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FRANKFORT HEALTHCARE & REHAB CENTER	**2500 EAST ST. LOUIS STREET WEST FRANKFORT, IL 62896**

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F 000	INITIAL COMMENTS Complaint #1651002/IL83590 - F157, F309, F323, F332, F431, F465 Complaint #1651309/IL83943 - F323	F 000		
F 157 SS=D	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.	F 157		4/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/04/2016

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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility to notify the Physician of change in condition, ineffective medication and follow policy and procedures. This failure affects three residents (R1, R2 and R3) of 6 residents reviewed for changes in conditions in a total sample of 14. Finding Include: 1.) On 2/24/16 at 10:00 AM, Z8 POA (Power of Attorney) stated R1 has been admitted to the facility after a hospital stay for TIA's (Transient Cerebral Ischemic Attack). Z8 stated R1 has very specific symptoms with these that consist of "teeth gnashing together, left arm pain and weakness, twitching and jumping in her arms and legs." Z8 stated R1 had these symptoms happen during a physical therapy session on 2/18/16. Z8 stated R1 had told the therapist that she (R1) was concerned because R1 knows these are her symptoms of a TIA or stroke. Z8 stated as far as she knew the therapist never relayed the incident to the nursing staff and it was not taken care of or addressed when it happened because the therapist did not communicate with the nursing staff. Z8 stated she had asked to speak with E7 RN on 2/19/16 about the incident and to make sure R1 was assessed and the doctor was made aware. Z8 stated she asked to speak to E7 at 3:00 PM but did not get to speak to E7 until 5:00 PM. Z8 stated on 2/19/16 at around 5:00 PM she and R1 discussed with E7 about R1's TIA episode. Z8 stated E7 told Z8 and R1 that if there were any health issues that they needed to tell the nursing staff because the CNA (Certified	F 157		

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Nursing Assistants) and Therapist get busy and forget to let nursing know if something happens. E7 told Z8 and R1 that TIA's are no big deal but would monitor and send R1 to the emergency room if necessary. Z8 stated the E7 did say that R1 should be monitored if there was an issue.

On 2/24/16 at 3:20 PM R1 stated she had told the therapy staff and nursing staff that she was having episodes of left arm pain and weakness, twitching and jumping. R1 also stated she was having the problem with her teeth gnashing and these are all things that have happened in the past when she has had mini-strokes. R1 stated these episodes had occurred last week and therapy and nursing did not act concerned.

R1's Occupational Therapy note dated 2/18/16 shows R1 complicating factors, including patient having some pain in shoulder and increased weakness on left side on previous day preventing the patient from achieving all established goals. No documentation can be found where this was communicated to the nursing staff or they are aware of any change in condition

R1's notes from the discharging hospitals dated 2/6/16 shows weakness, Transient episodes of left face and arm weakness, likely TIA, facial twitching, stroke-like symptoms.
No documentation found on 2/18/16 or 2/19/16 where doctor was made aware of R1's increase and/or change in symptoms, condition or POA and residents voiced concerns about health status or therapist documented complicating factors on 2/18/16.

On 3/3/16 at 3:00 PM, E3 RN/CPC (Care Plan Coordinator) stated the therapy staff should be

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making nursing aware of any of any complaints or concerns made by the resident so the nurse can assess them. E3 stated if a resident is complaining of problems or voicing concern then nursing should assess them and contact the doctor if needed.

On 3/1/16 at 2:20 PM Z2 (Primary Care Physician) stated if a resident is having changes in their condition or increase in signs or symptoms of a condition then the primary care physician should be made aware or the resident should be sent to the emergency room for further evaluation by nursing staff after an assessment. Z2 stated he could not remember staff making him aware of any R1's voiced concerns or possible increased activity with TIA's.
R1's assessment with reference date of 2/14/15 shows test for mental status at a 15 out of 15, making her able to make appropriate and adequate decisions.

2.) On 2/25/16 at 9:45 AM, R2 stated he is told all the time that he cannot get his pain medication. R2 stated the CNA's and the nurses will tell him it is not time yet. R2 stated he was recently diagnosis with Pancreatic Cancer and he knew he was dying and he did not think it was too much to ask to not be in so much pain. R2 stated when he complained the nurses didn't assesses him; they would just tell him if it was time for him to get a pain pill or not. R2 stated if it was not time for a pain pill then he would have to be in pain until his next one was due. R2 stated he had spoken to his doctor about his diagnosis and his pain management and the doctor told him he should not have to be in pain.

On 2/25/16 at 10:10 AM, E6 RN came into R2's

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room. R2 told E6 that he had told the CNA about an hour ago that he was hurting and wanted to know if he could have something for pain. E6 told R2 that it was not time for his pain medication and he would have to wait until 11:00 AM until he could get his next one and E6 exited the room. R2 stated that his pain was at an "8" and he was hurting in is abdominal area and in his lower back. When R2 moved from his right side to his back he had facial grimacing and body tensing. R2 stated, "See it hurts every time I move."

R2's MAR (Medication Administration Record) for 2/2016 shows on 2/25/16 R2 was not given pain medication of Oxycodone 10 mg (milligram) until 3:45 PM. R2's assessment with reference date of 2/16/16 shows test for mental status at a 15 out of 15 making him able to make appropriate decisions and make wants and needs known.

On 3/1/16 at 2:20 AM, Z2 (Physician) stated that staff should make him aware if a resident is having any significant changes or they can always call the ambulance and send the resident to the hospital for an evaluation. Z2 stated staff should not allow resident to remain in pain. Z2 stated that if a resident is on pain medication and it is not effective or not lasting through or until the next does then the staff should be notifying him for a change in the order or possible evaluations at the hospital. Z2 stated the resident should not be expect just to wait until the next pain pill is due. Z2 stated the R2 does have a diagnosis of pancreatic cancer and this can be a very painful diagnosis and condition and he (Z2) had even spoken to R2 about his concerns regarding pain management.

3.) On 2/24/16 at 1:30 P.M, R3's face was

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covered in blue, purple, black, gray discolored bruising to entire face. R3 also had a laceration under her chin with a Band-Aid. R3 also had a skin tear on her outer right elbow with a transparent dressing with light yellow drainage. On 2/25/16 and 3/1/16 bandages under chin were unchanged except the area under chin had large black scabbed area around band aid. Drainage under transparent dressing on 3/3/16 at 9:40 AM was yellow and bloody with drainage and wrinkled and rolled up on the edge.
On 3/3/16 at 9:40 AM, R3 stated no one had changed the Band-Aid under her chin or the bandage on her arm since it had happened on 2/20/16 and she had asked them to change the one under her chin more than once because it was itching and bothering her.

R3's assessment with reference date of 2/11/16 shows her mental status to be a 15 out of 15 which makes her able to make appropriate decisions and voice wants and needs.

