323	Continued From page 8 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to establish post fall interventions and failed to ensure post fall interventions were consistently implemented. This applies to four of nine residents (R1, R9, R12, R13) reviewed for falls in the sample of 14.

The findings include:

The facility's Procedure for Resident Falls & Incidents, dated 11/19/07, states staff will determine the root cause of falls and implement interventions.

1) The 12-28-14 Occurrence Report states R1 was found on the floor of her bedroom on 12/28/14 at 12:45 PM, sustaining a fractured left hip. Interventions include to reassess R1 upon re-admit to the facility. R1's care plan, initiated on 9/2/14, does not include any post fall interventions following R1's return from the hospital. On 9/3/15 at 3:00PM, E2 (Director of Nurses) stated R1 did not need any interventions implemented upon return from hospital.

The 5-19-15 Occurrence Report states R1 was found on the floor of her bedroom on 5/19/15 at 10:30 AM, sustaining injuries to her left ear and left elbow. Interventions included placing

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F 323	Continued From page 9	F 323		

non-skid strips to the floor next to R1's bed. On 9/3/15 at 10:05AM, there were no strips on the floor by R1's bed. On 9/3/15 at 10:05AM, E14 (Certified Nursing Assistant) stated R1 has not had non-skid strips by her bed. On 9/3/15 at 1:00 PM, E2 stated the non-skid strips were placed on the floor in R1's previous room, but had not been moved when R1 changed rooms.

2) The 5-12-15 Occurrence Report states R12 fell in her room on 5/12/15 at 10:50 PM, sustaining a bruise to the right side of her face. Interventions stated a scoop mattress was in place. There were no other post-fall intervention recommended. The Occurrence Report dated 1/11/15, states the use of a scoop mattress was initiated following R12's fall on 1/11/15.

The Occurrence Report states R12 was found on the floor of her bedroom on 8/10/15 at 4:35PM. R12 did not sustain any injuries. Interventions include to toilet R12 routinely and pin the laptop cushion to the personal safety alarm. The Occurrence Reports dated 8/6/15 and 6/11/15 already included interventions regarding toileting R12. The Occurrence Report dated 1/16/15 already included interventions to pin the laptop cushion to the personal safety alarm.

3. The Physician Order Sheet dated September 2015 documents the following diagnoses for R13: Cerebral Infarction, Amnesia, Iron Deficiency Anemia, Urinary Retention, Type 2 Diabetes Mellitus; Peripheral Vascular Disease, Muscle Weakness and Essential Hypertension.

The Facility Fall Log Documents that R13 had a fall on 12/30/14.

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F 323		F 323		

Continued From page 10

The Minimum Data Sheet (MDS) dated 8/14/15 documents that R13 requires one person assist and supervision with ambulation and transfer.

The Care Plan dated 8/18/15 documents that R13 has self-care deficit related weakness. Intervention requires one person constant guidance and physical assistance for transfers. The Care Plan also documents R13 at risk for falls related to history of falls and risk factors including impaired balance and unsteady gait. Interventions include: R13 is to have a high/low bed with mat beside it, wearing non-slip footwear, bed sensor and chair sensor.

On 9/3/15 at 1:35pm R13 was lying in bed, bed in low position, bed sensor in place and mat on floor beside bed. E9 (Registered Nurse) and E10 (Clinical Coordinator) changed R13's wound dressing. After changing the dressing, the bed was returned to the low position and bed sensor was in place. The mat was not returned to the floor next to the bed. The mat was folded in half leaning on front of the recliner.

Between 1:45pm and 3:45pm on 9/3/15 R13's mat remained folded in half leaning on front of the recliner.

On 9/3/15 at 1:50pm E9 (Registered Nurse) stated that "(R13) is to have bed in low position, bed sensor and mat on floor when lying down."

4. The Physician Order Sheet dated September 2015 documents the following diagnoses for R9: Vascular Dementia with Behavioral Disturbance, Anxiety, and Difficulty in Walking, Muscle Weakness and Essential Hypertension.

