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F 000	INITIAL COMMENTS	F 000		
F 241 SS=E	Annual Licensure and Certification Survey. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to follow it's policy and ensure that staff respect the privacy and dignity of two residents (R3, R11), in the sample by knocking on the door and requesting permission to enter the residents room, failed to cover the private parts of one resident (R6) in the sample of 24 while leaving them unattended for an extended amount of time and failed to provide privacy during glucose monitoring for one resident (R30) of three residents reviewed for glucose monitoring in the supplemental sample. Findings include: On 4/11/16 at approximately 9:45am during initial tour, E17 LPN (Licensed Practical Nurse) entered room 519 without knocking on the door, or requesting permission prior to entering. At 9:55am, E18 CNA (Certified Nurse Assistant) entered room 523 without knocking or requesting permission to enter. On 4/12/16 at approximately 2:00pm, E19 (Housekeeping) entered the room of R3 and R11,	F 241		

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

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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without knocking or requesting permission to enter, and went directly into the closet. E19 never asked permission, or explained to R3 and R11 why E19 was going into their private space. After E19 left the room, R3 and R11 indicated staff enter the room on various occasions without knocking, explanations or permission to enter from either resident.
On 4/12/16 at 11:10am, E22 LPN (Licensed Practical Nurse) was observed performing blood glucose monitoring on R30, in the 100 unit dining room.

E22 stated, I did the accucheck (blood glucose monitor) because R30 wanted me to check it really fast. That is not what we normally do, we usually take them to the room to do the accucheck.

On 4/13/16 at 10:25am, E2 DON (Director of Nursing), stated it is not normal practice to perform accuchecks in the dining room for privacy and dignity reasons. E22 and the other nurses have been inserviced regarding not taking accuchecks in the dining room.

Review of the Blood Glucose Monitoring (Observational Competency) documents that the nurse is to explain to the resident the procedure and provide privacy.

The facility's Dignity Policy (dated 10/09) indicates that staff shall promote, maintain, and protect resident privacy during treatment procedures.

"Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality".

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F 241	Continued From page 2 The Policy Interpretation and Implementation section states: "1. Residents shall be treated with dignity and respect at all times. 6. Residents private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents' rooms." On 4/13/16 at 10:20am, during an observation of a wound treatment for R6, observed as E6 LPN (Licensed Practical Nurse) prepared R6 for treatment by removing R6 ' s pants and incontinence briefs. E6 informed surveyor that she had to get a face mask to continue the treatment. E6 left the room and left R6 uncovered with R6 ' s buttocks and legs exposed. A review of the facility policy with a revised date of October 2009 and titled, "Quality of Life-Dignity" indicates in part: "1. Residents shall be treated with dignity and respect at all times; 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." On 4/13/16, E9 (ADON) Assistant Director of Nursing stated, "It was unacceptable for R6 to be left uncovered while E6 LPN (Licensed Practical Nurse) left the room to retrieve a face mask before treatment."	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that the nurse call light is accessible to three of seven residents (R3, R11 and R20) in the sample of 24, reviewed for accountability of needs and one resident (R29) from the supplemental sample.
Findings Include:
On 4/11/16 at 1:40pm, R29 ' s call light was noted on the floor while R29 was noted in bed. E12 CNA (Certified Nurse ' s Aide) stated the call light should be within the reach of the residents at all times.
On 4/12/16 at 9:20am, R20 was noted sitting in the chair in the room and the call light was noted not within reach of R20. E13 (CNA) stated in part that call lights are supposed to be within reach of the residents while in bed or sitting in a chair at all times.
The facility ' s Answering the Call Light policy with revision date November 2010 indicated under guidelines that " When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. " This guideline was not followed.
On 4/11/16 between 9:30am and 10:00am,during the initial tour with E17 (Wound Care Nurse), R3 was observed in bed with the nurse call light hanging off the side of the bed, almost touching the floor. E17 placed it within reach of R3 with prompting.