Review of R3's TAR (Treatment Administration Record) and POS (Physician Order Sheet) for February 2016 done on 3/1/16 shows no treatments or physician order for treatment to any of the areas after the initial one on 2/20/16. There are also no assessments after the initial one done with fall on 2/20/16. On back of February 2016 TAR shows on 2/20/16 wounds to right outer forearm 3.5 x 1.5 cm (centimeters) covered with clear dressing; laceration under chin 2 cm x 1 cm closed and covered steri-strips and band-aid

On 3/1/16 at 2:20 AM, Z2 (Physician) stated that if nursing staff didn't have an order and they did not have a skin tear policy, then the longest a clear dressing or any dressing should stay on was

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7 days. Z2 stated that if a dressing was on longer than 7 days, without being changed, and there was no order or no treatment then nursing staff should take the initiative and call and make him aware and get orders for treatment. Z2 stated that facility staff often notify him by reciprocity however, but his expectation is that all the orders and information is still documented in the residents charts.

According to the facility policy titled "Change of Condition" dated 2/2013 shows it is the policy that resident change in condition will be assessed promptly and follow up activity will occur as appropriate and in a timely manner. Change in condition is defined as an improvement or decline in the resident's physical, mental or psychosocial status that effects less than two areas of activities of daily living. Significant change is defined as an improvement or decline in there resident's physical, mental or psychosocial status that effects two or more areas of activities of daily living.

Under Procedure shows:

1.)The staff person who first notices the change reports resident change in condition immediately to the licensed nurse.
2.)The licensed nurse assesses the resident including vital signs and notes signs and symptoms, regarding physical and mental changes in condition.
3.)The results of the assessment, including the vital signs, signs, symptoms and physician and/or mental changes in condition are documented in the resident's medical record.
4.)The resident's primary care physician or designated alternate will be notified immediately

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F 157	Continued From page 7 of any changes in resident's physical or medical condition, this includes: a.)Accident involving the resident b.)Deterioration in health, mental, or psychosocial status c.) need to alter treatment (i.e. need to discontinue an existing form of treatment due to adverse consequences or to commence new form of treatment). 5.)Notification of physician and/or responsible parties shall be documented in the clinical record as well as on the 24 hour report form. Status changes, which are not significant enough to be reported, must also be commented in the medical record.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure ongoing, accurate and comprehensive assessments for pain, wounds, Transient Cerebral Ischemic attacks and follow facility policy and procedures for three residents (R1, R2, R3) in a sample of 6 residents reviewed for resident assessment in a total sample of 14. This failure resulted in R2 experiencing un-relieved pain at an "8" and a	F 309		4/4/16

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hospital admission and R3 receiving no ordered wound care or comprehensive wound assessment for over 9 days.

Findings Include:

1.) On 2/25/16 at 9:45 AM, R2 stated he is told all the time that he cannot get his pain medication. R2 stated the CNA's and the nurses will tell him it is not time yet. R2 stated he was recently diagnosed with Pancreatic Cancer and he knew he was dying and he did not think it was too much to ask to not be in so much pain. R2 stated when he complained the nurses didn't assesses him they would just tell him if it was time for him to get a pain pill or not. R2 stated if it was not time for a pain pill then he would have to be in pain until his next one was due. R2 stated he had spoken to his doctor last night about his diagnosis and his pain management and the doctor told him he should not have to be in pain.

On 2/25/16 at 10:10 AM, E6 RN came into R2's room. R2 told E6 that he had told the CNA about an hour ago that he was hurting and wanted to know if he could have something for pain. E6 told R2 that it was not time for his pain medication and he would have to wait until 11:00 AM until he could get his next one and exited the room. R2 stated that his pain was at an "8" and he was hurting in is abdominal area and in his lower back. R2 had facial grimacing and wincing when he turned from his left side to his back. R2 stated, "See it hurts every time I move." When asked R2 if staff ever attempted any non-pharmacological interventions, R2 stated he had never heard of anything like that from staff. R2 stated this had been going on with staff for about a month. R2 stated he would be

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comfortable if his pain level was at a "4" on a scale of 1-10.

R2's MAR (Medication Administration Record) for 2/2016 shows on 2/25/16 was not given pain medication of Oxycodone 10 mg(milligram) until 3:45 PM. R2's Physician Progress Note dated 2/23/16 shows patient has pancreatic cancer and says if he is dying he does not want to be in pain, will increase his Oxycodone to 10 mg every 4 hours and see if this controls his pain better.

R2's POS (Physician Order Sheet) for 2/16 shows on 2/23/16 an order by Z2 (Physician) for OK to change Oxycodone 7.5 mg one by mouth every four hours for pain

On 2/25/16 at 4:00 PM, Z5 POA (Power of Attorney) for R2 stated he was not aware R2 was having more issues with staff not medicating R2 for his pain. Z5 stated that his had happened before and because of this R2 had ended up in the hospital so he could get his pain managed and that is when R2 was diagnosed with Pancreatic cancer. Z5 stated that the staff had told him and R2 that they (facility) could not get R2 the new medication for pain medication because the doctor would not come in and sign the prescription to be filled. Z5 stated R2 did not want to go to the hospital but by 2/13/15 R2's pain was so bad that R2 could not stand it so R2 finally agreed to go to the hospital so his pain would be taken care of because the facility kept telling R2 they couldn't do anything because the doctor wouldn't come in and sign the order for the pain medication. Z5 stated the CNA's and nurses would tell R2 all the time that it wasn't time for his pain medication and just tell R2 when he could have it and make R2 wait until it was due. Z5

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stated he did not know of any assessment the nursing staff did except to say if it was time for a pain pill for R2 or not. Z5 stated he was in the facility several times a week to visit R2 and he had never seen or heard the staff to rate his pain on a scale from 1-10 and the most he had ever heard staff ask R2 about his pain was where it was at.

On 2/25/16 at 4:30 PM, R2 stated he never wanted to go the hospital on 2/13/16 but he finally agreed to it because he was hurting so bad. R2 stated the nurses and CNA's were telling him it was not time for his pain pills and the doctor wouldn't come in and sign the new order so he couldn't get the stronger pain medication that the doctor had ordered. R2 stated he was admitted to the hospital on 2/13/16 and was sent to St. Louis and was diagnosed with the Pancreatic Cancer. R2 stated that staff at that hospital and the doctors had explained to him this was probably going to become a very painful process because pancreatic cancer was usually like that. R2 stated staff had not been giving him pain medication when requesting or even assessing the pain for about a month.

On 3/1/16 at 3:00 PM E6 RN stated she had taken off the order 2/11/16 from Z2 to stop Percocet and start Ocycodone 7.5 mg by mouth every six hours by mouth as needed for pain. E6 stated she does not remembering giving R2 the Oxycodone before R2 went to the hospital on 2/13/16 but thought she had given him the Percocet because it was the same thing except it had the Tylenol in it. E6 stated she was not aware of any policy of being able to get a three day emergency supply. E6 stated she thought the doctor had to sign a hard script because it is a

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controlled.medication E6 stated R2 had been admitted to the hospital on 2/13/16 and that was when R2 was diagnosed with pancreatic cancer.