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F 323	Continued From page 11 The Facility Fall Log documents R9 had a fall on 6/21/15. The Minimum Data Sheet (MDS) dated 7/22/15 documents R9 requires one person assist and supervision for transfer. The Care Plan dated 7/28/15 documents R9 has self-care deficit related to confusion and inability to follow direction. R9 requires one person and constant guidance and physical assistance with tranfers. The same Care Plan documents R9 is at risk for falls due to past falls, restlessness at times and confusion. R9's fall interventions require a high/low bed with mat beside it, non slip footwear, bed and chair alarms are to be in place, wedge cushion, rear tilt with chair and reinforcement to R9 regarding using the call light. The Facility Occurrence Report for the fall on 6/21/15 documents the root cause of the fall to be R9 rolled out of bed to the mat on the floor. The post fall intervention was that the Care Plan and Fall Interventions were reviewed and in place. No changes were made or other attempted interventions documented. On 9/4/15 at 10:30am E2 (Director of Nursing) stated "There are no other interventions that can be put in place for (R9)".	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		9/23/15

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F 329	Continued From page 12 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to comprehensively assess, monitor, and evaluate the medical/behavioral need for psychotropic medication usage for one of two residents reviewed for psychotropic medication usage in a sample of 14. Findings include: On 9/1/2015 at 9:40AM, R2 was sitting at the table with R2's head down dozing and 1:30PM lying on left side sleeping. On 9/2/2015 at 8:30AM, R2 was up at the dining room table eating with assistance and 10:30AM sitting in the day area with head down sleeping. On 9/3/2015	F 329		

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at 9:15AM, R2 was sitting in the dining room with hands over face sleeping. At no time during the survey did R2 display any behaviors.

R2's face sheet dated 3/17/2014, documents the following diagnosis Alzheimer Dementia with Behavioral Disturbance and Anxiety.

The Minimum Data Set dated 7/15/2015 documents R2 is severely cognitively impaired.

R2's Physicians Order Sheet (POS) dated 7/1/2015 documents Ativan 0.5 milligrams (mg) take one half a tablet (0.25mg) by mouth at bedtime as needed (PRN) for restlessness.

R2's Quarterly Psychoactive Medication Assessment dated 7/20/2015 documents the following: Ativan 0.25mg at bedtime as needed, Diagnosis-Anxiety, no adverse reaction, behavioral symptom- restless at times, non-pharmacological intervention- leave alone for a while.

R2's care plan with a target date of 10/28/2015 documents Focus: Taking psychotropic Medications for anxiety, Goal: will show improvement in mood/behavior, Interventions: evaluate effectiveness and side effects of medication, monitor for mood, signs of tremors, appropriate interactions with peers. There are no individualized specific non- pharmacological interventions or specific target behaviors identified in the plan of care.

R2's Progress Notes from 5/30/2015 through 8/31/2015 identify four documented behaviors; 7/12- very anxious in wheel chair running into people, 7/25- would not stay in bed when placed

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in wheel chair ran into objects, 7/29- in wheelchair propelling aimlessly steering into other residents, 8/4- rocking back and forth in wheel chair, and 8/5- wandering up and down halls and in resident rooms in the wheelchair.

R2's Controlled Substance Proof of Use sheets for June 2015 through August 2015 document administration of Ativan PRN 50 times.

The Medication Administration Record (MAR) for PRN medications had no documentation of amount, route, reason for giving, date, time or signature of the nurse for 32 doses administered to R2 documented on the back of the MAR in July and August of 2015 and no initials on the front of the MAR next to the PRN administered on the date given.

On 9/1/2015 at 2:30PM, E2 (Director of Nursing) stated "any time a nurse administers a PRN medication the reason for the medication, dose, route must be documented on the back of the MAR. It is not necessary for the nurse to initial the front of the MAR next to the PRN medication being administered. It is especially important for PRN psychotropic medications for tracking use. We do not use behavior tracking sheets all behaviors are either documented in the progress notes or on the back of the PRN medication sheet."

The facility "Medication Administration" policy documents "#6) When giving PRN medications, the PRN page is to be used. The date, medication, amount, route, reason, and signature should be written. The nurse must write results on MAR at the appropriate time for follow up."