At around 2pm on 4/12/16, R11 observed in the room, sitting up in his wheelchair. R11's call light was stretched across the bed, but was still not

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F 246	Continued From page 4 within reach of R11. R11's call light is too short to reach the side of the room that R11 prefer to sit on. R11 was asked how do you call the nurse, with your call light being out of reach. R11 indicated that he wheels his chair around the bed to the other side, to reach the call light when he has to call the nurse.	F 246		
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 follow physician ' s orders for wound care and glucose monitoring for two residents (R4, R28) of three reviewed for following physician ' s orders in a total sample of 24. Findings include: R4 was admitted to the facility on 3/30/16 with the following diagnoses; DVT (Deep Vein Thrombosis), HTN (Hypertension), PVD (Peripheral Vascular Disease) bilateral lower extremities, Abdominal Wound. On 4/12/14 during review of R4's physician telephone order sheet dated 3/31/16, R4 was to	F 309		

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receive a wound care consult from Z1 (Physician). Review of physician orders from 3/30/16-4/11/16 and R4's medical record lacks documentation Z1 was notified of the wound consult order to see R4 and also lacked documentation that Z1 has ever seen R4.

At 1:04pm, on 4/12/16 E2, DON (Director of Nursing) stated, "There are no notes in the computer or the chart from Z1. Z1 hasn't seen this resident (R4).

Records indicate that no effort was made to address the consult for R4 until 12 days later, and R4 will not be seen by Z1 until a scheduled appointment date of 4/19/15 per outpatient appointment record received from E2, DON (Director of Nursing) on 4/12/16 at 4:19pm.

On 4/14/16 at 10:44 am E2, DON (Director of Nursing) stated, "There is nothing written about when orders should be taken off, but my staff had training and know that orders should be taken off as soon as the orders are written. Staff was trained in orientation."

Received telephone order policy on 4/14/16 at 10:44am telephone order policy dated 2008 does not address routine orders or implementation of orders.

R28 was admitted to the facility on 4/5/16 with diagnoses of Type 2 Diabetes Mellitus according to the Admission Record.

On 4/12/16 at 1:40pm, E10, LPN (Licensed Practical Nurse) entered into R28's room in order to perform an ordered blood glucose monitoring check. R28 already consumed lunch prior to E10

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F 309	Continued From page 6 entering room. E10 stated that we usually check R28's accucheck after meals because R28 likes to eat late. Review of R28's Physician Orders (dated 4/5/16) indicates an order to " check blood sugar before meals (ac) " . On 4/13/16 at 11:45am, R28 stated, they (nurses) check my sugar (blood sugar) sometimes before I eat and sometimes after I eat, but mainly after because it is better like that. E2, DON (Director of Nursing) stated on 4/13/16 at 12:02pm, that accuchecks are done at 6:00am, 11:00am, 4:00pm, and 9:00pm. The times might change a little, but as long as the checks are done before the meals, that are what matters. During interview on 4/13/16 at 1:15pm, E16 (Unit Manager) stated, "It is expected that nurses take accuchecks before meals. It is not ok after meals because the order is to take it before meals." On 4/14/16 at 9:20am, E2, DON (Director of Nursing) stated, the nurses have been inserviced about taking accuchecks. They are supposed to take accuchecks prior to meals. Review of the facility's Blood Glucose Monitoring (rev. 4/10), indicates that all residents requiring blood glucose monitoring will have accurate testing with physician's order and to verify the order.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

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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, interview and record review, the facility failed to ensure that standards of practice associated with indwelling catheter care, dignity and infection control were followed. This failure applies to 3 of 4 residents(R4,R7,R8),in the sample of 24, reviewed for indwelling catheter care.
Findings include:
On 4/11/16 at approximately 10:05am, during initial tour with E9 ADON (Assistant Director of Nurse ' s) R8 ' s urinary drainage bags with tubing were noted touching the floor. When E9 was asked about the urinary drainage bag tubing E9 stated in part that they are not suppose to be on the floor for infection control purposes. E9 then picked up the bag and did hang it on the side of R8 ' s bed.
On 4/11/16 during the same initial tour at approximately 10:15am R7 was noted in the room in bed with urine drainage bag hanging without privacy covering and exposed where anyone in the hall way can visually see the drainage bag. E9 stated the urine collection bag should be placed in a privacy bag.
The facility quality of life on Dignity policy documents in part that each resident shall be

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cared for in a manner that promotes and enhances quality of life that includes but not limited to dignity. This guideline was not followed.