R2's POS shows on 2/11/16 for orders to stop Percocet and give Oxycodone 7.5 mg one by mouth every six hours as needed for pain. This is a telephone order given by Z2 and signed off as taken by E6.

R2's Nursing Note dated 2/13/16 at 10:00 AM shows resident states he is ready to go to the emergency room. R2 transported and POA made aware per residents request.
R2's resident admission record shows last return date of 2/18/16.

On 3/1/16 at 2:20 PM, Z2 (Physician) stated that staff should make him aware if a resident is having any significant changes or they can always call the ambulance Z2 stated staff should not allow resident to remain in pain. Z2 stated that if a resident is on pain medication and it is not effective or not lasting through until the next does then the staff should be notifying him for a change in the order or possible evaluations at the hospital. Z2 stated the resident should not be expect just to wait until the next pain pill is due. Z2 stated the R2 does have a diagnosis of pancreatic cancer and this can be a very painful diagnosis and condition. Z2 stated he had even spoken to R2 about his concerns regarding pain management. Z2 stated that before R2 had received the cancer diagnosis he was having issues with pain and according to his records on 2/11/16 he gave telephone orders for Oxycontin 7.5 mg every six hours for pain. Z2 stated that because this is a scheduled and regulated medication that a "Hard" signed prescription is

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FRANKFORT HEALTHCARE & REHAB CENTER	**2500 EAST ST. LOUIS STREET WEST FRANKFORT, IL 62896**

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usually required. Z2 stated that he is able to speak directly to the pharmacy for an emergency three day only supply as needed. Z2 stated this helps when these medications are needed over the weekend and he is not readily available to sign the hard prescription and the nursing staff should be aware of this. Z2 stated according to his documents he gave the facility verbal orders for R2 to get Oxycodone 7.5 mg one by mouth every six hours as needed for pain on 2/11/16. Z2 stated however that this was not signed and or filled until 2/13/16 when R3 was admitted to the hospital and subsequently diagnosed with pancreatic cancer. Z2 stated he did not know why R2 would not or did not receive this medication because this was the order because R2 had been complaining of increasing pain in abdominal area.

On 3/2/16 at 6:00 PM during daily status meeting, E2 DON (Director of Nursing) stated with controlled medications like Percocet and Oxycodone they have an agreement with their pharmacy and they will and can fill it for three days only without the "Hard" physician signed prescription. E2 stated this is usually for weekends and holidays so residents are not without pain medication. E2 stated the nursing staff should be aware of this.

R2's Plan of Care with last care conference date 2/10/16 shows a problem category of pain and the goal is that R2 will be free from signs/symptoms of pain or discomfort and identified approach's are to address complaints of pain promptly with medication; assess pain characteristic, duration, location, intensity, etc; assess pain frequently each shift using rating scale acceptable to resident; assess pain

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frequency each shift using rating scale acceptable to the resident; assure the pain medication is available if needed; encourage to report pain; explore non-pharmacological methods for reducing pain promoting comfort: back rubs, slow rhythmic breathing, repositioning, diversion activities such as music, TV, etc, monitor for sign/symptoms of pain, notify MD as needed, ongoing assessment of pain status.

R2's Request for Controlled prescriptions shows medication: Oxycodone tab 5 mg, take 1 and 1/2 tab (7.5 mg) by mouth every 6 hours as needed for pain. This is signed by the physician on 2/13/16.

R2's MAR (Medication Administration Record) form 2/1/16 to 2/13/16 shows he received the following as needed pain medications: Percocet 7.5/325 mg on 2/5/16 at 10:30 PM, 2/6/16 at 3:00 PM and 4:00 PM and 2/11/16 at 6:30 AM. No documentation was found where ordered increase/change in pain medication with received verbal order on 2/11/16 was given to R2 prior to hospitalization on 2/13/16.

On 3/3/16 at 3:00 PM, E3 RN/CPC (Registered Nurse/Care Plan Coordinator) was asked if she knew what non-pharmacological interventions were effective on R2's pain; she stated, "No." When E3 was asked if she knew what R2's acceptable level of pain was or what he considered his "comfort" level, she stated, "No." E3 stated she is the one that does the residents care plans and normally keeps them up to date. E3 stated she had done R2's care plan including pain care plan.

R2's assessment with reference date of 2/16/16

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F 309	Continued From page 14 shows test for mental status at a 15 out of 15 making him able to make appropriate decisions and make wants and needs known. According to the facility policy titled "Pain Management" dated 7/2014 shows it is the policy that residents are evaluated and treated for pain. Under procedure shows: 1. With any significant change staff will assess resident for pain and record the assessment on the Pain Assessment Form. 2. Pain is assessed and recorded on the Pain Assessment Form whenever the resident expresses or appears to be in pain. 3. After completion of the assessment, the resident will receive interventions to reduce or alleviate the pain. These interventions may be non-pharmacological or pharmacological. 2.) On 2/24/16 at 1:30 AM, R3 stated she had been attempting to go to the bathroom and had fallen and that was why she was all bruised and cut up. R3's face was covered in blue, purple, black, gray, red discolored bruising to entire face. R3 also had a laceration under her chin with steri-strip covered with a Band-Aid. R3 also had a skin tear on her outer right elbow with a transparent dressing with light yellow drainage. R3 also had a scratch on the right side of her nose that was uncovered, steri-strips on the left hand with a skin tear. On 2/25/16 and 3/1/16 bandages under chin were unchanged, except the area under chin had large black scabbed area around steri-strip. Band aid and drainage under transparent dressing was now bloody and a darker yellow and edge of transparent dressing	F 309		

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was rolling up, area to nose remained unchanged. Area to left hand has no dressings, band-aid or steri-strips.

On 3/3/16 at 9:40 AM, R3 stated no one had changed the Band-Aid under her chin or the bandage on her arm since it had happened on 2/20/16 and she had asked them to change the one under her chin more than once because it was itching and bothering her. R3 stated no one had changed any of the other dressings; they had just fallen off or she had taken them off herself. R3 stated the area on her right arm was becoming more painful as well.

R3's TAR (Treatment Administration Record) for 2/2016 on the back shows on no breakdown noted, resident fall earlier this shift: 1.) left skin tear right outer forearm 3.5 x 1.5 cm (centimeters) covered with clear transparent dressing after cleansed with w/c (washcloth). 2.) 1 cm scratch to outer left nares. 3.)Skin tear to top of right hand 1.5 cm x 1 cm - cleansed with w/c covered/closed with band aid. 4.) Skin Tear left index finger cleansed and closed with steri-strips 1.5 cm length. 5.) Laceration under chin 2 cm x 1 cm - cleansed, closed and covered with steri strips and Band-Aid for pressure. 6.) laceration to throat (superficial) - closed after cleansing and covered with clear transparent dressing. No further documentation or assessment found

On 3/1/16 at 11:45 PM, E6 RN stated she had not been doing any treatment on R3 and she did not see any treatment orders written on R3's POS (Physician Order Sheet) for the areas to her chin and right arm.

