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	145978	A. BUILDING _____ B. WING _____	03/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 Federal Oversight and Support Survey	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		

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

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify a physician regarding incident of a very high blood sugar reading for 1 of 2 residents (R8) reviewed for blood sugar monitoring in the sample of 12. Findings include: 1. R8's physician order dated 12-29-14 indicates he is to be notified when R8's blood glucose results are greater then 351. On 02-03-15 at 4:00 PM, R8's blood glucose result was 354. On 02-07-15 at 4:00 PM, R8's blood glucose result was 429. On 02-08-15 at 4:00 PM, R8's blood glucose level was 364. On 02-23-15 at 4:00 PM, R8's blood glucose was 376. On 02-28-15 at 4:00 PM, R8's blood glucose was 388. On 03-08-15 at 8:00 PM, R8's blood glucose was recorded as 381. R8's physician was not notified of these high blood glucose levels per review of the nurses notes documented in February, 2015 or in March, 2015. Nor did R8's February, 2015 and March, 2015 Medication Administration Records note his physician was notified of the high blood sugar results. On 03-11-15 at 4:10 PM, E14 (Registered Nurse) indicated she had not called R8's physician, when his blood sugars were above 351.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	F 164		

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F 164	Continued From page 2 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to provide privacy for 3 of 3 residents (R2, R10, R11) reviewed for privacy in the sample of 12. Findings include: 1. On 03-09-15 at 3:20 PM, R2 was observed in bed and his gown was wet. E7 (Certified Nurse Aide) and E9 (Certified Nurse Aide) came into change R2's gown. R2 was noted to have a	F 164		

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F 164	Continued From page 3 bowel movement, when he was turned over in bed, while care was being provided. E7 and E9 did not pull the privacy curtain, when they were changing R2, and providing care. R2 was left uncovered and exposed during this time. E6 (Licensed Practical Nurse), E7 and E9 were observed going in and out of R2's room--multiple times--opening R2's door to the hallway, while the care was being provided exposing R2. 2. On 03-11-15 at 1:45 PM, R11 was noted laying on her bed wearing her bra and underwear. E6 came into R11's room to provide a treatment. E6 was unable to pull the privacy curtain due to a malfunction of the privacy curtain tract to assure R11 had total privacy during the treatment. 3. On 03-11-2015 at 2:00 PM, E4 (Certified Nursing Assistant) and E12 (Certified Nursing Assistant) pulled the privacy curtain, donned a pair of gloves and removed R10's clothing to provide perineal care. Neither E4 nor E12 covered R10 with a sheet during pericare, leaving R10 completely exposed. After E4 and E12 did pericare on R10, E12 went to the closet to get R10 a gown and when she couldn't find a gown, E12 went out of the door without checking the privacy curtain to ensure it was completely closed and did not shut the door, exposing R10 to people in the hallway. On 03-11-2015 at 3:30 PM, E2 (Director of Nursing) stated that the staff know that they need to close the doors and pull the privacy curtains and E2 stated that she has in-serviced them on providing privacy.	F 164		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		

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F 166	Continued From page 4 A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to redirect and prevent confused residents who entered other resident rooms, uninvited and lying on beds, rummaging through belongings, and putting on other resident's clothing for 4 residents (R5, R7, R8, R11) reviewed for grievances in the sample of 12 and 2 residents (R14, R15) in the supplemental sample. Findings include: 1. On 03-09-2015 at 10:30 AM, R13, R18 and R22 were wandering up and down the 100 hall and the 200 hall and R18 went into R5 and R11's room and was told to get out by R11. On 03-10-2015 throughout the day, R13 and R18 rattled the door knob to room 102 and at 2:15 PM, R13 came into the room and asked the surveyor where the bathroom was. On 03-11-2015 at 2:00 PM, R18 pulled the velcro "stop sign" off of the door to room 212 and went into the room. On 03-16-2015 at 12:00 noon, R22 went into R2's room and was redirected to go to the dining room by a surveyor. R13, R18 and R22 were not redirected by any of the facility staff. On 03-09-2015 at 3:10 PM, R5 stated on 03-08-2015 she came back to her room and found R18 was lying in her bed and that wasn't	F 166		

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F 166	Continued From page 5 the first time R18 had been in her room. R5 stated R18 and R13 come into her room and they have gone through her belongings and R18 has put on her clothing and urinated in her bed. R5 also stated she keeps telling the staff about the confused residents entering her room uninvited, but they don't do anything about it. On 03-10-2015 at 10:00 AM, R7, R14 and R15 stated during Group Interview that several residents kept coming into their rooms and rummaged through their belongings and they all stated they have reported those incidents to the staff. On 03-09-2015 at 2:45 PM, E1 (Administrator) stated about 6 months ago some of the residents complained about the confused residents coming into their rooms and that is why she started putting up the velcro "stop signs". E1 also stated that her staff know they are supposed to redirect and stop the confused residents from entering other resident rooms. 2. According to R8's Minimum Data Set (MDS) dated 1/12/15, R8 scored 15 on the Brief Interview for Mental Status (BIMS). This reflects R8 as being cognitively intact. R8 was interviewed at 1:10pm on 3/11/15. R8 said there is a female resident that comes into his room at times. R8 said this resident is confused and thinks he is her husband. R8 said he has to turn on the call light to notify the staff she is in his room so they can assist her out. R8 said there is a velcro stop sign covering his door but this does not stop her from coming into his room.	F 166		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

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manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to provide meal service in a dignified manner for 1 of 1 resident (R9) reviewed for feeding assistance in the sample of 12 and 2 residents (R13 and R18) in the supplemental sample.

Findings include:

1. On 03-09-2015 at 12:15 PM, R18 placed her cloth napkin to the side of her plate and put her mashed potatoes and peas onto the napkin with her fingers. E6 (Licensed Practical Nurse), E4 (Certified Nursing Assistant), E7 (Certified Nursing Assistant), E8 (Certified Nursing Assistant), E9 (Certified Nursing Assistant) and E10 (Certified Nursing Assistant) were in the dining room and did not remove the napkin with the potatoes and peas or give R18 more potatoes and peas. E9 was sitting at the table assisting R9 with the noon meal, but did not talk to her or any of the other residents during the meal. R13 was putting her chicken strips on top of her drink and was playing with her food. No staff redirected or encouraged R13 to eat her meal.