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F 329	Continued From page 15 The "Psychotropic Medication Use" policy documents "#4.- Documentation of PRN psychoactive medications given will be on the back of the MAR and will include the reason the medication was given, any non-pharmacological interventions that were tried and failed, and the outcome after." On 9/2/2015 at 1:30PM, Z2 (Nurse Practitioner) stated " It appears pharmacy placed the wrong physicians ordered dose of Ativan 0.5mg on the August POS. As you see I reduced the Ativan on 8/26/2015 to 0.25mg at bedtime as needed. I would have just discontinued the medication if I would have noticed the error. The nurses should have caught the error when checking the MAR. (R2's) displays anxious behavior wheeling (R2's) wheel chair in and out of other peoples rooms." On 9/2/2015 at 10:30 AM, E11(Minimum Data Set Coordinator) stated " I do the quarterly psychotropic medication assessments for (R2). (R2's) behavior is that (R2) is restless wheeling around in (R2's) wheel chair and looking in other residents doors. (R2) is resistive to care, but not aggressive to other residents. I base the assessment on the documented behaviors in the progress notes and PRN use on back of the MAR. I am not able to accurately assess the behavior if the nurses are not charting, therefore I'm not sure the medication should continue."	F 329		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		9/23/15

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to administer the proper physician ordered dose of Ativan on 31 occasions for one of two residents (R2) reviewed for psychotropic medication use in a sample of 14.

Findings include:

R2's face sheet dated 3/17/2014, documents the following diagnosis Alzheimer Dementia with Behavioral Disturbance and Anxiety.

R2's Physicians Order Sheet (POS) dated 7/1/2015 documents Ativan 0.5 milligrams (mg) take one half a tablet (0.25mg) by mouth at bedtime as needed for restlessness.

R2's Controlled Substances Proof of Use Sheet dated 7/9/2015 documents Ativan 0.5 mg take one tablet by mouth at bedtime as needed 30 tablets received 7/9/2015. The Controlled Substance Proof of Use Sheet documents R2 was administered one 0.5mg tablet 18 times in July - 9,12,13,14,15,16,19,21,24,25 x2 (twice), 27, 28 x 2,29,30 x 2,and 31. In August R2 received Ativan 0.5mg 13 times in August 2015 - 1,3,4,5,6,8,9,17,18, 22, 24, 29 and 30.

R2's POS dated 8/1/2015 documents Ativan 0.5 mg take one tablet at bedtime as needed. There was no documented Physicians Order for the increase in Ativan in the record.

On 9/2/2015 at 2:40PM, E6 (Licensed Practical Nurse) stated " That is my signature on the Controlled Substance Proof of Use Sheet dated

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F 333	Continued From page 17 7/9/2015-8/24/2015. I administered a whole pill (0.5mg) each time I gave (R2) Ativan on those dates in July and August. I'm not sure where the increase order was written. I don't remember seeing it on the POS. I gave the whole 0.5mg tablet since that was what pharmacy sent." On 9/2/2015 at 11:15AM, Z2 (Nurse Practitioner) reviewed R2's POS stating "I did not increase the Ativan for (R2). The order was for Ativan 0.25mg as needed at bedtime. The medication should never be given more than one time a day at bedtime." On 9/2/2015 at 11:40AM, E2 (Director of Nursing) stated "Nurses are to check the POS and Medication Administration Records to ensure the proper dose, route and frequency of medication are correctly administered." The facility "Medication Administration" policy dated 9/11/2008 documents "Check labels against Medication Administration Record (MAR). Pictures are in MAR for all residents. " On 9/4/2015 at 12:45AM, E2 (Director of Nursing) stated the MAR's are checked on the last couple of days of the previous month by the nurses for accuracy the new months compared to last months. The Ativan dose discrepancy of 0.5mg should have been corrected to the correct physicians order of 0.25mg when the nurses check the MAR. No they do not sign off who checks the MAR or what date it was checked."	F 333		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		9/23/15

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(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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to properly dispose of expired food, ensure contaminants did not fall onto the food preparation area or cooking surfaces, perform glove/handwashing techniques to prevent the spread of foodborne illness, and utilize a sanitized food thermometer to check food temperatures. These failures have the potential to affect all 54 residents residing at the facility.