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On 3/1/16 at 3:00 PM, E7 RN stated she had not been doing any treatment on R3 and she did not see any treatment order written on R3's POS for the areas to R3's chin or right arm.

On 3/3/16 at 3:40 PM, E8 RN stated she was the one that did R3's weekly skin assessment that was to be done on 1/27/16. E8 stated she did not remove the dressing to R3's right arm and she did not remove the Band-Aid under her chin. E8 stated she did not do any measurements of the area to assess for any healing or lack of healing. E8 stated she just saw it was there and was just looking to see if she had any skin breakdown for pressure areas. E8 stated she had not being doing treatments to R3's chin or right arm before the concern was brought to her by the Director of Nursing on 3/2/16. E8 stated she did not know if R3 had any orders for her skin or not.

On 2/24/16, 2/25/16 and 3/1/16 R3 had no noted specified plan of care or treatment for laceration and skin tears that resulted from fall on 2/20/16.

On 3/1/16 R3's TAR (Treatment Administration Record) had no documentation or treatments to lacerations or skin tears that resulted from fall on 2/20/16 and scheduled skin assessment on 2/27/16 was not signed as having been completed.

On 3/1/16 at 2:20 AM, Z2 (Physician) stated he was made aware of R3's open areas because he was made aware of the fall that caused them. Z2 stated he expected staff to be monitoring them and assessing it. Z2 stated he could not remember if he gave any orders for treatments for R3. Z2 stated the facility should have a skin tear protocol they could follow. Z2 stated that if

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the areas were not improving or were changing or needed new orders then the staff needed to make him aware so he could give new orders if they were needed.

R3's Care Plan has identified problem of risk for skin breakdown on 1/22/16 and the goal is that R3 will be free from signs and symptoms from skin breakdown with good skin integrity and under approaches shows body audit at least weekly and treatments as order. Identified skin breakdown on 1/20/16 was not noted on R3's current plan of care.

On 3/3/16 at 3:00 PM, E3 RN/CPC stated residents assessments should be accurate and complete and residents care plans should reflect these comprehensive, complete and accurate assessment. E3 stated this should usually happen within 24 hours of the problem being identified. E3 stated she did not know if R3 was getting treatment for her wound and open areas since it happened or not.

According to the facility document titled "Wound Care Program" with date of 7/2014 shows "In developing a comprehensive treatment plan for wounds, the clinician should assess not just the wound, but the whole person. The factors affecting the ability of the wound to close and ultimately heal need to be included in the overall treatment plan. With the physician choose the appropriate option and order, specifying type, size and amount of all dressings and supplies utilized. Skin tears: Option #1 Skin Flap Present: Inspect daily, apply dressing and monitor as needed. Option #2 No skin flap/skin flap present: apply dressing and ensure area remains moisturized, monitor as needed, change every 3-5 days and

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F 309	Continued From page 18 as needed if soiled, until closed healed." R3's assessment with reference date of 2/11/16 shows her mental status to be a 15 out of 15 which makes her able to make appropriate decisions and voice wants and needs.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure for a safe environment to prevent resident injury for 4 residents (R1, R3, R4, R14) of 6 residents reviewed for environmental safety and accidents and injuries in the total sample of 14. These failures resulted in R4 with a fractured right metatarsal, R4 with facial bruising covering her entire face, laceration on her face and skin tears on her body which resulted in increased pain, and resident voicing issues with self esteem and not wanting to be seen by other resident because of the condition of her physical appearance and R14 with an actual injury to neck and subsequent visit to emergency room after voicing suicidal ideation and actual suicidal actions. Finding Include:	F 323		4/4/16

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1.) On 2/24/16 at 2:40 PM, R4's right hand on the fourth and fifth digit and on the outer aspect of the right hand was noted to be bluish gray with discoloration. R4's fifth digit (pinky) was at an abnormal angle. When questioned, R4 stated that she had walked out of her bathroom this morning and caught her foot on the soda can cases sitting in the floor by the bathroom doorway. R4 stated she had stumbled forward and had attempted to catch herself but had fallen on her knees in front of her recliner and attempted to catch herself with her right hand and it had bend backwards. When she had done that (tried to catch herself), R4 stated it was just a little sore. R4 stated she had not told any staff at this time. R4 stated that she never had enough room for her stuff and she and her roommate were always trying to find more space or trying to figure out where to put things. R4 had her TV/cable box, two cases of soda, books, magazines on the floor by her dresser in the walkway between her bathroom and her recliner. R4 stated she and her roommate had gotten the soda over the weekend and had been there since because it was the only place she could find to put it.

R4's Care Plan with admit date of 6/11/12 and identified problem start date for falls of 1/18/16 shows identified intervention of: observe resident environment and personal routine; ensure resident's safety and goal is R4 will remain free from falls for 90 days with target goal of 4/21/16.

R4's Accident/Incident Report dated 2/24/16 at 2:40 PM shows was made aware resident had tripped over soda box onto floor. R4 stated that she hurt pinky finger but is fine. R4's roommate witnessed fall. Neither reported to staff. Slight

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ecchymosis noted to right pinky finger. Range of motion within normal limits. Residents denies pain at this time. Completed by E2 DON (Director of Nursing).

R4's Post Fall Investigation dated 2/24/16 done by E2 shows swelling/redness/bruising to right fifth digit hand, assessment of environment is cluttered area.

R4's document to IDPH (Illinois Department of Public Health) with message of Initial and follow up to follow dated 2/25/16 shows: Date of incident is 2/24/16 and per resident she ambulated without walker from bathroom to chair. R4 stated, "I tripped on soda box went to my knees and right hand landed on chair." Resident stated she was fine. No complaints of pain. On 2/25/16 R4 complained of pain in right hand and doctor was notified and x-ray ordered. Results are acute fracture of fifth digit

2.) On 2/24/16 at 1:30 AM, R3 stated she had been attempting to go to the bathroom and had fallen and that was why she was all bruised and cut up. R3's face was covered in blue, purple, black, gray, red discolored bruising to entire face. R3 also had a laceration under her chin with steri-strip covered with a Band-Aid. R3 also had a skin tear on her outer right elbow with a transparent dressing with light yellow drainage. R3 also had a scratch on the right side of her nose that was uncovered, steri-strips on the let hand with a skin tear.

R3's TAR (Treatment Administration Record) for 2/2016 on the back shows no breakdown noted, resident fall earlier this shift: 1.) left skin tear right outer forearm 3.5 x 1.5 cm(centimeters) covered

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with clear transparent dressing after cleansed with w/c (washcloth). 2.) 1 cm scratch to outer left nares. 3.) Skin tear to top of right hand 1.5 cm x 1 cm - cleansed with w/c covered/closed with band aid. 4.) Skin Tear left index finger cleansed and closed with steri-strips 1.5 cm length. 5.) Laceration under chin 2 cm x 1 cm - cleansed, closed and covered with steri strips and Band-Aid for pressure. 6.) laceration to throat (superficial) - closed after cleansing and covered with clear transparent dressing.