2. On 03-09-2015 at 12:45 PM, E6 was asked why R18's mashed potatoes and peas were left on the table while R18 ate her lunch and E6 stated that she always does that with her food.

3. On 03-10-2015 at 5:30 PM, E2 (Director of

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F 241	Continued From page 7 Nursing) was standing beside R9 and was feeding her. 4. On 03-11-2015 at 3:25 PM, E2 stated that she didn't have room enough to pull up a chair to assist R9 with her meal, so that was why she was standing and stated that she should have gotten a chair and sat down to feed R9.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide one on one activity for 1 of 1 resident (R10) reviewed for activities in the sample of 11. Findings include: On 03-10-2015 at 10:00 AM, R10 was in the dining room in front of the television with the volume off, and she was facing away from the other residents that were playing Bingo. At no time during the activity did E16 (Activity Director) bring R10 over to be included in the activity. R10 was placed in front of the television on 03-09-2015 through 03-12-2015 from 10:00 AM to 1:30 PM those days without any staff attempting to engage R10 with conversation or activity.	F 248		

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F 248	Continued From page 8 On 03-11-2015 at 11:30 AM, E16 stated that R10 was not officially on a one on one activity but could put her on it. E16 also stated that she didn't have time to do one on one's with R10. R10's Care Plan dated 01-19-2015 stated that R10 has a diagnoses of Alzheimer's Dementia and glaucoma. R10's vision is severly impaired and R10 is also cognitively impaired and under "Goals"; the Care Plan documents that resident will maintain or improve level of cognitive functioning through next review; then it is stated under "Approaches"; Encourage activity programs for added stimulation-assist as necessary and Activities will provide a one on one with R10.	F 248		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to provide an adequately lighted environment for one of one resident (R8) reviewed for lighting in a sample of 12. Findings include: On 3/11/15 at 1:10pm, R8 was interviewed in his room. When asked if there was enough light in his room R8 said "Not really. It's kind of dark in here." The room was illuminated by one light fixture mounted on the wall between bed one and	F 256		

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F 256	Continued From page 9 bed two. There was a light fixture above the sink that had two bulbs burning and one socket without a bulb in it. There was no overhead lighting in the room.	F 256		
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: Based on interview, observations, and record review the facility failed to develop a care plan related to left shoulder pain for 1 of 1 residents (R1) reviewed for care plans in the sample of 12. Findings Include:	F 280		

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R1's Cumulative Diagnosis dated 5/21/12 documents the following diagnoses: Left Hemiplegia, Dysphagia, Dysuria, Osteoarthritis, Depression, and Pain Syndrome. The Care Plan, last dated 10/21/2013, focuses on Spinal Stenosis, Bulging Disc, and Intractable Back Pain. Physician's Order sheet dated 3/1/15 to 3/31/15 documents the last medication change for pain medication (Ultram, Norco and Neurontin) was 3/24/14.

E2 (Director of Nurses) stated on 3/10/15 at 10:00AM, R1 has subluxation (incomplete dislocation) of the left shoulder and there is nothing we can do for R1's pain. E3 (Unit Assistant) stated, on 3/10/15 at 3:40 PM, R1 has pain when she is on her left side so we use pillows to support her arm. E3 stated she often tells the nurse that R1 is requesting pain medication. E8 (Certified Nurse Assistant) stated, on 3/10/15 at 3:45 PM, he often repositions R1 to help with the pain. E8 also stated R1 hurts every time we get her up and it is a daily problem, and we always report R1's pain to the nurse. E4 (Certified Nurse Assistant), on 3/10/15 at 3:50 PM, stated that R1 complains of pain several times a day, mostly related to her right heel and her left shoulder. R1 stated, on 3/11/15 at 9:55 AM, her left shoulder and arm always hurts and the medications she receives does not help. E16 (Activity Director) stated, on 3/12/15 at 10:20 AM, R1 is in pain all of the time and sometimes does not attend activities because of the pain. E12 (Certified Nurse Aide) stated, on 3/12/15 at 11:30 AM, she does not turn R1 when she is in pain. E12 stated that R1 often will request to return to her back to decrease the amount of pain in her shoulder. E6 (Licensed Practical Nurse, LPN), on 3/10/15 at 9:30AM,

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F 280	Continued From page 11 stated R1 receives Neurontin 100 milligrams three times a day, Ultram 50 milligrams four times a day, Norco 5/325 milligrams twice a day. E6 stated there is no order for an "as needed" medication for pain. On 3/10/15 at 12:50 PM during pericare R1 yelled with pain when being turned. On 3/11/15 at 9:30 AM, during Range of Motion, R1 yelled several times when E4 (Certified Nurse Aide) moved her left arm. R1's Care Plan, last dated 10/21/2013, focuses on pain related to Spinal Stenosis, Bulging Disc, and Intractable Back Pain. On the Care Plan there is no intervention or approach related to the pain in R1's left shoulder, no intervention or approach related to anticipation of pain when turning or transferring, or no intervention or approach related to scheduled medication and other modalities related to R1's left shoulder pain. There is no plan to address R1's decrease mobility related to pain.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to adequately follow established Standards of Practice by having hand rolls in place for residents with contractures, and failed to allow skin to dry after being prepped with alcohol prior to a finger stick, and injections	F 281		

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of insulin for three of three residents (R2, R8, R10) in the sample of 12 reviewed for contracture prevention, and skin prep with alcohol prior to a finger stick, and injections of insulin, and three residents (R16, R17, R20) in the supplemental sample.

Findings include:

1. On 03-09-15 at 9:00 AM, 11:20 AM, 2:45 PM, and 3:20 PM, R2 was observed in bed. R2's left hand was noted to be contracted. R2 was not able to open his left hand upon request. R2 did not have any hand roll in his left hand to alleviate skin to skin contact, and prevent contractures. R2's Nursing Admission Assessment dated 03-03-15 by E15 (Licensed Practical Nurse) indicates: Extremity Inspection (ROM/Contractures)--Contracture left hand. R2's Risk Score and Treatment Options dated 03-03-15 by E17 (Certified Occupational Therapy Assistant) was 13, which is moderate risk (50-80 % functional range of motion of joint). The treatment may include but is not limited to basic range of motion, positioning, ambulating as indicated by individual resident needs. R2's initial care plan dated 02-24-15 does not address his contractures or a plan to prevent skin to skin contact, and contracture prevention.

