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ROCK FALLS REHAB & HLTH CARE C	430 MARTIN ROAD ROCK FALLS, IL 61071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint Investigation # 1513914/IL78784 - No deficiencies	F 000		
F 164 SS=E	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. 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:	F 164		

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

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F 164	Continued From page 1 Based on observation, interview, and record review the facility failed to provide privacy by not pulling the curtain during resident cares, not knocking prior to entering, and yelling resident personal health information down the hall. This applies to 3 of 10 residents (R2, R4, R8) in the sample of 10 reviewed for privacy and 13 residents (R11-R23) in the supplemental sample. The findings include: 1. On July 21, 2015 at 11:00 AM E12 (License Practical Nurse-LPN) yelled to E11 (Certified Nursing Assistant-CNA), whom was at the opposite end of the hallway, "Did R12 have loose stools?" E11 yelled back, "Not today, he didn't yesterday either." On July 21, 2015 at 3:25 PM, E2 (Director of Nursing-DON) stated, "I expect the staff to walk down the hall and talk to the CNA and ask if the resident had loose stools." E1 (Administrator) stated, "We have a problem with staff yelling across rooms. The staff need to get up and move across the room to ask their questions." The facility's Notice of Privacy Practices (undated), shows "Resident has the right to receive confidential communications and is required by law to maintain the privacy of your health information." The facility's Employee Confidentiality Agreement dated March 3, 2009, shows "As an employee I am aware that persons, conversations, material, information, and data are to be treated in a confidential and professional manner at all times. Confidential information regarding residents will	F 164		

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F 164	Continued From page 2 not be disclosed to any person, entity or agency without the express written permission of the resident." 2. On July 20, 2015 at 1:35 PM, E11 (Certified Nursing Assistant-CNA) removed R11's incontinence brief and provided peri care without pulling the privacy curtain. On July 21, 2015 at 3:50 PM, E2 (Director of Nursing) stated, "Staff should pull the curtain for privacy when providing cares that expose a resident." The facility's Beginning and Completion Tasks privacy is to be provided to the resident, curtains are to be closed prior to attending to cares and open upon completion of cares. The facility's Perineal Care Checklist (undated), shows to "Cover the resident appropriately to avoid exposure and maintain dignity". 3. During the group interview on 7/20/15 at 1:30 pm involving R2, R4, R8, R13-R23 it was stated that staff do not always knock before entering resident rooms and staff discuss resident's medical care where other resident can hear. An undated document entitled, "Long Term Care Facilities Resident Rights" under privacy shows, "Facility staff must knock before entering resident's rooms. Your (Residents) medical and personal care are private."	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to	F 221		

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F 221	Continued From page 3 treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to have a physician's order for the use of a restraint, offer periods of release during supervision, failed to obtain a consent, and failed to have a medical symptom that warrants the use of the restraint. This applies to 1 of 1 resident (R6) reviewed for restraints in a sample of 10. The findings include: On July 20, 2015 at 11:30AM, R6 was in the assisted dining room in her wheel chair with a seat belt restraint and chair alarm attached. R6 was leaning to the right. The July 2015 Physician's Order Sheet shows, R6 was admitted to the facility on April 25, 2013 with diagnoses to include: Alzheimer's Disease, Unspecified Psychosis, Anxiety State. There was no order for the use of the seat belt or times for release. On July 22, 2015 at 8:10am, E4 (MDS coordinator) said, "R6 was admitted with the restraint. We tried a couple of times to take it off/reduce it. She is a fall risk that's why she has it, she fell at home. (R6's) daughter really wants it. The belt is released. They do unlatch it (belt) at meal times." The Minimum Data Set (MDS) dated 5/20/15 shows, R6 has severe cognitive impairment. R6	F 221		

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F 221	Continued From page 4 did not walk during the assessment period and a trunk restraint is used daily. R6's care plan dated 5/19/15 shows, "Self-release belt is used for position safety. An approach included: "Self-release belt is released every 2 hours, resident is observed. A personal alarm is on while belt is off." The Occupational Therapy Note dated January 27, 2015 shows R6's current level of function: "Patient has self-releasing seat belt in w/c (wheelchair), but unable to release on command." The Occupational Therapy Note dated March 19, 2015 shows, "Staff instructed to release seat belt during meals or transfer patient to a dining room chair during meals." On 7/20/15 at the noon meal, E14(CNA), E5 (Licensed Practical Nurse-LPN) and E2 (Director of Nursing-DON) alternated feeding R6 lunch. R6's seatbelt was not released. On 7/21/15, E14 (CNA) fed R6 breakfast and E8 (CNA) fed R6 lunch. R6's seatbelt was not released for either meal. On 7/22/15 at 8:05 am, E11 (CNA) fed R6 breakfast. R6's seat belt was not released during the meal.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