R3's Accident/Incident Report dated 2/20/16 at 4:10 PM done by E10 LPN (Licensed Practical Nurse) shows resident report coming to bathroom in wheelchair unassisted, got up from wheelchair grabbed commode riser and it moved, resident reports falling forward and face/chin hit commode riser, then hit floor.

On 3/3/16 at 1:45 PM at 1:45 PM, E10 stated she had been the nurse that had taken care of R3 when she had fallen and taken care of her immediately afterward. E10 stated the commode riser was not bolted to anything and it was moved out and away from the commode so E10 could get to R3 to assess her. E10 stated from what she understood the old commode risers had been replaced with new bolted ones because of the incident with R3 and it being a safety issue. E10 stated after R3's injury she had looked "horrible" and had bruising over entire face plus some cuts on her face, neck and body. E10 stated R3 had an increase in pain medications recently.

On 2/24/16 and 2/25/16 R3 stated she did not want to come out of her room because her face looked so bad with all the bruising and she didn't want anyone to see her like that. R3 also stated

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that she had been taking pain medication ever since the fall on 2/20/16 because the pain was so bad in her face and all over from the fall.

On 2/25/16 at 2:45 PM, Z7 (Physical Therapy Assistant) stated R3 prior to fall on 2/20/16 had been coming out on occasion during therapy. Z7 stated that since R2's fall on 2/20/16 she had not been able to get her to come out of her room. Z7 stated R3 made statements that she looked awful. Z7 stated R3 had also been complaining of increase in her pain since her fall on 2/20/16.

On 2/25/16 at 5:30 PM during daily status meeting with E1 administrator, stated the previous commode risers (that R3 had been using during her fall on 2/20/16) had been removed from the building and she was working with maintenance and had ordered new commode risers for the whole building that were bolted to the toilet so they would not move and would be stationary.

R3's Care Plan with admit date of 1/14/16 shows R3 is at high risk for falls and the goal is R3 will remain free from falls. R3 had a hand written update on 2/20/16 that stated one on one with resident to use call light and wait for assistance with transfers and tilting however, this is already addresses as an intervention on 1/22/16. No new interventions were in place after most recent fall.

On 3/2/16 R3's Care Plan behind nurses station in binder had no update after fall on 2/20/16.

On 3/3/16 at 3:00 PM, E3 RN/CPC stated residents assessments should be accurate and complete and residents care plans should reflect these comprehensive, complete and accurate

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assessment. E3 stated this should usually happen within 24 hours of the problem being identified. E3 stated she was not the one that updated R2's plan of care on 2/20/16 that the Director of Nursing had done that. E3 stated there are two place Care plans are kept and that is in the residents chart and in a binder behind the nursing station.

R3's assessment with reference date of 2/11/16 shows her mental status to be a 15 out of 15 which makes her able to make appropriate decisions and voice wants and needs.

3.) On 3/10/16 at 11:30 AM, R14 stated he had to go to the emergency room last night because he was so upset and tried to cut his neck with a pocket knife. R14 stated he didn't want to be here anymore and did not feel that anyone cared for him and at the time he just felt like he wanted it all to end. R14 stated he had the knife since he was admitted to the facility last May. R14 stated it was not the first time he had told staff he had wanted to die.

R14's Nursing note date 3/9/16 at 7:20 PM shows "CNA reported R14 refusing to go to bed; writer suggested resident be transferred to recliner if agreed. CNA walked down hall to R14's room and yelled, 'he is cutting his neck with a knife;' writer noted resident with pocket knife in right hand and laceration to left side of neck with minimal bleeding. CNA reports R14 trying to cut with knife. Writer told CNA to call 911. R14 refused to drop knife. R14 states, 'I want to kill myself, I want to die.' Police arrived and forced knife out of resident's right hand. EMS (Emergency Medical Services) arrived and transported resident to hospital."

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R14's document titled "Patient Care Summary" dated 3/9/16 shows "asked patient why he would want to take a knife to his neck. Patient states, 'It was the heat of the moment. I just got caught up; it was silly to do. I was just so irritated.' Also shows, 'I told them I might do something to myself and today I cut myself with a pocket knife.'"

On 3/30/16 at 10:10 AM Z13 (Medical Staff) stated R14 had come into the ED (Emergency Department) last night because he had tried to cut himself with a knife. Z13 stated he was not happy at the care center and he had told them (facility) he was not happy and he was going to try to do something to himself/hurt himself . Z13 stated R14 was evaluated by the ED doctor and the doctor stated R14 was very alert and oriented and this was not something that warranted a psychiatric evaluation. Z13 stated R14 was discharged back to the facility after he was evaluated. Z13 stated the areas R14 had cut on his chest were superficial and had been cleansed and no dressing was required.

On 3/10/16 at 5:00 PM, E7 RN stated she had been the nurse on duty when R14 had went to the ED 3/9/16. E7 stated she did not know where R14 had gotten the knife but as far as she knew no residents in the facility should have a knife. E7 stated R14 had cut his shirt as well as his neck but it was superficia,l but she had other staff call 911 because R14 would not put the knife down and would not let any of the staff have the knife and she was concerned for not only R14's safety but the rest of the residents and staff safety. E7 stated the police had to take the knife from R14 because he would not give it to her or

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any staff. E7 stated all staff know not to approach R14 by himself because he makes accusations against staff that are not true and it is part of his plan of care. E7 stated R14 had an episode back in February where R14 had been given Ativan but she was not sure what it was for.

On 3/10/16 at 4:45 PM E16 Social Service stated R14 had a previous episode of voicing plans/ideation's of suicide and R14 had made them to her. E16 stated at the time E3 RN was at the facility and she made E3 aware of what R14 was saying about wanting to die/be dead. E16 stated she and R3 where the main staff to take care of the situation. E16 stated the first incident of R14 having suicidal thoughts had occurred at the beginning of February of this year. E16 stated at that time R14 was put on 15 minute checks, was moved into a different room and all possible items he could hurt himself with was removed such as shoe strings, belt, cords, curtains, etc. E16 stated she thought staff had checked R14's room for any possible issues or problems related to him being able to hurt himself. E16 stated she does not know where or how long R14 had his knife. E16 stated she didn't think any resident was suppose to have a knife in the building for safety reasons.

On 3/11/16 at 11:00 AM, E3 RN/CPC (Registered Nurse/Care Plan Coordinator) stated she was the nurse that had been here when R14 had his first episode of voicing that he might want to hurt himself. E3 stated she had made the doctor aware and she with the staff had checked R14's room for any safety issue/items. E3 stated R14 was placed in a different room when this happened and all items that could pose a risk had been removed, such as shoe laces, strings, belts,

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cords and R14 was placed on a every 15 minute check. E3 stated the doctor gave orders to give R14 Ativan 0.5 mg IM (Intramuscularly) now for acute agitation. E3 stated she does all the care plans for resident. E3 stated R14 had a recent quarterly Care Plan done (3/7/16). E3 stated R14's issues with possible self harm was not put on his plan of care. E3 stated all staff should know they are not to go into R14's room by himself because he makes allegations that are not completely true and accurate.