2. On 03-10-15 at 4:00 PM, R17 was observed sitting in a reclined chair in her room. R17's hands were noted to be contracted. There were no hand rolls in place to prevent skin to skin contact, or to prevent contractures. R17's Nurse Progress Review dated 02-03-15 indicates: both hands contracted. R17's care plan dated 01-28-15 does not address R17's contractures, or a plan to prevent skin to skin contact, and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 281	Continued From page 13 contracture prevention. 3. On 03-09-2015 at 10:00 AM, R10 was in a reclining wheel chair in front of the television and her right and left hands were contracted and had an odor. R10's fingernails were long and had a brown substance under them and R10's fingernails were cutting into the palms of R10's hands. R10 did not have hand rolls in her right or left hands to prevent skin to skin contact and further contracture. 4. The Fundamentals of Nursing Concepts and Practices (dated 2010) indicates: Helps prevent deformity and contractures by placing a hand roll in the residents hand to position and maintain the wrist and fingers in a functional position. 5. On 03-10-15, E6 (Licensed Practical Nurse) was observed to administer an insulin injection to R16 at 8:30 AM. E6 prepped R16's right side of his abdomen with an alcohol prep pad. E6 did not allow the skin to dry. At 11:10 AM, E6 wiped R16's left thumb with an alcohol swab to prep for a glucose test, and did not allow the skin to dry. At 11:15 AM, E6 was observed administering insulin to R16's right upper outer arm. E6 did not allow the skin to dry after using an alcohol swab to prep the area. 6. On 03-10-15 at 11:00 AM, E6 was observed to cleanse R20's left ring finger with an alcohol swab, and did not allow the skin to dry prior to obtaining blood for a glucose test. 7. On 03-10-15 at 11:20 AM, E6 was observed to prep R2's left index finger with an alcohol swab, and did not allow the skin to dry prior to obtaining	F 281		

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F 281	Continued From page 14 blood for a glucose test. At 11:25 AM, E6 was observed to prep R2's right thigh with an alcohol swab, and did not allow the skin to dry prior to administering an insulin injection. 8. On 03-10-15 at 4:15 PM, E14 (Registered Nurse) was observed to wipe R8's left index finger with an alcohol swab, and did not allow the skin to dry prior to obtaining blood for a glucose test. 9. On 03-10-15 at 4:40 PM, E14 was observed to wipe R16's right middle finger with an alcohol swab, and did not allow the skin to dry prior to obtaining blood for a glucose test. E14 was observed to administer an insulin injection to R16's upper left arm. E14 did not allow R16's skin to dry after prepping his skin with an alcohol swab. 10.The facility's policy and procedure for Subcutaneous Injections (Insulin/Heparin) (Revised 4/7/12) indicates: #12. Cleanse the injection site with an alcohol pad, using friction. Allow to dry.	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to follow orders for	F 282		

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F 282	Continued From page 15 floating heels, insulin, negative pressure wound device, laboratory test and pain relief for 4 of 11 residents (R1, R2, R6, and R8) reviewed for physician orders in the sample of 12. Findings include: 1. On 03-10-15 at 3:55 PM, R8 requested E14 (Registered Nurse) to check his blood sugar. At 4:15 PM, R8's blood sugar result was 325. R8 has a physician's order dated 12-29-14 for sliding scale coverage of 15 Units of Humalog Insulin for a blood glucose result of 301-350. R8's blood sugars are to be checked at 6:00 AM and 8:00 PM per physician's order dated 01-22-15. On 03-11-15 at 4:10 PM, E14 stated she did not administer any insulin to R8 on 03-10-15, nor did she recheck R8's blood sugar at bedtime. On 03-11-15 at 4:15 PM, R8 stated the nurse did not give him any insulin after his blood sugar was checked on 03-10-15 at 4:15 PM. 2. R1's Physician Order dated 2/18/15 documents order to float heels. The order is not included on the March Physician Order sheet. On 3/9/15 at 3:15 PM, R1 has padded heel protectors on both feet and stated right heel hurts and burns. There is no floatation device in R1's room at this time. R1, on 3/10/15 at 10:00 AM, has no floatation device on and no heel protectors on. E2 (Director of Nurses) stated, on 3/10/15 at 1:00 PM, she is unaware of the floatation order and R1 probably wouldn't use it anyway. When asked if the facility has tried using a floatation device E2 replied, on 3/10/15 at 1:15PM, they have not used a floatation device to float R1's heels.	F 282		

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F 282	Continued From page 16	F 282		

3. The Physician's Order Sheet on 11/19/14 for R6 has an order written by the physician for Basic Metabolic Profile and Complete Blood Count to be done today (11/19/14) and then every two months. No laboratory results for these labs were found in R6's medical record except for the laboratory results completed on 11/19/14. On 3/13/15 at 11:30am, E2 (Director of Nursing) said the laboratory tests were not completed in January 2015 as they should have been.

4. R6's untimed Nurses Notes dated 3/3/15 documents, " Up at nurses station in wheelchair leaning forward in wheelchair. Face red. Complaining of headache and hip pain. Very agitated. Refused vital signs. Will monitor. " R6's Medication Administration Record (MAR) for 3/1/15 through 3/31/15 documents Tylenol 500 milligrams is to be given to R6 as needed. There is no documentation on this MAR that Tylenol or any other medication was given to R6 for his complaints of pain. On 3/10/15 at 3:30pm, E14(Registered Nurse) said no pain medication was given to R6 on 3/3/15 or it would be signed out on the MAR. On 3/12/15 at 11:50 am, E6 (Licensed Practical Nurse) stated R6 takes his medication and never refuses it.

5. R2 has a physician's order dated 02-24-15 to float heels on bilateral pillows (2). On 03-09-15 at 2:45 PM, R2 was observed in bed. There were two pillows positioned between his knees and legs. Both of R2's heels were on the bed not being free floated with the two pillows per physician's orders.