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F 225	Continued From page 5 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure staff immediately report and thoroughly investigate all allegations of abuse. This applies to 3 residents (R17, R18 and R23) in	F 225		

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the supplemental sample reviewed for abuse.

The facility's Reportable Log for 2015 was reviewed for abuse investigations.
The facility abuse investigations reviews show the following:

On July 14, 2015 at 3:15 PM, R18 called R17 a " cracker a**, mother f***** " . E1 (Administrator) was notified July 15, 2015 at 9:15 AM.

On June 21, 2015, R18 bumped his wheelchair into R23. R23 called out racial slurs towards R18 and struck R18. R18 then struck R23. The facility was not able to locate the abuse investigation.

On July 22, 2015 at 11:00 AM, E1 stated she was the abuse prevention coordinator. E1 stated that she expects to be notified immediately of any allegations of abuse. E1 stated she should have been notified on July 14, 2015 of the abuse allegation not the next day. E1 stated that she was not able to find the abuse investigation for the incident occurring on June 21, 2015. E1 stated that a thorough investigation including witness statements and conclusions needs to be done with all allegations of abuse.

On July 22, 2015 at 4:30 PM, the facility provided R23's statement. The facility was not able to provide any other evidence of an investigation being done for the incident occurring on June 21, 2015.

On July 23, 2015, the facility provided R18's statement (undated).

The facility's Abuse Prevention Program dated March 5, 2009, shows employees are required to

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F 225	Continued From page 7 immediately report any occurrences of potential/alleged mistreatment they observe, hear about or suspect to a supervisor or the administrator. Supervisors shall immediately inform the administrator or designee of all reports of potential/alleged mistreatment. Upon learning of the report, the administrator or designee shall initiate an investigation. The final investigation report shall include the name age, diagnosis and mental status of the resident allegedly abused or neglected, the original allegation, facts determined during the process of the investigation , review of the medical record and interview of witnesses, conclusion of the investigation based on known facts ... summary of all interviews conducted .... And willingness to testify.	F 225		
F 241 SS=D	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 interview and record review, the facility failed to treat a resident with dignity by not speaking in a respectful manner. This applies to 1 of 9 residents (R4) reviewed for dignity in a sample of 10. The findings include: On July 20, 2015 at 1:30 pm, during the group	F 241		

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meeting, when residents were asked how the facility staff treat the residents, several residents commented that "R4 got yelled at by E3 (Food Service Supervisor-FSS) in the dining room." R4 said, "It upset me. I felt like a little kid."

A typed document entitled R4's statement shows, "On July 6, 2015, R4 told E3, "the eggs taste like charcoal." R4 said, "Just try them." E3 (FSS) said, "I'm not going to taste your eggs. I'll take your word for it." E5 (LPN) came over and said, "Let's take this outside." E3 didn't want to go outside. E5 put her hand on E3's shoulders. That made E3 upset. R4 said, E3 pushed E5's hand off her. E3 said, "Don't touch me!" This typed statement was not signed by R4.

On July 20, 2015 at 10:30AM, E7 (LPN) said, "On July 6, 2015 the kitchen was short on staff and didn't have enough food. E3 was called in. E3 said to R4, "What's going on R4?" R4 said to E3, "Can you try the eggs? E3 yelled at R4, "I'm not trying those eggs!" E5 (LPN) tried to take E3 outside and E3 said, "Get your f**king hands off me." R4 came up to me later, and he was in tears about what had happened. Xanax (anti-anxiety) was prescribed because of the incident."

On July 20, 2015 at 2:10pm, E5 (LPN) said, "On July 6, 2015 there was no hot cereal for breakfast. Dietary personnel had only had 3 days of training. I called E3 (Food Service Supervisor) in to help in the kitchen. R4 said the eggs tasted nasty. E3 looked at R4 and yelled at him. What do you want me to do about it. I tried to guide her outside and she said, "Get your f**king hands off of me! R4 was shaking he was so upset."