On 3/10/16 at 7:30 PM E24 CNA (Certified Nursing Assistant) stated she had been the one who had originally found R14 with the knife in his hand cutting at his neck. E24 stated she had attempted to put him to bed earlier and R14 had refused so she had left the room. E24 indicated that she had been in the room by herself when R14 refused to go to bed. E24 stated R14 previously had voiced an episode where he intended to harm himself, in early February 2016 and R14 had been put on 15 minute checks and put in another room. E24 stated that only lasted a few days and he was returned back to his original room. E24 stated she did not know who if anyone had checked R14's room for any items he could possibly hurt himself with. E24 stated she thought R14's room had been checked and did not know how R14 had gotten the knife he had hurt himself with on the evening of 3/9/16.

On 3/11/16 at 2:20 PM Z2 (Primary Care Physician) stated R14 had issues with depression and had previous episode where he had voiced/made threats he was going to hurt himself. Z2 stated at that time he had ordered a one time dose of Ativan. Z2 stated R14 and no residents should have access to a knife to be able to hurt

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themselves while in the facility. Z2 stated R14 never seems happy and is very hard to please and often gets irritated and will get worked up fast. Z2 stated it is important that staff continue to follow that plan of care and make sure they always go into take care of R14 according to his plan of care and be consistent. On 3/ 1/16 at 2:20 PM, Z2 stated that even though he communicates a lot with staff through reciprocity, his expectation is that everything that happens and is going on with the resident as well as orders are documented in residents charts.

R14's nursing note dated 2/11/16 at 1:35 PM shows social service reported to writer resident is agitated; Z2 called and stated give IM Ativan 0.5 mg x 1 now for acute agitation. Call if doesn't get better.

R14's POS (Physician Order Sheet) shows 2/11/16 to give Ativan 0.5 mg IM x 1.

Review of R14's Care Plan with admit date of 5/26/15 shows no identified problems related to suicidal ideation/threats, goals or interventions. R14's Care Plan does state to use 2 people with all ADL's (activities of daily living) due to contradictory statements made per resident.

R14's most recent brief mental assessment done one 3/4/16 show it is a 15 out of 15 and is able to make needs and wants known.

4.) R1's Nursing notes dated 2/25/16 at 2:20 PM shows resident was witnessed to lose balance and sat down in the floor onto her buttock in the hallway outside of her room with no apparent injuries.

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R1's care plan with admit date of 2/7/16 show identified problem of falls related to advanced age and weakness's and the goal is she will remain free from falls for 90 days.

On 3/1/16 R1's Care Plan was reviewed and R1's fall on 2/25/16 is not identified on the plan of care for re-assessment and no new interventions were put in place to prevent further falls

R1's Fall Risk Assessment has only one completed on 2/8/16 and R1 is scored at a moderate risk for falls on this, there is no re-assessment after fall on 2/25/16.

On 3/3/16 at 3:00 PM, E3 RN/CPC (Registered Nurse/Care Plan Coordinator) stated if a resident falls then a new fall risk assessment should be done and the care plan reviewed and update. E3 stated the day of the fall would be on there as well as a new intervention. E3 stated all of a residents individualized care is based of the residents own care plan.

On 2/24/16 at 10:00 AM, Z8 POA (Power of Attorney) stated R1 has been admitted to the facility after a hospital stay for TIA's (Transient Cerebral Ischemic Attack). Z8 stated R1 had fallen before due to these TIA's.

On 2/24/16 at 3:20 PM R1 stated she had fallen before because the TIA's had happened. R1 stated she had come to the facility after being in the hospital for a TIA and to help build up her strength because she was having some weakness.

R1's notes from the discharging hospital dated 2/6/16 shows R1 with weakness, Transient

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episode of left face and arm weakness, likely TIA, facial twitching, stroke-like symptoms.

On 2/25/16 at 2:45 PM, Z7 (Therapist) stated she had been treating R1 since her admission and R1 had problems with gait, balance and generalized weakness.

R1's Fall Risk Assessment for 2/8/16 in not scored accurately an/or staff is unable to provide corresponding information. Under Section B.) history of falls- has no falls in past 3 months. Z8 and R1 both stated R1 has fallen in last 3 months due to TIA's. Under section E.) Gait/Balance/Ambulation-balance problem while stand/walking are not scored; decreased muscular coordination/jerking movement is not scored. On 2/25/16 therapist states R1 had both of these indicated upon admission and throughout stay at facility. Under Section F.) Systolic Blood Pressure lying and standing drops is marked as no problem but when asked RN's E3, E6 and E8 none were able to provide information where this was completed. E3 signed off as having completed the form. On 3/3/16 at 3:00 PM, E3 stated floor nursing usually does the vital signs with admission.

R1's Fall Risk Assessment dated 2/8/16 shows a score of 9, moderate risk for falls. This assessment indicates a total score above 10 represents high risk for falls. If staff had complete and accurate assessment and marked falls noted per family, and balance and muscular movement noted per therapist, this would have made R1's Risk Assessment Fall Score at least a 13, which puts her at a high risk category and identifies R1's actual identified risk factors for falls. R1's Fall Risk Assessment for 2/8/16 is not

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F 323	Continued From page 30 accurate or comprehensive and does not identify R1's actual identified risk factors. Review of R1's original Care Plan for fall Risk dated 2/16/16 does not have identifying information that R1's TIA's are possible in contributing to her risk of falls. R1's care plan does not identify R1's TIA as a risk or problems identified at all for R1. On 3/3/16 at 3:00 PM, E3 RN/CPC indicated all resident care plans are based off resident assessments and if a care plan is to be comprehensive, complete, accurate and then the residents assessments must be comprehensive, complete and accurate. E3 stated she did not realize R1 was discharged from the hospital due to TIA's and stated the signs and symptoms R1's complains of having with her TIA's were not incorporated in her plan of care. R1's assessment with reference date of 2/14/15 shows test for mental status at a 15 out of 15, making her able to make appropriate and adequate decisions.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer medication	F 332		4/4/16

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according to physicians orders. There were 32 opportunities and 10 medication errors which resulted in a 31.25% medication administration error rate. The errors involved 5 residents (R3, R7, R8, R9, R10) in a sample of 10 residents reviewed during the medication administration observation.

Findings Include:

1.) On 3/2/16 at 3:15 PM, E8 RN(Registered Nurse) went into R3's room to administer her inhaler Symbicort 160/4.5. Rinse mouth after use and spit out. E8 handed R3 the inhaler and R3 attempted to push down the plunger and was unable. R3 stated, "I can't do it; I'm just so tired." E8 then took the inhaler from R3, shook it placed it in R3's mouth and depressed it. After E8 had depressed it she stated, "you need to hold you breath," however, R3 had already exhaled the medication. E8 did the same technique with the second inhalation as well. After E8 gave R3 her Symbicort inhaler she did not provide any means for R3 to rinse out mouth with water and then spit it out.