The facility's policy and procedure for Preventative Skin Care (Revised 10/06) indicates: #7. Pillows and/or bath blankets may be used

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F 282	Continued From page 17 between two (2) skin surfaces or to slightly elevate bony prominences/pressure areas off the mattress. Pressure relieving devices may be used to protect heels and elbows.	F 282		
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 interview, observation, and record review the facility failed to address pain and implement interventions for 1 of 1 residents (R1) reviewed for pain in the sample of 12. Findings include: R1's Cumulative Diagnosis dated 5/21/12 documents the following diagnoses: Left Hemiplegia, Dysphagia, Dysuria, Osteoarthritis, Depression, and Pain Syndrome. Physician's Order sheet dated 3/1/15 to 3/31/15 documents the last medication change for ordered pain medication (Ultram, Narco and Neurontin) was 3/24/14. Physician Order dated 12/15/14 documents order for R1 to receive Occupational Therapy for Positioning and Neurological Evaluation. On 3/10/15 at 11:30 AM, E17 (Certified Occupational Therapy Assistant) stated she evaluated R1 for positioning in her wheelchair	F 309		

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F 309	Continued From page 18	F 309		

and positioning devices for her left shoulder. E17 stated she was unaware of R1's continuous pain.

E2 (Director of Nurses) stated during interview, on 3/10/15 at 10AM, that R1 has an incomplete dislocation of the left shoulder and there is nothing we can do for R1's pain. E3 (Unit Assistant) stated, on 3/10/15 at 3:40 PM, R1 has pain when she is on her left side so we use pillows to support her arm. E3 stated she often tells the nurse that R1 is requesting pain medication, but there is no medication to give her. E8 (Certified Nurse Assistant) stated, on 3/10/15 at 3:45 PM, he often repositions R1 to help with the pain. E8 stated R1 hurts every time we get her up and it is a daily problem, and we always report her pain to the nurse. E4 (Certified Nurse Assistant), on 3/10/15 at 3:50 PM, stated that R1 complains of pain several times a day, related to R1's left shoulder coming out of the socket. E16 (Activity Director) stated, on 3/12/15 at 10:20 AM, R1 is in pain all of the time and sometimes does not attend activities and stays in her room because of the pain. E12 (Certified Nurse Aide) stated, on 3/12/15 at 11:30AM, she does not turn R1 when she is in pain. E12 also stated R1 often will request to return to her back to decrease the amount of pain in her left shoulder. E6 (Licensed Practical Nurse, LPN), on 3/10/15 at 9:30 AM, stated R1 received Neurontin 100 milligrams three times a day, Ultram 50 milligrams four times a day, Norco 5/325 milligrams twice a day. E6 also stated R1 does not have an "as needed" pain medication for break through pain and pain medication orders have not been changed since 3/24/14. R1 stated, on 3/11/15 at 9:55 AM, her left shoulder and arm always hurts and the medications she receives does not help. R1 also stated the nurses tell her frequently that it is not

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F 309	Continued From page 19 time for pain medication. During pericare on 3/10/15 at 12:50 PM, R1 yelled with pain when turned to her left side and again when she was turned to right side. R1 stated, at 1:05 PM on 3/10/15, "it hurts so bad when they turn me". E6 (LPN) stated, on 3/10/15 1:30PM she will receive her next scheduled pain medication at 4 PM. E4 (Certified Nurse Aide), on 3/11/15 at 9:30 AM during Range of Motion, stopped Range of Motion to left shoulder due to R1 yelling with pain. Pain Assessment, dated 12/22/14, did not include pain assessment during mobility and activities. E6 (Licensed Practical Nurse), on 3/16/15 at 10:15AM, stated pain assessment is not done every time a pain medication is given because the pain medications are given on a scheduled basis. Pain Management Flow Sheet dated 3/1/15 through 3/15/15 documents pain assessment 1 to 3 times a day, scheduled pain medication is given 5 times a day. Care Plan, dated 10/21/2013, focuses on Pain related to Spinal Stenosis, Bulging Disc, Intractable Back Pain. On the Care Plan there is no intervention or approach related to the pain in R1's left shoulder, no intervention or approach related to anticipation of pain when turning or transferring, and no intervention or approach related to scheduled medication and other interventions related to R1's left shoulder pain.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 20 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to provide grooming and feeding assistance for 4 of 11 residents (R1, R3, R5, and R10) reviewed for grooming and feeding assistance in the sample of 12 and 2 residents (R13, R18) in the supplemental sample. Findings include: 1. On 03-09-2015 at 1:45 PM, E4 (Certified Nursing Assistant), E7 (Certified Nursing Assistant), E8 (Certified Nursing Assistant), E9 (Certified Nursing Assistant) and E10 (Certified Nursing Assistant) were asked by this surveyor which one fed R10 at lunch, and all of them stated they had not fed R10. On 03-10-2015 at 9:00 AM, E2 (Director of Nursing) stated E8 was the one who fed R10 on 03-09-2015. On 03-10-2015 at 1:40 PM, via telephone, E8 stated he fed R10 after everyone realized she hadn't been fed and it was around 1:30 PM or maybe 2:00 PM. E8 also stated the kitchen didn't have a tray set up for R10 and that was why she didn't get fed. 2. On 03-09-2015 at 12:15 PM, R3, R13 and R18 were sitting at the dining room table waiting for their lunch tray. Each of these residents had long fingernails with a dark brown substance underneath them. R10, R13 and R18 also had uncombed hair. On 03-09-2015 at 3:10 PM, R5's fingernails were long and had a dark brown	F 312		

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F 312	Continued From page 21 substance underneath them and her hair was uncombed. 3. On 03-09-2015 from 10:00 AM to 1:45 PM, R10 was sitting in a reclining wheel chair in front of the television facing away from other residents throughout lunch. R10 did not recieve a meal tray and was not fed by the staff until this surveyor asked who fed R10. R10 also had long fingernails with a dark brown substance underneath them and her hair was uncombed and R10's teeth had food debris on them. 4. On 3/11/15 at 9:30AM R1's left hand is foul smelling and skin to thumb is moist and easily removed when touched. R1's fingernails on both of her hands were long, ragged, and contain brown material underneath. E2 (Director of Nursing) stated, on 3/11/15 at 5:35 PM, it is the Activity Director's job to clean R1's nails.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, and record review, the facility failed to administer a treatment for a stage	F 314		