During initial tour of the facility on 4/11/16 at 9:41am R4's entire Indwelling Catheter Drainage bag is on the floor and unattached to bed. E11 (Unit Manager) states, "R4 is a fall risk and we can't raise the bed to keep the bag off the floor so we put it in a protective bag." When E11 was asked if this is sanitary or if this practice posed potential of pulling out the Indwelling Catheter , E11 states, "I guess it shouldn't be on the floor", and proceeded to secure the bag on the rail of R4's bed.

On 4/12/16 at 9:50am R4's family states that R4's catheter bag is being place in a pillow case on the back of R4's wheelchair above R4's bladder. R4's family continue to verbalize that a report was made with E9 ADON (Assistant Director of Nursing). Review of the concern log, incident report and progress notes of R4 from admission to current is without any mention of R4's families concerns about the placement of R4's indwelling catheter bag.

At 3pm on 4/12/16, E2 DON (Director of Nursing) was asked if the above situation was presented regarding R4's indwelling catheter, and E2 states, " Yes I remember, I think we gave the concern to E11, the unit manager. We did an investigation and made sure that R4's catheter is placed in a privacy bag."

On 4/13/16 at 10:10am the facility presented a concern feedback form with statement from

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F 315	Continued From page 9 involved CNA (Certified Nursing Assistant) that states that no privacy bag was available during time of care. Documents further indicate that inservices were being done on 4/4/16 to educate staff on placement and maintaining dignity with urinary catheters. Facility policy dated 2010 indicate that the urinary drainage bag should be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage from flowing back into the urinary bladder.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to properly store and serve food under sanitary conditions , failed to ensure the concentration of sanitizer in sanitizing bucket, dishwashing machine and the three compartment sink, label and date foods, monitor food temperatures, failed to maintain kitchen equipment in sanitary condition. These failures have the potential to cause food borne illness for all 140 residents receiving oral	F 371		

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diets in the facility.
Findings include:
On 4/11/16 at 9:43 am, during the initial tour of the kitchen accompanied by E4, Dietary Supervisor, observed a red bucket that E4 identified as a " sanitizer bucket " . E4 used a test strip to check the concentration of quaternary sanitizer in the red sanitizer bucket. The result was 100 ppm (parts per million). E4 was asked how many ppm should the sanitizer be in the sanitizing bucket. E4 stated, " It should be from 150-400 ppm. " E4 used a test strip to check the concentration of quaternary sanitizer in the three-compartment sink. The test strip read " 100 ppm (parts per million) of quaternary sanitizing solution. E4 was asked what should the level of sanitizer be in the three compartment sink. E4 stated, " It should be around 150-400 ppm. " Continuing the initial tour with E4, observed inside the reach in refrigerator a tray holding (2) six-eight ounce cups of dark purple liquid which E4 stated were prune juice, (3) six-eight ounce cups of whitish liquid which E4 which E4 stated was a supplement, (18) six-eight ounce cups of yellowish colored liquid which E4 stated was apple juice. E4 was asked what is the facility policy for labeling and dating food opened from the original container. E4 stated " We usually put the label on the lip of the tray. Continuing the initial kitchen tour observed an approximately sixteen ounce white Styrofoam cup half filled with a red liquid sitting on top of the uncovered mobile steam table. E4 was asked if it is acceptable to store the cup on top of the portable steam table. E4 stated, " One of these guys (staff) must have left it there but we are not using it today, we use it for parties on the units. " Continuing the initial tour of the kitchen, E4 was asked to test the level of chlorine sanitizer in the low temperature dish