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F 241	Continued From page 9 On July 21, 2015 at 2:05pm, E6 (Business Manager) stated, "R4 was upset about his eggs not tasting right. When E3 was first approached by R4 she said, "What?!" "I'm not trying those eggs!" E3 raised her voice and was rude to R4. E3 acted like it was a bother to respond to R4."	F 241		
F 248 SS=E	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 a meaningful, variety of activities to meet the needs of the residents, failed to provide/offer evening activities or have activities on the weekends, failed to assess resident activity preferences and failed to follow the planned activity calendar. This applies to 4 of 9 residents (R2,R4, R6, R8) reviewed for activities in a sample of 10 and 11 residents (R13-R23) in the supplemental sample. The findings include: During the group interview on July 20, 2015 at 1:30 pm involving R2, R4, R8, R13-R23, it was stated that there is not much to do and they do not know what activities are going on. R22 said,"My wife died about 2 months ago. I don't have any relatives that visit me. There is nothing	F 248		

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to do. I am glad that I have a computer." R18 said, "I would like to go to [local store] just to get out, or go for a walk outside."

The activity calendars for June and July 2015 shows the same activities listed every week. The calendars show the daily activities occur at 10am/10:30AM/11:00 am or 2:00 pm. The activity calendars for April, May, June and July 2015 show "Movies, Puzzles and Games" as the activity every Saturday and Sunday. The months of April, May and July have 1 activity after 2 pm. The month of June has no activities after 2:00 pm.

On July 21, 2015 the activity calendar shows 10:00 am, Healthy Living; 11:00 am, Music Therapy and Bingo at 2:00 pm. The 10:00 am and 11:00 am scheduled activities did not occur. During these times, residents were sitting in the main dining room or assisted dining room asleep in their wheel chairs or at the tables. There were no snacks or beverages offered, the television was off and there was no music playing. Only residents that could serve themselves could get coffee. At 10:05 am, R22 was walking around the facility with his hands in his pockets asking for something to do. At 10:40 am, R18 said, "E9 (Activity Director) talked about a walk today. I want to go see if we can go outside." E9 said to R18, "I would feel safer if you walked inside right now. You are on a walk to dine program. I don't want you to get over exerted outside."

On July 22, 2015, the only scheduled activities was bible study/church. One beginning at 10:00 am and the other beginning at 2:00 pm. There were 2 residents in the 10:00 am bible study and 3 residents in the 2:00 pm church service. There

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was no other activities for
those who did not go to the church services. The television was on in the main dining room and played "infomercials". Residents were asleep at the tables or in their wheel chairs. There were no snacks or beverages offered.

R2 only had 2 activity progress notes. The note on July 16, 2015 that documents, "Resident complains she feels ignored." The note for July 20, 2015 shows, "R2 stated her concerns about activities again...she said she wants to do more things she likes and wants to go shopping more."

R6's last activity assessment was dated 12/10/14 and shows R6's interest as: showers, snacks and music. On July 21, 2015, R6 was wheeled into the assisted dining room or in the main dining room asleep in her wheelchair.

The facility was unable to provide any current resident activity assessments.

On 7/22/15 at 1:40 pm, E9 said, "I have been here [at the facility as Activity Director]since Memorial Day. I went to another facility for training and I used the past activity calendars from the previous activity director. I am trying to get all the paperwork done. E4 (MDS coordinator) is going to help me with the documentation. E4 completes the resident participation and interest levels. My hours are Monday through Friday from 8:30AM to 4:30 pm. There is no one here on the weekend to do activities." E9 said she would have to leave early and come back later to do activities in the evenings. E9 said R18 hasn't been to the [local store] because he doesn't have the money. E9 said she has had no formal training to be an