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F 314	Continued From page 22 three pressure area to promote healing, and prevent infection for one of one residents (R2) observed for treatment of a pressure ulcers in the sample of twelve. Findings include: 1. R2 was admitted to the facility with three stage three pressure sores per review of his nursing assessment record dated 02-24-15. On 03-09-15 at 3:20 PM, R2 was noted with fecal material under the clear dressing on the left lower buttocks connected to the negative pressure wound device. R2 has a physician's order dated 02-24-15 for a dressing for left lower buttocks, cleanse with saline, apply skin prep to where adhesive will be applied, non adhesive dressing prior to foam for incision lines, black foam secure with Vac drape, Santyl to wound base before foam. On 03-09-15 at 3:35 PM, E6 (Licensed Practical Nurse) was observed to cleanse the stage three wound on the left lower buttock with a moistened cloth that contains purified water, aloe, citrus based preservative, cocamidopropyl betaine, allantoin, colloidal silver, lauryl glucoside, beta glucan, dimethicone, methyl paraben, propyl paraben, EDTA, Fragrance, Vitamin E per review of the products label. E6 did not use saline to cleanse the stage three wound per physician's orders. E6 did not use the black foam, nor did she use the Vac drape to secure the black foam dressing per physician's orders. E6 put saline on a gauze and placed it in the wound bed, cut the tip end off of a drain tube with multiple holes, placed the drain tube on top of the wet gauze, covered the drain with another gauze, and covered the area with a clear adhesive dressing.	F 314		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		

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F 315 SS=D	Continued From page 23 RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to provide appropriate pericare for 2 of 2 residents (R1, R10) receiving pericare in the sample of 12. Findings include: 1. R1 received pericare on 3/10/15 at 3:50PM from E4 (Certified Nurse Aide). E4 wiped once in the pubic area in a front to back motion using a packaged antiseptic wipe. E4 then turned R1 and wiped once in the peri-anal area from the base of the labia to the coccyx. E4 did not clean the inner aspect of both thighs, did not clean the anterior labia down to the base of the labia, and did not dry the thigh and pubic area. After turning the resident E4 did not clean the buttock and did not dry the peri-anal and buttock area. 2. On 03-11-2015 at 2:00 PM, E4 (Certified Nursing Assistant) and E12 (Certified Nursing Assistant) did perineal care on R10. E4 and E12 donned a pair of gloves, took off R10's clothing	F 315		

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F 315	Continued From page 24 and positioned R10 on her left side. E4 opened a package of perineal cleansing wipes and took one wipe and wiped down the left side of R10's buttock, disposed of the wipe, then took another wipe and wiped down the right side of R10's buttock. E4 did not cleanse R10's anal area and after pericare was complete, R10 continued to have an odor. 3. The facility's Pericare Policy (undated) documents the following: #12. Wash pubic area including upper inner aspect of both thighs and front portion of perineum. a. Use long strokes from the most anterior down to the base of the labia. b. After each stroke refold the washcloth to allow use of another area. #14. Dry thoroughly. #17. Turn resident and wash the peri-anal area thoroughly with each stroke beginning at the base of the labia and extending up over the buttock. a. Refold the cloths, as before, to provide clean area. b. Washing should alternate side to side, ending with center anal area. #18. Rinse cloth and entire area in same sequence as above. Dry thoroughly.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318		

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F 318	Continued From page 25 Based on interview, observation, and record review, the facility failed to provide adequate services, complete range of motion or use appropriate adaptive devices for the treatment of current contractures on three of three residents (R1, R7, R10) reviewed for Passive Range of Motion in the sample of 12. Findings include: 1. On 03-09-2015 at 10:00 AM, R10 was sitting in a reclining wheel chair in front of the television. R10's right and left hands were contracted and had an odor. R10's fingernails were cutting into the palms of her hands, and there were no hand rolls in her right or left hands to prevent further contracture. R10's Range of Motion Assessment dated 01-27-2015 documents R10 is high risk (Score 15) for contractures and is a candidate for Passive Range of Motion. There is no documentation on R10's Restorative Nursing Program Documentation record to indicate Passive Range of Motion was done on R10. 2. E4 (Certified Nurse Aide), on 3/11/15 at 9:55 AM, performed Range of Motion to R1's upper extremities. R1 stated, on 3/11/15 at 10:10 AM, this is the first time in a long time she has received Range of Motion. R1 also stated she always does ROM if they offer it to her. R1 has contracture of left hand and limited ROM of her right wrist as noted on 3/11/15 at 10:10AM. Minimum Data Set dated 12/22/14 documents R1's Brief Interview Mental Status as 15 of 15, cognitively intact. Restorative Nursing Program Documentation sheet dated 3/15 documents the	F 318		

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F 318	Continued From page 26 following goal: Passive Range Of Motion to left upper extremity 15 repetitions one time a day, 7 days a week. The Restorative Nursing Program Documentation sheet dated 2/15 and 3/15 documents R1 has received passive Range of Motion every day. Restorative Nursing Program Documentation sheet dated 3/15 documents the following goal: Active Range Of Motion to right upper extremity 15 repetitions one time a day, 7 days a week. The Restorative Nursing Program Documentation sheet dated 2/15 and 3/15 documents R1 has received active Range of Motion every day. 3. R7 stated, on 3/10/15 at 1:30 PM, that he does not on get Range of Motion to arms. Restorative Nursing Program Documentation sheet, dated 3/15, documents the goal as Active Range of Motion-bilateral upper extremities 15 repetitions once a day, seven days a week. R7's Minimum Data Set dated 12/8/14 document his Brief Interview Mental Status as 15 of 15, resident is cognitively intact.	F 318		
F 323 SS=D	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, record review and	F 323		

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F 323	Continued From page 27	F 323		

interview the facility failed to use the interventions assigned to prevent falls for 2 of 5 residents (R6, R9) reviewed for falls in the sample of 12.