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machine. The testing strip reading was 0 ppm.
On 4/12/16 at 10:55am, during a kitchen observation of food preparation for lunch service, accompanied by E21 cook, observed the large stand mixer stained with dried food particles and brown colored debris. E21 stated, " It should be clean. "
Continuing the observation of food preparation for lunch service E4 Dietary Supervisor was asked when food temperatures are taken during meal service. E4 stated, " We take temperatures when the food is placed on the steam table for serving the individual plates. " E4 was asked if food temperatures were taken at any other time. E4 stated, " We only take temperatures one time. "
On 4/13/16 at 12:30pm during the lunch meal services R25 was asked if R25 ' s lunch was hot enough. R25 stated, " No this is cold. "
Observed R25 did not eat the entrée portion of the meal that should have been hot. R25 refused a replacement meal. R2 also complained of cold food. R2 stated, " The food is always cold. " R2 did not eat the lunch entrée. Observed E4 obtain food temperature on the lunch entrée for R26. The thermometer reading result was 122 degrees Fahrenheit.
A review of the facility policy dated 1/1/16 and titled " Sanitizing Buckets " indicates in part: " 3. Test solution to ensure ppm ' s are between 150 and 500. "
A review if the facility policy dated 1/1/16 and titled " Serving Food " indicates in part: " Foods should be maintained on the serving line outside the danger zone (below 40 degrees Fahrenheit or above 135 degrees Fahrenheit. "
A review of the facility policy dated 1/1/16 and titled " 3 Compartment Sink Procedure " indicates in part: " ... Quat (Quaternary) testing strip paper should rad between 150 and 400ppm.

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F 371	Continued From page 12 " A review of the facility policy dated 1/1/16 and titled " Policy for dating and Labeling Foods " indicates in part: " 2. Once food is opened, the item is to be dated with open date. 3. If item is removed from original container, it must be labeled with what the product is. " A review of the facility policy dated 1/1/16 and titled " Ware Washing Procedure- Conveyor (Low Temp) " indicates in part: " strip should read at a minimum of 50 ppm to a maximum of 100 ppm. " A review of the facility policy dated 1/1/16 and titled " Procedure for Cleaning Mixers, Food Processors, Slicers to be completed after each use. " " Wash base of machine with warm soapy water. " A review of a statement dated 4/12/16 and signed by E4 indicates dishwashing machine company service person recommended replacing the sanitizer solution. "	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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F 431	Continued From page 13 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, interview and record review the facility failed to properly store drugs and biologicals. The facility failed to remove outdated or expired medication from the active medication supply. These failures have the potential to affect one resident (R5) in the sample, 1 of 1 residents reviewed; and seven residents in the supplemental sample (R31, R34, R35, R36, R37, R38), receiving intravenous therapy in the facility. Findings include: On 4/11/16 at 11:00am during the initial tour accompanied by E5 Unit Manager, observed (16) expired 1000 milliliter intravenous fluid bags labeled D 5%/ 0.45 NACL as follows: March 2015- (3) bags April 2015- (6) bags October 2015- (1) bag	F 431		

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F 431	Continued From page 14 November 2015- (1) bag December 2015- (5) bags E5 was asked who is responsible for making sure that expired meds are removed from the supply room. E5 stated, "The nurses who stock the supply room are responsible to make sure no expired supplies are in the supply room." A review of the facility policy with a revised date of April 2007 and titled, "Storage of Medications" documents: " 4. The facility shall not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. "	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. (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	F 441		

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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, interview and record review the facility failed to follow infection control practices with hand hygiene with resident care and maintenance of resident equipment for three (R4, R8, R12) of four residents reviewed in the sample of 24, and one resident (R31) in the supplemental sample.