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F 248	Continued From page 12 activity director.	F 248		
F 282 SS=D	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 observation, interview, and record review the facility failed to administer a physician ordered medication per R24's plan of care. This applies to 1 of 12 residents (R24) observed in the medication pass. The findings include: On July 20, 2015 at 12:00 PM E7 (Licensed Practical Nurse-LPN) did not give R24 his scheduled cabidopa-levodopa. E7 stated, "We are out of medication cards for R24's carbidopa-levodopa. R24 last got carbidopa-levodopa yesterday am. The medication has been ordered." R24's left hand was shaking while he was sitting in his chair waiting for his medications. On July 21, 2015 at 8:00 AM, R24's hands and right leg were shaking while he was sitting in a chair by the nurses station waiting for his medications. R24's physician order sheet dated July 1, 2015 to July 31, 2015 states, "Diagnosis: Traumatic brain	F 282		

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F 282	Continued From page 13 injury. Medication: Carbidopa-Levodopa 25-100 take one tablet by mouth three times daily". On July 21, 2015 at 8:30 AM, E12 (LPN) stated, "R24 has missed his carbidopa-levodopa since Sunday July 19, 2015 at noon. Carbidopa-levodopa is not in the convenience box." R24's medication administration record states R24 did not receive carbidopa-levodopa at 12:00 PM or 8:00 PM on July 19, 2015 and at 8:00 AM, 12:00 PM, and 8:00 PM on July 20, 2015.	F 282		
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, interview and record review the facility failed to prevent the development of a pressure ulcer in a resident assessed at moderate risk for skin breakdown and implement pressure relief interventions. This applies to 1 of 3 residents (R3) reviewed for pressure ulcers in the sample of 10. The findings include: R3 was admitted to the facility on March 1, 2014	F 314		

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F 314	Continued From page 14	F 314		

with diagnoses including Parkinson ' s, frequent falls and osteoarthritis. The Minimum Data Set (MDS) dated May 22, 2015, shows R3 requires extensive assistance with transfers and bed mobility. R3 is totally dependent with ambulation in the hallway. R3 ' s care plan (undated), shows R3 has impaired mobility and fragile skin (prone to bruising and/or skin tears) related to Parkinson ' s, diabetes and frequent falls. R3 ' s care plan interventions include turning and repositioning per the resident ' s reposition schedule.
On July 20, 2015 at 11:50 AM, R3 was sitting in main dining room awaiting lunch. R3 received his lunch tray at 12:20 PM. At 12:45PM resident remained seated at the dining room table. R3 stated he had finished his lunch and was ready to go back to his room. R3 stated he had to wait for the aides to take him to his room. At 1:30PM, E14 (Certified Nursing Assistant- CNA) placed a gait belt around R3 and walked next to R3 as he ambulated with a four wheeled walker to his room. E14 assisted R3 to the toilet. R3 had an occlusive dressing on each buttock. E14 stated that R3 had two open areas and was prone to breakdown. E14 assisted R3 to his recliner. A one inch gel cushion was on the seat of the recliner with a folded bed sheet on top of the gel cushion. R3 stated he was aware of the two open areas on his buttocks. R3 stated that he spends the majority of his day in his recliner. R3 stated he does not like to lie down during the day because it is very difficult to reposition himself in the bed because of the mattress. R3 stated he had a rail on his bed at home that enabled him to reposition himself. R3 stated if he had a rail he could turn himself and would lie down after lunch. R3 stated he was told by the nurses that he could not get up by himself and had to call for the aides. R3 stated " sometimes I sit so long that I sweat down there

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F 314	Continued From page 15 (buttocks). " R3 stated he wished he could walk more at the facility. R3 stated he was an avid walker prior to coming to the facility. E14 stated she was not aware of a turning and repositioning schedule for R3. On July 21, 2015 at 8:15 AM, R3 was sitting at the table in the dining room. His breakfast dishes were empty. E9 (Activity Director) was sitting at the next table talking to a resident. R3 stood up and sat down three times. R18 approached R3 and stated " R3 you are going to fall. " R3 replied " I got to find someone to walk me home. " R18 replied, " someone will come it takes time. " E9 glanced over at R3 and R18 and then returned her attention to the resident at the table. At 8:20 AM, E8 (CNA) assisted R3 to his room. On July 20, 2015 at 1:00PM, E5 (Licensed Practical Nurse) stated R3 had two open areas on his buttocks that were discovered over the weekend. E5 stated R3 was prone to skin breakdown because " he refuses to get out of his recliner. " On July 21, 2015 at 1:20PM, E4 (MDS Coordinator) stated she notified R3 ' s physician on July 20, 2015 and received treatment orders. E4 stated R3 likes to sit a lot and does not like to get into bed. On July 21,2015 at 9:30 AM, E2 (Director of Nursing) stated R3 sits in his chair for hours at a time and refuses to get out of his chair. E2 stated that R3 does not like to walk. R3 ' s wound documentation dated July 13, 2015, showed R3 had stage 1 pressure ulcers to the right and left buttock. R3 ' s wound documentation dated July 17, 2015 shows R3 has open areas measuring 1.0x1.0x 0.1 cm on the right and left buttock. An occlusive dressing was applied to each area.	F 314		