R3's POS (Physician Order Sheet) for March 1-31/2016 shows order for Symbicort AER 80-4.5: Inhale 2 puffs by mouth twice daily - Rinse mouth after use and spit.

On 3/3/16 at 1:00 AM, Z12 (Pharmacist) stated R3 could not have gotten the full dose of Symbicort if she was unable to properly inhale and hold in the medication. Z12 stated it is also very important that staff provide for the resident to rinse their mouth out with water and then spit it out after because Symbicort is a corticoidsteroid and if it is not rinsed out of the mouth after use

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then the resident is at risk for thrush. Z12 stated R3 was not administered her Symbicort correctly and did not receive the ordered amount of medication.

2.) On 3/2/16 at 5:40 PM, E8 administered R7's medication in the main dining area. E8 gave R7 Donepezil 10 mg (milligram) and Namenda XR Capsule 28 mg. E8 took these and 6 other medications and crushed them all together and put them in applesauce and administered them to R7 by mouth.

R7's POS for March 1-31/16 shows orders for Donepezil tab 10 mg- take one tablet by mouth every night at bedtime- 8 PM.

The POS also shows Namenda XR (extended release) Cap 28 mg - Take one capsule by mouth every night at bedtime - 8 PM.

On 3/3/16 at 1:10 PM, Z12 stated R7's Donepezil and Namenda XR was given too early to be accurate and because the Namenda is a capsule and an extended release medication it should not be crushed.

3.) On 3/2/16 at 3:20 PM, E8 went into R8's room and administered Gabapentin 100 mg and Aceteminophen 325 mg one tablet from a stock bottle out of the medication cart.
R8's POS for March 1-31/16 shows orders for Gabapentin Cap 100 mg - take one capsule by mouth three times a day - 6 AM/ 12 PM/ 6 PM.
R8's Gabapentin was given at the wrong time.

R8's POS also shows orders for MAPAP tab 500 mg - substitute for: Tylenol - Take two tablets (1000 mg) by mouth twice daily (floor stock) - 5

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AM/ 4 PM. R8 was given the wrong dose of Aceteminophen/MAPAP/Tylenol.

4.) On 3/2/16 at 3:30 PM, E8 went into R9's room to administer his afternoon medications. E8 gave R9 from a stock bottle from the cart Calcium D 3 600 mg/400 IU. E8 also gave R9 Sinemet 25-100 mg.

R9's POS for March 1-31/16 shows orders for Oyster Shell Calcium 250 mg + Vitamin D one by mouth twice daily. On 3/3/16 at 1:20 PM, Z12 stated these two medications are not the same and R9 did not receive the correct medication for his ordered Oyster Shell Calcium 250 mg + Vitamin D.

R9's POS also shows orders for Carbidopa/levodopa (Sinemet) 25-100 one tab by mouth three time a day (4 AM-6 AM/ 12 PM-3 PM/ 8 PM-11 PM). On 3/2/16 at 3:30 PM, this medication had been signed as given for the 4 AM-6 AM dose as well as the 12 PM - 3 PM dose. E8 signed this medication out as given for the 8 PM - 11 PM dose. On 3/3/16 at 1:20 PM, Z12 stated she did not know why the nurse gave R9 his Sinemet 25-100 mg so close to the dose of the 12 PM-3 PM dose. Z12 stated she would consider this a duplicate of the 12-3 PM dose and an omission of the 8-11 PM dose

R9's POS also had orders for Docusate Sodium 100 mg one by mouth twice daily (4 AM-6 AM/ 4 PM-7 PM) E8 did not administer this medication but signed off that it had been given when she administered the medications at 3:30 PM. On 3/3/16 at 3:40 PM E8 stated she doesn't remember giving R9 the colace at all and thinks she might have mixed the Sinemet up with the

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F 332	Continued From page 34 colace. R9's POS also shows orders for Ocuvite Lutein and Zeaxanthin take one capsule by mouth twice daily (4 AM-6 AM/ 4 PM-7 PM). On 3/2/16 E8 made no attempt to administer this medication but did state, "Well I don't see this. I'll have to find out where it might be at." On 3/3/16 at 3:40 PM E8 stated R9 did not receive this medication yesterday because she could not find it. E8 stated she did not know she was suppose to call the pharmacy if she did not have it. E8 stated she did not call the doctor to make him aware it was not available to give either for further directions. On 3/3/16 at 1:20 PM, Z12 stated R9 should have received the Ocuvite Lutein and Zeaxanthin and if the facility didn't have any available they should have notified the pharmacy immediately and they could have provided it within 24 hours or notify the physician that he is not getting it for a possible discontinuation of the medication or a change of the medication. 5.) On 3/2/16 at 3:40 PM, E8 went into R10's room to administer her medication. E8 gave R10 Metformin 850 mg. R10 still had not received her supper tray at 4:55 PM R10's POS for March 1-31/16 shows order for Metformin 850 mg one by mouth two times a day with meals at 6 AM/ 5 PM. On 3/3/16 at 1:30 PM Z12 stated R10's Metformin was not given according to physician order. Z12 stated if an order reads that a medication is to be given with a meal then it is supposed to be done that way. Z12 stated that there is also a one hour grace period before and after a medication is due	F 332		

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F 332	Continued From page 35 that it can be given. Z12 indicated R10 could have received the Metformin as early as 4:00 PM and as late as 6:00 PM if the order had just been written to administer at 5:00 PM but because it was written to administer with meals then that is the physicians order. Z12 states so R10's Metformin was early because it was given at 3:40 PM and it was given incorrectly because it was not given with meals according to the physician order. According to the facility policy titled "Administering Medication" with revision date of 4/2010 shows medication shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame	F 332		
F 431 SS=D	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	F 431		4/4/16

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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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to follow policy and procedures to reconcile and monitor scheduled medications to help prevent diversion of controlled substances for 3 (R2, R6, R13) of 10 residents reviewed for controlled substances and medication administration in the total sample of 14.

Findings Include:

On 2/25/16 at 11:20 AM, R6 had 7 unopened bottles of Ativan 2 mg (milligram)(injectable) and one opened bottled of Ativan 2 mg (injectable). R6's Controlled Substance Administration Log shows she should have 10 and 1/2 bottles of Ativan 2 mg (injectable).

On 2/25/16 at 11:25 AM E2 DON (Director of Nursing) stated that staff should not be putting used bottles back in bag and 1/2 bottles should

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be wasted. E2 stated she was not sure why the number of bottles didn't match the number on the Controlled Substance Administration Log but it should.

On 3/2/16 at 1:50 PM, E6 RN (Registered Nurse) and E8 RN were counting the controlled substance between shift and the following discrepancies were noted:
- R13's actual amount of Tramadol 50 mg did not match what was on his Controlled Substance Administration Log. E6 stated, "It does not match; I'll let E2 know so she can figure out what's wrong."
- R2's actual amount of Morphine Sulphate Immediate Release 15 mg did not match what was on his Controlled Substance Administration Log. E6 stated, "It doesn't match; I'll let E2 know, so she can figure it out." E6 RN stated, "Someone may have forgotten to mark something."

