DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145278	A. BUILDING ______ B. WING ______	05/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PAVILION	**105 EAST 23RD STREET STERLING, IL 61081**

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F 000	INITIAL COMMENTS Annural licensure and certification survey.	F 000		
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 observation, interview and record review, the facility failed to ensure a resident ' s dignity by not maintaining a resident's visual privacy. This applies to 1 resident (R19) reviewed for dignity in the supplemental sample. The findings include: On May 11, 2016 at 3:10 PM, R19 was sitting in a recliner in her room with both legs elevated. The door to her room was wide open. The call light was on and she was wearing only a long sleeved shirt and underpants. The resident was in full view of passersby with nothing covering her lower body. On May 12, 2016 at 9:45 AM, R19 was sitting in a recliner in her room with both legs elevated. The door to her room was wide open. She was wearing a shirt and undergarments only. She was uncovered from the waist down. She was in full view of passersby. She looked at this surveyor and just shook her head. On May 11, 2016 at 3:10 PM, R19 said are you going to get me something to cover myself up? On May 11, 2016 at 3:25 PM, R 19 said she is very modest as a rule and she feels degraded without visual privacy but sadly is getting used to	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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F 241	Continued From page 1 it while being a resident here. On May 12, 2016 at 8:45 AM, E2 DON (Director of Nursing) said it is her expectation staff ensure a resident ' s dignity and if this was not done they may become depressed and become withdrawn. On May 12, 2016 at 9:50 AM, E12 RN (Registered Nurse) said it is important to ensure resident dignity because this is their home and it shows respect. If a resident ' s dignity was not ensured a lowered self esteem and depression could occur. On May 12, 2016 at 11:35 AM, E14 CNA (Certified Nursing Assistant) said resident ' s should be covered when in full view of passersby through their room doorway and R19 being uncovered from the waist down with the door open (as she witnessed) was unacceptable. The Admission Nursing Assessment dated April 28, 2016 shows R19 is alert and oriented to person, place and time. The comprehensive assessment dated April 28, 2016 shows R19 requires assistance to reposition and with ADL ' s (Activities of Daily Living). The facility Dignity Policy dated November 2013 shows each resident shall be cared for in a manner that promotes and enhances quality of life and dignity.	F 241		
F 314 SS=E	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.	F 314		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to implement pressure relieving interventions for residents at high risk for pressure injury and residents with current pressure ulcers, and failed to ensure residents were repositioned to relieve pressure.
This applies to 4 of 10 residents (R1, R3, R5, R11) reviewed for pressure injuries in the sample of 17.
The findings include:
1. The face sheet for R1 documents she was admitted to the facility on February 26, 2016 with multiple diagnoses including a displaced comminuted fracture of the left femur.
The May 9, 2016 wound care clinic notes document R1 to have a pressure injury on the left Calcaneous (heel). The injury measures 3.3cm length x 3.5 cm width and 0.1 cm.
On May 10, 2016 at 9:15 AM, R1 was lying in bed with both legs on the bed including her heels. The left foot had a dressing covering the heel, and had no support under the leg to keep the heel off of the bed. The right foot was bare and lying directly on the bed. At 10:50 AM, R1 was in the same position. At 2:15 PM after lunch, R1 was observed back in bed with both heels on the bed with no support to float the heels.
The April 11, 2016 care plan for R1 documents the cast was removed and R1 was found to have a heel pressure injury and had an intervention initiated to have her heels floated.
On May 11, 2016 at 7:30 AM, R1 was lying in bed with a boot on her left heel and said she has always had a boot, some (nursing staff) put it on me and some do not.
On May 11, 2016 at 11:45 AM, E3 LPN (Licensed

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F 314	Continued From page 3 Practical Nurse/ Wound nurse) said R1 has Eschar on her left heel and has the dressing changed every other day. E3 said R1 should have a heel boot on her foot to keep the heel off of the bed, and she has had a boot since her cast was removed on April 11, 2016. E3 said on April 27, 2016 R1 had a heel left boot to replace the first boot. E3 said it was not good that R1 had her heels on the bed all day without having her heels floated. On May 11, 2016 at 11:30 AM, E15 CNA (Certified Nursing Assistant) said R1 had a full leg cast when she was admitted, but now has a leg brace. E15 said R1 had a blue heel boot in her room a couple of weeks ago and should have the boot on when she is in bed. E15 said R1's heels should always be floated. The April 12, 2016 wound care clinic instructions include off-loading with an off loading boot and to make sure (the) left heel is not resting on any surface. 2. The face sheet for R5 documents she was admitted to the facility on August 8, 2014 with multiple diagnoses including history of stroke and dementia. The April 25, 2016 Braden scale for predicting pressure sore risk showed R5 is a high risk for pressure injury. The May 2016 physician order sheet for R5 documents an order dated June 29, 2015 for heel boots to both feet to reduce skin irritation over bony prominences, and an order on August 31, 2015 to off load bony prominences. On May 10, 2016 at 9:00 AM, R5 was lying in bed sleeping with no pillow under heels and no boots to her feet to keep her heels off of the bed. At 11:20 AM, R5 had a pillow under her knees and her heels remained on the bed. At 2:15 PM, R5 was in bed on her back and had nothing on her heels to keep them off of the bed. At 4:00 PM R5	F 314		