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F 314	Continued From page 16 R3 ' s Braden Scale for Predicting Pressure Ulcer Risk dated May 9, 2015 shows R3 is at moderate risk for skin breakdown and interventions in use are pressure reducing cushion for chair and bed and a turning and repositioning program. R3 ' s care plan (undated) does not address R3 ' s risk for skin breakdown or refusal of getting out of his chair. The facility ' s Pressure Sore Prevention Guidelines dated November, 2012, states residents scoring high or moderate risk for skin breakdown will utilize pressure sore guidelines. Turn and reposition every two hours ... care plan entry with skin risk and appropriate interventions are to be placed on the care plan ... If despite interventions a pressure sore develops, the care plan must reflect updated interventions for healing of ulcers and additional interventions for further prevention of pressure ulcers.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		

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F 322	Continued From page 17	F 322		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to keep a resident's head of bed elevated while receiving tube feeding and failed to provide the tube feeding for the duration as ordered by the physician.

This applies to 1 of 1 resident (R1) in the sample of 10 reviewed for tube feeding.

The findings include:

R1's Physician Order Sheet dated July 1, 2015 to July 31, 2015 states, "Diagnosis: Multiple Sclerosis, Dementia, Spastic Quadriplegia, G-tube, and Aspiration Pneumonia. Diet orders: Jevity 1.2 At 75 ML/HR per G-Tube X 23 hours."

On July 20, 2015 at 10:00 AM, R1's head of bed was elevated less than 20 degrees and tube feeding was infusing via Gastrostomy tube (G-tube).

On July 21, 2015 at 9:15 AM, E12 (Licensed Practical Nurse-LPN) stated, "I am going to put his head up, I don't think that looks like 30 degrees."

On July 21, 2015 at 10:50 AM R1's head of bed was not elevated to at least 30 degrees and the tube feeding was infusing. E12 stated, "His head of bed is flat but the aides probably did it to

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F 322	Continued From page 18 change him." On July 21, 2015 at 11:00 AM, 11:50 AM, 12:25 PM, 1:42 PM, 3:30 PM, and 4:20 PM, R1's tube feeding was not infusing. At 4:20 PM E12 stated, "I don't know why R1's tube feeding is not running. R1's tube feeding should be running." On July 21, 2015 at 1:58 PM E12 stated, "R1 is on antibiotics for Pneumonia." On July 22, 2015 at 2:40 PM E2 (Director of Nurses), stated, "I do not know why R1's tube feeding was not running on July 21, 2015. If it is ordered to run 23 hours, it should be running for 23 hours." R1's care plan signed July 22, 2015 states, "See Physician Order Sheet for current diet continuous tube feed, be sure head of bed is elevated at all times." The facility's Policy on Tube Fed Residents revised October 2013 states, "Continuous tube feedings shall be calculated to run for 23 hours per day unless otherwise ordered, to allow for down time for medication administration, water flushes, repositioning, toileting, bathing, etc."	F 322		
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:	F 332		

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Based on observation, interview, and record review the facility failed to administer medications as ordered.

There were 32 opportunities with two errors resulting in a 6.25% error rate.

This applies to 2 of 12 residents (R5 and R24) observed in the medication pass.

The findings include:

1. On July 21, 2015 at 9:00 AM, E12 (Licensensed Practical Nurse-LPN) administered Advair 250/50 via inhalation to R5. E12 stated, "I am giving her advair 250/50."

R5's diagnoses include: Chronic obstructive pulmonary disease and sleep apnea.

R5's physician order sheet dated July 1, 2015 to July 31, 2015 states, "July 14, 2015: Increase advair to 500/50 one inhalation twice daily."

On July 22, 2015 at 2:03 PM, Z1 (Local pharmacy technician) stated, "There are 60 doses in an Advair diskus."