Findings include:

1. On review of R6's Nurses Notes it was noted that R6 had a fall on 11/5/14 at 8:00 am. The notes document, " Resident up in wheelchair. Attempted to stand without assist. He fell in the floor sitting on buttocks." On 11/10/14 it is documented in the Nurses Notes as a late entry for 11/5/14, "Resident noted sitting on floor in front of wheelchair. Resident scooted to edge of wheelchair and attempted to stand. Reviewed by Interdisciplinary Team with recommendation of wheelchair alarm." R6's Care Plan for Potential for Self Injury has an intervention dated 11/20/14, to use personal alarm while in the bed.

R6 was in bed on 3/10/15 at 10:00 am and no personal alarm was being used. On 3/10/15 at 10:30 am, 3/10/15 at 1:00 pm, 3/11/15 at 8:30 am, and 3/12/15 at 12:15 pm R6 was up in the wheelchair without the use of a personal alarm.

E2 (Director of Nursing) stated at 4:00 pm on 3/10/15 that R6 had a fall in the past and an intervention was put in place by the interdisciplinary team to use a personal alarm when the resident is in the wheelchair. She agreed R6 did not have an alarm on at this time and said she thinks it had been removed. At 11:10 am on 3/12/15, E2 said R6 has not always had the personal alarm on like he should. E2 said the Interdisciplinary Team reviewed R6 on 3/10/15 and feel like it is safe to not use the alarm in R6's bed or wheelchair now.

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F 323	Continued From page 28 2. R9's Nurses Notes, dated 9/9/14, documents a fall in the dining room. E2 (Director of Nurses, DON), on 3/11/15 at 1:25 PM, stated the root cause analysis of the fall is R9's dementia. E2 also stated there were no changes in the interventions to prevent further falls as R9 is a "jack in the box" and very difficult to control. R9's Nurses Notes, dated 2/17/15, documents a fall in the dining room and sustained a hematoma on the left side of the head and skin tear 2 centimeter long to the right index finger. Nurses Notes dated 02/18/15 documents the Interdisciplinary Team lowered and tilted R9's wheelchair seat to prevent future occurrence. E2 (DON) stated, on 3/11/15 at 1:30 PM, the root cause analysis of the fall is R9's dementia.	F 323		
F 332 SS=D	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 medications at the time ordered, or draw up the correct dosage of insulin ordered by the physician. There were twenty-six opportunities with three errors resulting in a 11.5% medication error rate. The errors involved one resident (R8) in the sample of twelve, and one resident (R16) in the supplemental sample. Findings include:	F 332		

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F 332	Continued From page 29 1. On 03-10-15 at 8:30 AM, E6 (Licensed Practical Nurse) had pulled up 42 Units of Lantus Insulin to be administered to R16. E6 was asked to allow surveyor to check the amount of insulin she had drawn up to give R16. E6 was asked to recheck the amount of the insulin she had drawn up before administering it to R16. E6 stated, "It is over 40 units". E6 pushed out the extra two units of insulin. R16 has a physician's order dated 01-19-15 for 40 Units of Lantus to be administered subcutaneous at 8:00 AM. 2. On 03-10-15 at 11:10 AM, E14 (Registered Nurse) drew up 10 Units of Humalog Insulin to be administered to R16 for a blood glucose test result of 165. E14 was asked to allow surveyor to check the insulin in the syringe before administering it to R16. The surveyor noticed air bubbles in the insulin. E14 was asked to recheck the insulin before administering it to R16. E14 stated, "I see the air bubbles". E14 pushed the insulin back into the insulin bottle and redrew the insulin. 3. On 03-10-15 at 3:55 PM, E14 was observed to administer a Duoneb breathing treatment to R8. R8's physician's order dated 12-07-14 for the Duoneb breathing treatment indicates to be administered every six hours (6AM, 12Noon, 6PM and 12 Midnight). R8's breathing treatment was not due to be administered until 6:00 PM. The facility's policy and procedure (Revised 10-27-10) for Medication Administration indicates : #6. Medications must be identified by using the five (5) rights of administration: Right resident, Right drug, Right dose, Right time and Right route.	F 332		

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F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review the facility failed to serve palatable food at acceptable temperature, This has the potential to affect all of the 45 residents living in the facility.

Findings include:

The facility's Residents Census and Condition of Residents form, dated 3/9/15, documents the facility has a census of 45 residents.

During kitchen observation, on 3/9/15 at 11:45AM, 6 serving cups of peas were noted sitting uncovered next to the hot table. They were not placed on a resident tray for 15 minutes. Pureed chicken, on 3/9/15 at 12:00 PM, was noted to be 120 degrees when checked by E18 (Dietary Cook) with the facility's thermometer and surveyor's thermometer. Pureed chicken was reheated on stove to 145 degrees, 3 pureed trays were served. Pureed chicken temperature was rechecked by surveyor, temperature was 120 degrees at 12:15 PM. The pureed chicken was then placed on the stove to reheat. E18 ran out of mashed potatoes on the serving line at 12:25 PM. Mashed potatoes were made and E18 did not check the temperature of the mashed potatoes. After sending one tray with the mashed

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F 364	Continued From page 31 potatoes to the cart, the remaining mashed potatoes were at 124 degrees. E18 was notified and continued to serve the mashed potatoes. Cart was sent to the dining room. E13 (Dietary Manager) stated, on 3/9/15 at 12:30 PM, the food temperatures were taken as the food was removed from the stove before placing them on the serving line. E13 stated the temperature is not taken again during serving and there are 10 residents recieving pureed diets. Food Temperature policy, dated 10/09, #5. Hot foods must read a minimum of 135 degrees before residents can be served. #7. Inform the Food Service Manager or designee of any temperature not within acceptable range. Appropriate action should be taken to ensure food safety. For hot food, it should be immediately reheated to 165 degrees Fahrenheit for at least 15 seconds before it can be served to residents. During the Group Interview, on 3/10/15 at 10:00 AM, E15, E7, and E14 stated the food that is supposed to be hot is often cold. Hot temperatures were taken and recorded with the surveyor's thermometer that was calibrated by the ice point method to + or -2 degrees Fahrenheit on 3/8/15. The food temperatures were taken and verified by E18 (Dietary Cook) and found to be accurate against E18's facility thermometer. All temperatures were taken and reported in degrees Fahrenheit.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	Continued From page 32 (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 interview, observation, and record review the facility failed to store food under safe and sanitary conditions. This has the potential to affect all of the 45 residents living in the facility. Findings include: The facility's Residents Census and Condition of Residents form, dated 3/9/15, documents the facility has a census of 45 residents. 1. During initial tour on the kitchen, on 3/9/15 at 9:00 AM, in the food storage room/Dietary Manager's office on the bottom shelf was a box of potatoes and next to a basket containing nail polish remover, antiseptic spray, alcohol 70% labeled flammable, perfume, Vitamin E lotion, calming lotion, and a wooden door stop. 2. During the inital tour of the kitchen, on 3/9/15 at 9:15 AM, in the front cabinets facing the entrance into the kitchen was wood debris on the lower shelf used for bowl storage. Under the prepping table were 4 bins, containing sugar, flour, and cereal that were dirty and not labeled and not dated. In the sugar bin was a plastic cup	F 371		