Findings include:

On 4/13/16 at 11:10am E7 (Wound Tech) enters R4's room with gloves on and starts removing R4's wound vacumn dressing with dirty gloves. Once E7 removed the old dressing, the tip to the suction tubing is not covered and placed inside of the side of the bag containing the suction equipment, hand hygiene is performed and new gloves applied. With gloved hand E7 opens the package containing the wound sponge and drops it onto the bedside table that's covered with a blue pad. E7 cuts pieces of the black sponge and packs the sponge into the open wound with depth

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on R4's right femoral region using the same contaminated gloves. When E7 is questioned as to what technique should be used during dressing change of open wounds, E7 states, "I use clean technique because you can only use sterile technique in surgery." Once the dressing was complete, E7 reconnected R4's clean tubing to the contaminated tube removed from the bag holding the suction machine without any aseptic technique being performed.

At 4:04pm on 4/13/16 E9 ADON (Assistant Director of Nursing) states, "Clean technique should be followed with wound care. If gloves are contaminated they should be removed and hand hygiene completed before applying new gloves. The dirty gloves should have been taken off."

Facility policy for "Personal Protective Equipment-Using Gloves", dated 2010 indicate that gloved hands should not be used to open packages, and hand hygiene is to be performed before applying gloves.

On 4/11/16 at approximately 10:05am, during initial tour with E9 ADON (Assistant Director of Nurses) R8 was noted in bed with wound vacuum noted in use and the tubing to the vacuum was noted touching the floor. When E9 was asked about the tubing placement concerning infection control prevention, E9 replied, "It should not be placed on the floor for infection control purposes. On 4/13/16 at 9:45am, E12 CNA (Certified Nurse's Aide) was noted rendering morning care to R31 with gloved hands. After touching R31's feet and adjusting the socks that had touched the floor, E12 did not remove the soiled gloves but proceeded to apply lotion to the soiled gloves and

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F 441	Continued From page 17 applied it on R31's hair. When asked about infection control hand washing, E12 acknowledged that she should have removed the gloves and wash her hands. On 4/11/16, 4/12/16 and 4/13/16, three days of the survey the facility did not provide the policy on wound vacuum machine care.	F 441		
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: Based on observation, interview and record review the facility failed to ensure that the environment is clean, functional and free of potential hazards and in good repair condition. This has the potential of affecting all 140 residents in the facility. Findings include: During the environmental tour on 4/12/16 between 10:30am and 12:00pm, the following observations were made with E3 (Assistant Administrator), E15 (Housekeeping Director), E14 (Maintenance Director). On the 200 unit hallway closet, the two closet door knob covers were noted loose with sharp edges, E3 (Assistant Administrator), and E14 (Maintenance Director) acknowledged it should have been corrected for safety issues. In rooms 301 and 500 back unit, the call light bulbs located outside the door in the hallway did not light up when pulled to alert staff. E3	F 465		

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F 465	Continued From page 18 (Assistant Administrator), stated in part that they must be burnt and should be replaced. In the 300 unit common shower room soiled towels were noted on the bare floor and hanging on the toilet seat grabs bars. In the 500 back unit area common shower room soiled towels were located on the toilet seat grab bars and on the floor. And on the 500 suite unit area common shower room two inches by four inches tiles were missing on the base wall area. E14 (Maintenance Director), stated in part that (E14) (Maintenance Director) was not aware of what happened but it will have to be repaired In rooms 101,118, 120, 421 and 532 the privacy curtains were missing and these rooms have multiple residents residing in them. E14 (Maintenance Director), stated it will be corrected, "I did not see that before now, it makes sense for each resident to have it (Referring to the privacy curtain)." In the laundry room the chemical storage closet door was left open andunlocked; the metal gate door left open and not visible to laundry aide staff. E15 (Housekeeping Director), stated in part that the metal door should have been locked. On 4/13/16 at 11:50am, E3 (Assistant Administrator), acknowledged that the door to the closet should have been locked " we put a padlock on it and I believe that it's to be locked. " E3 (Assistant Administrator), further presented a procedure documentation titled "Job to Be Done: Care of Storage Area and Janitor Closets", dated 1/1/2000 that documented in bold letters "always lock door."	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to maintain accurate, complete and organized clinical information for one resident (R4) of three residents reviewed for accurate clinical records, in a sample of 24, and one resident (R32) in the supplemental sample.