Findings include:

1. On 9/1/2015 at 9:40AM during initial tour the refrigerator near the dining room door had one can of whip cream dated to expire 5/21/2015. E2 (Dietary Manager) stated "That whip cream should be thrown away it is expired."

2. On 9/1/2015 at 9:45AM, the hood over the oven, stove, salad preparation, and steamer were covered with a sticky grease like substance with dust particles hanging off the vents and there was a brown/black thick built up substance on the edges of the hood. The dust particles were moving due to exhaust air flow over the cook surfaces and blowing down onto the stove and oven area.

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3. On 9/1/2015 at 9:50AM, the stove top had dried brownish colored food debris spilled in several areas of the burners. There was also a buildup of dark brown grease like substance inside of the oven, on the stove top and in the steamers.

4. On 9/1/2015 at 9:55AM, there were two wall unit fans covered with dust particles blowing over the dessert area and the sanitizing area. Another stationary fan covered with brownish/grey dust particles was sitting on a stool blowing at the salad preparation area.

On 9/1/2015 at 9:56 AM, E2 (Dietary Manager) stated " the fans are very dirty and should not be blowing on the food preparation areas or sanitizing area. The stationary fan is cleaned by my staff and the wall unit fans are cleaned by maintenance. The fans need to be cleaned at least one time a month. The under side of the hood, ovens, stove tops are to be wiped down daily and as needed to be kept free of food debris."

The facility "Kitchen Cleaning" policy dated 10/20/2014 document "the hood will be kept clean and free of grease to avoid cross contamination. Front sections of the filters will be cleaned weekly more as needed following food service."

5. On 9/2/2015 at 11:20AM, E4 (Cook) touched the underside of the steamer door with six plain cooked chicken breasts while transferring the chicken from one pan to another. The underside of the steamer door was coated with a brown grease like substance.

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6. On 9/2/2015 at 11:25AM, E4 (Cook) touched the contaminated counter top, unwrapped foil wrapped potatoes, picked the potatoes up with an ungloved hand and placed the potatoes on a plate to serve a resident.

7. On 9/2/2015 at 11:26AM, E5 (Evening Cook) placed a clean food thermometer with out a cover on the grease and food debris covered cutting board with the tip in a pool of grease. Without first sanitizing it, E5 then picked up the thermometer and placed it in a cooking chicken breast.

8. On 9/2/2015 at 11:37 AM, E5 touched a grilled cheese sandwich with an ungloved contaminated right hand.

On 9/2/2015 at 11:40AM, E4 (Cook) did not wash hands after touching the contaminated counter top & oven door handle, then served trays without washing hands. E4 laid the serving utensils (knives and tongs) on the contaminated counter in front of the steam table with serving surface touching the counter.

On 9/2/2015 at 12:20PM, E2 (Dietary Manager) stated " cooking utensils should not be placed on the counter in front of the steam table. The utensils should be left in the serving containers. The staff should be changing gloves and washing hands after touching any counter surface, pans, or ready cooked foods."

The undated facility policy "Handwashing and Glove Use" documents "wash hands after touching anything like work surfaces. Wash hands before putting gloves on and when changing to a new pair."

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F 371	Continued From page 21 The Resident Census and Condition report dated 9/1/2015 documents 54 residents reside at the facility.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(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. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to clarify a medication order with the dispensing pharmacy, which resulted in failing to properly dispense the physician ordered dose of Ativan on 31 occasions, for one of two residents (R2) reviewed for psychotropic medications in a sample of 14.	F 425		9/23/15

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Findings include:

R2's face sheet dated 3/17/2014, documents the diagnosis Alzheimer Dementia with Behavioral Disturbance and Anxiety.

R2's Physicians Order Sheet (POS) dated 7/1/2015 documents Ativan 0.5 milligrams (mg) take one half a tablet (0.25mg) by mouth at bedtime as needed for restlessness.

On 9/2/2015 at 11:15AM, Z2 (Nurse Practitioner) reviewed R2's POS stating "I did not increase the Ativan for (R2). The order was for Ativan 0.25mg as needed at bedtime.