On 3/1/16 at 4:15 PM E2 stated she had no current investigations regarding any issues with Controlled Substance irregularities.

On 3/1/16 at 1:40 PM, Z3 (Pharmacist) stated the Controlled Substance Logs need to be done according to the facility policy because this helps prevent from diversion of controlled substances. Z3 stated it is not a good practice to use 1/2 a bottle of Ativan but instead the portion order should be used and the rest should be wasted/disposed of according to the facilitate policy.

According to the facility policy titled "Controlled Substances" with no date shows the facility shall comply with all laws, regulations, and other

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F 431	Continued From page 38 requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Under Policy and Interpretation: 1.) Controlled Substances must be counted upon delivery 2.) Unless otherwise instructed by the DON (Director of Nursing) Services, when a resident refuses a non-unit dose medication or it is not given, or receives partial tablets or single dose ampules, or it is not given, the medication shall be destroyed, and may not be returned to the container. 3.) Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going of duty must make the count together. 4.) The DON shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties	F 431		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain the building and its furnishings in clean, orderly, odor free and in good repair. These failures have the potential to affect all 41 residents in the facility. Finding Include:	F 465		4/4/16

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According to the Facility's Census and Roster dated 2/24/16 there are currently 41 residents in the facility.

On 2/24/16 at 1:25 PM, the first common bathroom on the west wing had a sticky substance on the floor, the toilet was not flushed having a strong urine odor, a wet washcloth was on the back of the toilet with a brown and yellow substance, a soiled adult disposable brief on top of the trash can and the lid not closed ,and the riser and assistive device over the toilet was not secure and easily moved.

On 2/24/16 at 1:30 PM, the second common bathroom on the west wing had a strong urine odor and the riser and assistance device over the toilet was not secure and easily moved.

On 2/24/16 at 1:30 PM E11 CNA (Certified Nursing Assistant) walked into the second common bathroom on the west wing and stated all the common bathroom toilets used the same system over the toilet for the riser and assistant device. E11 stated they were moveable and as far as he knew were just what they used.

On 2/24/16 at 1:45 PM, R2's room had a strong urine smell and his urinal was on his bedside table half full of dark amber urine. E11 CNA and E13 CNA went past R2's open doorway and did not empty R2's urinal.

On 2/24/16 at 2:00 PM in room #19 there was a strong odor of urine and there was a urinal on top of the bedside table half full of urine

On 2/24/16 at 2:05 PM, the first common

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bathroom on east wing had a strong urine odor and there was a wet washcloth in the shower area and the toilet riser and assistance device was not secure and easily moved.

On 2/24/16 at 2:10 PM, the second common bathroom on the east wing had a strong odor, there was a dried brown spot larger than the size of a half dollar on the front edge of the on the toilet seat.

On 2/24/16 from 1:30 PM to 3:30 PM, the dressers in rooms 4, 5, 8, 9, 12,14, 18 were missing knobs.

On 2/24/16 at 2:40 PM, R4 stated that she never had enough room for her stuff and she and her roommate were always trying to find more space or trying to figure out where to put things. R4 had two clear full bags in front of her dresser. R4 stated they were her dirty clothes. R4 stated that no one had gotten them yet and she had put them there before lunch. R4 had her TV/cable box, two cases of soda, books, magazines. R4 stated she and her roommate had gotten the soda over the weekend and had been there since because it was the only place she could find to put it. R4 had 4 hangers with clothing hanging on the knob of her top dresser drawer. R4 had a dark gray adult brief laying in her window sill. R4 stated she didn't know why it was there and had been there as long as she could remember. R4 stated she figured they (facility) kept it there to keep the draft out from the window.

On 2/24/16 at 10:00 AM, Z8 POA (Power of Attorney) complained that knobs are off of residents dressers and have been since residents admission over a week and a half ago. Z8 stated

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that due to the resident missing knobs on her dresser the resident is not able to use it and the resident is also not able to have more of her personal belongings there. Z8 stated the facility is not clean and smells. Z8 stated the resident was admitted on the evening shift. Z8 stated there was a "hair ball" at the head of the bed by the nightstand. Z8 stated the facility always smelled when she was there. Z8 stated she tried to visit once or twice a week.

On 2/25/16 at 4:00 PM, Z5 (Family member) stated he comes in the facility three to four times a week and it always smells of urine in his family member's room. Z5 stated there have been too many times to count the incident that the residents urinal is full and not emptied and multiple staff coming in and out and not emptying it. Z5 stated he knows and has seen, E11, E13, E18 and E20 (all CNA's) doing this. Z5 stated E6 and E7 RN (Registered Nurses) have also left the residents urinal full of urine un-emptied and left the room. Z5 stated he has said stuff to staff before and then they will empty it but, does not feel should have to ask.

On 2/24/16 at 3:30 PM, R1 stated she couldn't use her dresser drawers because it was missing knobs.

On 2/24/16 at 3:10 PM, R6 stated he could get into his dresser drawers a lot easier if there were knobs.

On 2/25/16 at 10:10 AM, R2 had urinal on bedside table and was 1/4 full of dark amber urine. R2's room had strong urine smell. E6 RN entered R2's room and talked with resident and exited room. When E6 exited room urinal had not

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been emptied.

On 3/1/16 at 10:30 AM, R2's bedroom floor, by the bathroom there was a large area of semi-dried, yellow, sticky substance. E13 CNA was made aware and stated she would make housekeeping aware so they could clean it up.

On 3/1/16 at 10:30 AM in the bathroom between rooms 18 and rooms 19 there was a riser assistive device over the toilet that was not secure and easily moved.

On 3/1/16 at 4:30 PM during daily status, E1 (administrator) stated if there is something that needs to be cleaned up on the floor, any staff member can and should do it. E1 stated it should not wait for housekeeping staff and needs to be cleaned up as soon as possible. E1 stated it is all staff responsibility to make sure the facility is kept clean and any staff can make out a work order so maintenance can repair it. E1 stated all the previous riser assistive devices that had been in common bathrooms over toilet had all been removed from the facility after issues and concerns of resident safety were identified and were not to be in the building.

On 3/1/16 at 12:55 PM, E5 Maintenance Supervisor stated it was his job to make sure equipment was kept repaired or fixed. E5 stated he did this when he became aware of it and as he was able. E5 stated staff are to do work orders then he is able to know what needs fixed. E5 stated he was not aware all the dressers were missing knobs and was fixing them as he was made aware of them. E5 stated that once the administrator had discussed and told him to remove the riser/assistance device from the

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F 465	Continued From page 43 building, he did what he was told. E5 stated he had removed all of these from the building last week. E5 stated he understood they were being removed to be replaced by something that was able to be bolted on and remain stationary and not move. E5 stated he had ordered these according to what he and the administrator had discussed and had installed the new devices as they were coming in. E5 stated the old risers were taken out of the building and were not to be used anymore for resident safety.	F 465		