Findings include:

On 4/12/16 at 9:50am R4's family states that R4's catheter bag is being improperly placed on the back of R4's wheelchair in a pillow case above R4's bladder. R4's family continues to verbalize that a report was made with E9 ADON (Assistant Director of Nursing). Review of facility concern log, incident reports, and R4's progress notes is without any documentation of the incident.

At 3pm on 4/12/16, E2 DON (Director of Nursing) asked if the above situation was presented regarding R4's indwelling catheter, and E2 states, "Yes I remember, I think we gave the concern to E11, the unit manager. We did an investigation

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and made sure that R4's catheter is placed in a privacy bag."

On 4/13/16 at 10:10am the facility presented a " concern feedback form " with a statement that involved, E27, CNA (Certified Nursing Assistant) states that no privacy bag was available during time of care. Documents further indicate that inservices were being done on 4/4/16 to educate staff on placement and maintaining dignity with urinary catheters with attached concern feedback form dated 4/2/16.

On 4/12/14 during review of R4's Physicians Telephone order sheet dated 3/31/16, R4's was to receive a wound care Consult from Z1 (Physician). Review of Physician orders from 3/30/16-4/11/16, and R4's medical record is without any indication that Z1 was notified of the wound consult order to see R4, and also no documentation that Z1 has seen R4.

At 1:04pm on 4/12/16 E2 DON (Director of Nursing) states, "There's no notes in the computer or the chart from Z1. Z1 hasn't seen this resident (R4).

Records indicate that no effort was made to address the consult for R4 until 12 days later, and that R4 will not be seen by Z1 until a scheduled appointment date of 4/19/15 per outpatient appointment record received from E2 on 4/12/16 at 4:19pm.

On 4/14/16 at 10:44am E2 states, "It's nothing written about when orders should be taken off, but my staff had training and know that orders should be taken off as soon as the orders are written. Staff was trained in the orientation."

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Received Telephone order policy on 4/14/16/at 10:44am when routine order policy requested. Telephone order policy dated 2008 does not address routine orders or implementation of orders.

At 1:57pm on 4/14/16 E2 presented an inservice sheet indicating that the night shift nurse is responsible for reviewing residents ' orders to ensure that they are carried out. Further indicate that orders should be carried out by the end of the shift. The facility failed to present the reason for the delay in R4 seeing the consultant in a timely time.

On 4/12/16 at 8:40 am, E22 LPN (Licensed Practical Nurse) was observed administering medication to R32. During preparation of R32's medication, E22 stated, I can't give the Protonix because it says 4mg (milligrams) on the MAR (Medication Administration Record). We only have Protonix 40mg available.

R32's MAR documents Protonix 4mg. Protonix 4mg is initialed as given from the dates 4/1/16-4/11/16 by various nurses.

Review of R32's current Physician's Orders indicates an order for Protonix 40 mg.

E5 (Registered Nurse-Unit Manager) stated on 4/12/16 at 9:05 am, that R32's medication order is actually for Protonix 40 mg, not 4 mg (as indicated on the MAR). The night nurses are responsible for doing the chart audits and double checking if the orders are transcribed correctly.

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F 514	Continued From page 22 On 4/13/16 at 10:25am, E2 DON (Director of Nursing), stated, "I interviewed the nurses regarding R32's order for Protonix. E2 stated that the nurses gave 40mg instead of 4mg, but the MAR was not accurate." E2, DON (Director of Nursing) stated on 4/14/16 at 12:02pm, when the nurses receive the order, they transcribe the order on POS (Physician Order Sheet) and then onto the MAR. The night nurses check the orders and MAR to make sure they are accurate. On 4/14/16 at 1:45pm, E2 stated, depending on the medication, there is potential harm with writing the wrong medication dose on the MAR. Review of Guidelines for Medication Reconciliation presented by E2, DON (Director of Nursing) indicate: "6.) Night shift nurses will audit all orders to ensure all orders are carried out accurately."	F 514		