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F 371	Continued From page 33 containing sugar. E13 (Dietary Manager), on 3/9/15 at 9:30 AM, stated the bins are used to store sugar, flour, and cereal. E13 also stated the plastic cup is used as a scoop.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide physician progress notes for one of one resident (R10) reviewed for physician's visits in the sample of 12. Findings include: On 03-16-2015 at 10:30 AM, E2 (Director of Nursing) stated during interview that she could not find any progress note for R10. E2 also stated Z1 had not been in to see R10 and there were no Physician's Progress notes at Z1's office. R10's Medical record under "Progress Notes" had no documentation from Z1. R10's Admission note states that R10 was admitted to the facility on 01-19-2015.	F 386		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=E	Continued From page 34 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 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, record review and	F 431		

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F 431	Continued From page 35	F 431		

interview the facility failed to properly store/dispose of medications and failed to maintain full visual control of an unlocked medication cart during one of two medications passes, which has the potential to affect 1 of 1 resident (R9) reviewed for unsupervised mobility in a sample of 12, and residents (R13, R22-R26) in the supplemental sample.

Findings include:

1. On 03-10-15 during the 4:00 PM medication pass, E14 (Registered Nurse) left the medication cart unlocked, and out of visual control at the following times: On 200 Hall at 3:45 PM, E14 went down the hall to the 100 Hall mediation cart to get a glucometer; At 3:55 PM, E14 went into room 207 to administer medications to R8; At 4:00 PM, E14 went into room 206 to administer medications to R17; At 4:15 PM, E14 went into room 207 to check his blood sugar, and to turn off a patient breathing treatment machine; At 4:25 PM, E14 went into R7's room to administer his medications. R9, R22-R23 reside on the 200 Hall. On 03-09-15 at 9:30 PM, E6 (Licensed Practical Nurse) identified these residents as confused. .

On 03-10-15 at 4:40 PM, E14 began to pass medications on the 100 Hall. E14 was observed to leave the 100 Hall medication cart unlocked, and out of visual control, when she went into R16's room to check his blood sugar. R19 a confused resident was observed ambulating up and down the 100 Hall, while the medication cart was left unlocked and unattended. At 4:42 PM, E14 went back into R16's room to administer insulin, and E14 left a bottle of Humalog insulin out on top of the unlocked medication cart, and R18 and R19 were observed to be right near the

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F 431	Continued From page 36 100 Hall medication cart at that time. At 5:05 PM, E14 entered room 108 to administer medications to R21 leaving the 100 Hall medication cart unlocked, and out of visual control. R13 resides on the 100 Hall and on 03-09-2015 at 9:30 AM, R13 was identified as confused by E2 (Director of Nursing) and able to ambulate about the facility on her own. The facility's policy and procedure (Revised 10/27/10)) Medication Administration indicates: #5. Keep the medication cart in view at all times. If it is likely the medication cart will be out of visual control at any time, it must be locked. 2. On 03-11-15 at 8:40 AM the 200 Hall Medication Cart had one loose pill in the second drawer, and one loose pill in the third drawer. At 9:00 AM the 100 Hall Medication Cart had three loose pills in the second drawer.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 37 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to clean and disinfect the glucometer between residents to prevent cross contamination, failed to wash their hands to prevent cross contamination during a treatment of a pressure ulcer, after emptying a indwelling catheter bag, during a medication pass (no hand washing, and touched pills with bare hands), failed to provide a barrier during the medication pass for insulin syringes for 4 of 4 residents (R1 ,R2, R7, R8) in the sample 12 reviewed for infections and 3 residents (R16, R17, R20) in the supplemental sample. Findings include:	F 441		

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F 441	Continued From page 38 1. On 03-10-15 at 4:15 PM, E14, (Registered Nurse, RN) was observed to obtain blood from R8 to check his blood sugar. E14 did not wear gloves during this procedure. E14 was observed to obtain a moistened towelette to wipe off the glucometer for a couple of seconds, and the bottom portion of the glucometer was placed on top of the medication cart on top of the wipe. The entire surface of the glucometer was not kept visibly wet for three minutes. E14 did not wear any gloves when sanitizing/cleaning the glucometer. 2. On 03-10-15 at 4:00 PM, E14 was observed to use her finger to push a capsule into a medication cup, and administer the medication to R17. 3. On 03-10-15 at 4:25 PM, E14 was observed to use her fingers to break apart a tablet in two pieces, and administer the medication to R7. 4. On 03-10-15 at 4:40 PM, E14 was observed to obtain blood from R16 to check his blood sugar. E14 was observed to wipe off the glucometer for a couple of seconds, and the bottom portion of the glucometer was placed on top of the medication cart on top of the wipe. The entire surface of the glucometer was not kept visibly wet for three minutes. E14 did not wear gloves when sanitizing/cleaning the glucometer. 5. On 03-09-15 at 2:45 PM, E7 (Certified Nurse Aide) and E9 (Certified Nurse Aide) were observed in the soiled utility room after having emptied the urine out of R2's indwelling bladder catheter bag. Both E7 and E9 washed their hands, and then touched the paper towel	F 441		

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	145978	A. BUILDING _____ B. WING _____	03/16/2015