On July 22, 2015 at 1:45 PM R5 had Advair 500/50, dispensed July 14, 2015 with directions on the label that read, "administer twice daily". There was 56 puffs remaining. There was also Advair 250/50 with 53 puffs remaining in her medication drawer.

On July 22, 2015 at 2:40 PM E2 (Director of Nursing-DON) stated, "I would expect the nurse to look at the medication she is administering. When a medication is discontinued we keep the

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F 332	Continued From page 20 discontinued medication in case the new dose does not work. I know the advair doses do not match up. I also tried to figure it out. I gave the right dose this morning." 2. On July 20, 2015 at 12:00 PM, E7 (Licensed Practical Nurse) did not give R24 his carbidopa levodopa 25-100. E7 stated, "We are out of medication cards for his medication. His last dose was July 19, 2015 in the morning. It has been ordered." R24's medication administration record states that he did not receive carbidopa levodopa at noon or at 8:00 PM on July 19, 2015 and did not receive any of the three scheduled doses on July 20, 2015. The facility's Medication Administration policy revised on July 3, 2013 states, "Medications must be identified by using the six rights of administration: Right resident, right drug, right dose, right time, right route, and right documentation. When preparing medication for administration, check the label of the drug container at minimum three times for safety and accuracy."	F 332		
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	F 371		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to store and label thawing meat in the refrigerator to prevent cross-contamination. The facility failed to label and thaw lunch meat in the refrigerator. The facility failed to secure and label an open bag of beef patties in the freezer.
This applies to all 37 residents.
The findings include:
The CMS 672 (Resident Census and Condition Sheet) dated 7/20/2015 shows a census of 37.
On July 20, 2015 at 9:55AM, a tube of ground beef was on the bottom shelf of the refrigerator, undated, unlabeled and not on a tray. Meat juices were leaking from the tube and were inches from cross-contaminating produce on the same shelf. E3 (Dietary Supervisor) was asked if this is how they normally thaw meat stated " No, it should be on a tray. We have a lot of new people here. " Three packages of undated frozen lunch meat were on the kitchen counter. An unsecured, unlabeled bag of beef patties were in the freezer.
On July 20, 2015 at 1:10PM, the three packages of lunch meat (as above) were still on the kitchen counter. The packages were wet and not completely thawed.
Facility Refrigerator and Freezer Storage policy dated October 2014 reads, "It is the policy of (this facility's Corporation) that any item to be placed in the refrigerator and freezers must be covered, labeled and dated with a date-marking system that tracks when to discard perishable foods. " Policy further states "Place meats for

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F 371	Continued From page 22 thawing in a pan and store on the lowest shelf in the refrigerator. Label with the date the item was removed from the freezer and the thawing process started." Policy further states "When using only part of a product, the remaining product should be in the original package or air tight container and labeled and dated. "	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a residents scheduled medication was available.	F 425		

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F 425	Continued From page 23 This applies to 1 of 12 residents (R24) reviewed for medication administration. The findings include: On July 20, 2015 at 12:00 PM R24 did not receive his 12:00 PM dose of carbidopa-levodopa (anti-Parkinson's medication). E7 (Licensed Practical Nurse) stated, "We are out of medication cards for his medication." On July 21, 2015 at 8:30 AM, E12 (Licensed Practical Nurse) stated, "R24 has missed his carbidopa-levodopa since Sunday at noon. Carbidopa-levodopa is not in the convenience box." On July 21, 2015 at 3:50 PM E2 (Director of Nursing-DON) stated, "[Local pharmacy] is our back up pharmacy. Omnicare pharmacy has a courier that drops of medication or one of our staff members could pick up medications from [local pharmacy], even on weekends. Carbidopa-Levodopa should be called into the emergency pharmacy." R24's medication administration record dated July 1, 2015 to July 31, 2015 states R24 did not receive carbidopa-levodopa at 12:00 PM or 8:00 PM on July 19 or at 8:00 AM, 12:00 PM, and 8:00 PM on July 20, 2015. The facility's After Hours/STAT instructions (undated), shows "When a specific medication is not availabe in your boxes, you can place after hours or stat orders by calling your pharmacy. Remember that it is necessary for the nurse to call the pharmacy to receive an after hours or stat or order."	F 425		

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