R2's Controlled Substances Proof of Use Sheet dated 7/9/2015 documents Ativan 0.5 mg take one tablet by mouth at bedtime as needed 30 tablets received 7/9/2015. The Controlled Substance Proof of Use Sheet documents R2 was administered one 0.5 mg tablet 18 times in July - 9,12,13,14,15,16,19,21,24,25 x2 (twice), 27, 28 x 2,29,30 x 2,and 31. In August R2 received Ativan 0.5mg 13 times in August 2015 - 1,3,4,5,6,8,9,17,18, 22, 24, 29 and 30.

R2's POS dated 8/1/2015 documents Ativan 0.5 mg take one tablet at bedtime as needed. There was no documented Physicians Order for the increase in Ativan in the record.

On 9/2/2015 at 11:15 AM, Z1 (Pharmacist) stated " the pharmacy dispensed Ativan 0.5mg on 7/8/2015 for (R2). The order received on 7/8/2015 was confusing. Someone at the pharmacy should have called the physician for clarification. No one here did that. R2's Ativan was dispensed as 0.5

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F 425	Continued From page 23 mg from 7/8/2015 through 8/31/2015." The Controlled medication Prescription sheet for R2 documents the following: "Medication- Ativan 0.5mg, Number- 60 one half tablets, Dosage Form- tablet, Directions- take one tablet at bedtime as needed."	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431		9/23/15

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package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure disposal of Class II narcotics according to policy. This applies to two of 14 sampled residents (R1 and R14) reviewed for medications in the sample of 14 and seven residents (R8, R19, R20, R21, R22, R23, and R24) in the supplemental sample. The facility also failed to ensure expired medicine/medical supplies were properly disposed of.

Findings include:

1.) The pharmacy policy titled 8.2 Disposal/Destruction of Expired or Discontinued Medications states the "facility should dispose of discontinued medication, out-dated medications, or medications left in facility after a resident has been discharged in a timely fashion..."

On 9/3/2015 E8 (Licensed Practical Nurse) stated "We fold the (Fentanyl) patch in half, putting the sticky sides together then flush the patch down the toilet. There is no witness - we just do it ourselves."

The Disposal of Controlled Substances policy dated 2/19/2010 documents controlled substances are to be destroyed in a timely manner in the presence of two nurses.

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F 431	Continued From page 25 Pharmacy policy 8.2 Disposal/Destrustion of Expired or Discontinued Medications states that "wasted controlled medications should be destroyed by two licensed nurses employed by the Facility and the disposal should be documented on the accountability record on the line representing that dose." On 9/3/2015 at 11:50am E2 (Director of Nursing) states "3rd shift nurses are responsible for changing the (Fentanyl) patches. They have been instructed per policy to remove the patch, fold in half sticky side to sticky side and flush them down the toilet before leaving the resident's room." On 9/4/15 at 10:40am Z4 (Pharmacy Director) stated Fentanyl is a Class II controlled medication. The facility generated list of residents receiving "Fentanyl Patches" documents the following residents utilize Fentanyl Patches: R1, R8, R14, R19 through R24. 2.) On 9/3/15 at 9:45am the Medication Room on the 2nd Floor Urinalysis Culture and Sensitivity supplies were outdated. Four vaccutainers had expiration dates of 11/2014 and four vaccutainers had expiration dates of 6/2015. On 9/3/15 at 9:45am E7 (Licensed Practical Nurse - 2nd floor) stated the supplies were provided by a local hospital. These supplies were just brought in according to E7. 3.) On 9/3/15 at 10:00am the Medication Room on the 1st Floor had two IV (Intravenous) solutions with expiration dates of 5/2015 and one	F 431		

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F 431	Continued From page 26 bag of IV solution had an expiration date of 7/2015. 4.) On 9/3/2015 at 10:10am the Medication Room on the 1st Floor had a box of adhesive dressings. One dressing in the open box had an expiration date of 10/2014. On 9/3/15 at 10:25am E2 (Director of Nursing stated that "the medication rooms are checked by the nurses and pharmacy and myself." The pharmacy policy titled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles states the "Facility should ensure that medications and biologicals for expired or discharged residents are stored separately away from use, until destroyed or returned to the provider."	F 431		