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F 441	Continued From page 39 dispenser handle with their clean hands. 6. On 03-09-15 at 3:35 PM, E6 (Licensed Practical Nurse) was observed during a treatment for R2's stage three pressure ulcer. E6 did not wash or sanitize her hands between glove changes, when she wiped/cleaned fecal material from underneath the dressing to R2's left lower buttocks pressure ulcer, remove the old dressing, provide wound care, and reapply a dressing connected to a negative pressure wound device. 7. On 03-10-15 at 8:30 AM, E6 was observed to draw up insulin for R16, and she placed the syringe on top of the medication cart, and on the resident's over bed table without any barriers. E6 was observed to pick up the tubing from R16's CPAP machine off of the floor, and place the tubing in a plastic bag, and left it in R16's room. E6 did not wash her hands. 8. On 03-10-15 at 10:35, AM E6 was observed to check R1's gastrostomy tube for placement and residual contents. E6 washed her hands, then touched the handle on the paper towel dispenser with her clean hand. 9. On 03-10-15 at 11:00 AM, E6 was observed to place a syringe with insulin on top of the medication cart, and on R20's over bed table without any barrier. 10. On 03-10-15 at 11:10 AM, E6 was observed to place a syringe with insulin on top of the medication cart, and on R16's over bed table without any barrier. E6 did not wash her hands after administering the insulin to R16. 11. On 03-10-15 at 11:25 AM, E6 was observed	F 441		

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F 441	Continued From page 40 to place a syringe with insulin on top of the medication cart, and on R2's over bed table without any barrier. E6 did not wash her hands after administering the insulin to R2. 12. On 03-10-15 at 11:40 AM, at the nurses station, E6 was observed to wash her hands, then touch the faucet to turn off the water with her clean hand. The facility's policy and procedure for Cleaning and Disinfecting of Glucometer (Issues:6-9-10) indicates: #1. Cleaning and disinfecting with a Germicidal Disposable Wipe will be completed each time the blood glucose meter is used with a pre-moistened towelette. #2. Using gloved hands remove and unfold wipe. #3. Wipe down area to be cleaned. #4. Air dry. The moistened towelette the facility uses for disinfectant indicates: repeated use of the product may be required to ensure the surface remains visibly wet for three minutes...	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to provide at least 80 square feet of floor space in 11 of 13 four bed resident bedrooms, and 1 room used for therapy, but could be used as a four bed resident bedroom in the facility. This had the potential to	F 458		

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F 458	Continued From page 41 affect 4 of 4 residents (R5, R6, R10, R11) reviewed for undersized rooms in the sample of 12, and 22 residents (R14, R16, R19, R20, R21, R23, R26, and R27 through R41) in the supplemental sample. Findings include: Review of these rooms on 03-09-2015 at 8:50 AM to 9:30 AM, documents that room 213 is used as a therapy room. All other rooms are four bed resident rooms. E1, (Administrator) verified the information during interview on these undersized rooms on 03-09-2015 at 9:00 AM, and that the rooms are Medicare and Medicaid certified. On 03-09-2015 at 10:30 AM, R5 and R11 stated that they had enough room for their personal belongings, and no complaints regarding space. Observations on 03-09-2015 from 8:50-10:00 AM indicated these rooms provide space for personal items, care items and there were no infection control issues. Residents in these rooms according to the facility's Resident Rooms List provided 03-09-2015 are R5, R6, R10, R11 and R14, R16, R19, R20, R21, R23, R26 and R27 through R41	F 458		
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have	F 460		

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F 460	Continued From page 42 ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a privacy curtain that was in working order and provided full privacy for 2 of 2 residents (R8 and R11) reviewed for privacy curtains in the sample of 12. Findings include: On 3/11/15 at 11:05 AM in R8's room, the privacy curtain track did not extend to the end of the bed. This causes an area where the bed can be seen and full privacy is not maintained. On 3/11/15 at 1:45 PM the privacy curtain in R11's room would not slide all the way to the end of the curtain track. This caused the resident to be exposed and privacy was not maintained. On 3/18/15 at 9:30 AM, E11 (Maintenance) stated during interview that he was aware of these issues.	F 460		
F 465 SS=F	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:	F 465		

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F 465	Continued From page 43 Based on record review, observation and interview the facility failed to maintain all resident equipment, wall material, ceiling material, floor material, plumbing fixtures, air conditioning units, chairs and privacy curtains in a safe, sanitary and functional manner. This has the potential to affect all 45 residents living in the facility. Findings Include: The facility's Resident Census and Conditions of Residents form, dated 3/9/15 documented the facility had a census of 45 residents. 1. During the environmental tour of Hall 200 on 3/10/15 at 10:15 am the following was noted; -In the resident restroom for male residents there were brown colored stains under the sink. -In the resident restroom for male residents the sink was pulled away from the wall 1 inch. - The resident shower room had missing tiles in the floor and walls of the shower stall. -There were missing floor tiles outside of the shower stall in the shower room. - In the shower room a wood cabinet was scraped and had missing paint. - In the shower room the ceiling had cracked areas. -In the shower room the fan vent had dark material on it. -In the female resident restroom the sink was pulled away from the wall 1 inch. -In room 203 the baseboard was cracked and paint was missing on the lower part of the wall. -In room 206 the paint was chipped and coming off of the walls. 2. On 3/10/15 at 3:45 pm on the 200 Hall, the linen cart was being pushed up and down the	F 465		

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F 465	Continued From page 44 hallway three times, and the wheels were making a loud noise as they rolled across the floor. 3. On 3/11/15 at 11:05 am in room 207, the privacy curtain track did not extend to the end of the bed. This causes an area where the bed can be seen. In room 104 the privacy curtain will not slide all the way to the end of the track. 4. The following was observed at various times on 3/12/15; -The air conditioner in room 105 does not have material covering all the areas surrounding it. The outside could be seen through it. -Room 211 has water stained ceiling tiles. -In the sitting area on the 200 hall the burgundy colored chair has ripped arms and seat. The stuffing is showing. -The sitting area on 200 hall has a brown chair and it is visibly soiled. -R3's reclined wheelchair was observed being pushed into the dining area and was making a loud, squeaking noise. -R2's floor had a hole in the floor by the window. A wooden chair in R2's room was noted to be unsteady and robbled. R2 (Director of Nursing) said on 3/11/15 at 4:00 pm, during interview that she knew there were environmental issues.	F 465		