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F 314	Continued From page 4 remained in bed with nothing to float her heels off of the bed. On May 11, 2016 at 10:00 AM, E4 LPN (Licensed Practical Nurse) stated R5 was to have her heels floated to keep them from breaking down. E4 said R5's heels should always be floated when she is in bed. E4 stated R5 will not wear the boots she has ordered so pillows are used to keep her heels off of the bed. On May 11, 2016 at 10:15 AM, E5 CNA (Certified Nursing Assistant) stated R5 does not have boots, but we are supposed to float her heels with pillows. The facility's November 2013 pressure ulcer policy documents protocol and care strategies for pressure: c. Implement pressure-relieving devices in accordance with the resident ' s assessed needs. 3. R3's May, 2016 POS (Physician Order Sheet) shows R3 has diagnoses to include dementia and muscle wasting and atrophy. The MDS (Minimum Data Set) of February 9, 2016 shows R3 has severe cognitive impairment, and requires extensive assistance with bed mobility, transfers, dressing, hygiene, and bathing. The MDS shows R3 is always incontinent of urine and stool, is at risk for pressure ulcers, and has no pressure ulcers. R3's assessment for Predicting Pressure Sore risk dated April 25, 2016 shows R3 is at a high risk for developing pressure sores. The facility Weekly Pressure Ulcer Report dated May 3, 2016 shows R3 has a facility acquired, stage II pressure ulcer to her right and left buttock.	F 314		

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F 314	Continued From page 5 On May 10, 2016 at 11:30 AM, E5 and E6 (CNA) rolled R3 over in bed. R3 had a hydrocolloid dressing intact to her buttocks, and had a reddened area directly over her left hip bone. E5 said R3's hip is "not usually" red. E5 and E6 said R3 stays on her side, and will not turn by herself. On May 11, 2016 15 minute observations were made from 8:15AM to 10:30AM of R3. R3 was laying in her bed, with a wedge cushion in place behind her back, assisting her to stay on her right side. At 10:30AM, E5 entered R3's room, and said she was incontinent of stool, and she needed to clean her up. E5 left R3 on her right side, and cleaned R3 of stool. E5 rolled R3 over just long enough to remove the soiled pad, and pull a clean pad through (approximately 1 minute), and then placed R3 back onto her right side. R3's right hip was reddened, directly over her hip bone, when E5 rolled her over to change the pad. At 10:40 AM, E5 left R3 on her right side, and left the room. At 10:50 AM, E3 and E4 (LPNs) left R3 on her right side, and changed the dressing to R3's buttocks. R3 had two small open areas to to her right buttock, and pink discolored areas to her left buttock. After applying the new dressing, E4 and E5 left R3's room. E4 said R1 got the pressure ulcers "from incontinence" which is why R3 has the catheter. R3 remained on her right side (from 8:15 AM) until 11:20AM, when this surveyor took E3 back into the room, and had her assess the red area to R3's right hip. E3 pushed on the reddened area to R3's right hip and said "it does not blanch", and "it might open", and she was not aware of the reddened area. E3 said R3 will not move from one side to the other, and she will need to be repositioned from side to side, and R3 would need to be off a side for at least 30 minutes for it to be considered a repositioning attempt. E5 and	F 314		

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E6 said R3 is supposed to be repositioned every 2 hours.

R3's nurse noted dated May 11, 2016 at 1:02PM shows "noted to have redness to right hip..."

R3's Pressure Ulcer Care Plan dated March 17, 2016 shows "Educate the resident/family/caregivers as to causes of skin breakdown/including: ambulating/mobility, good nutrition and frequent repositioning" and "the resident needs monitoring/assistance to turn/reposition at least every 2 hours or more often as needed."

The February 4, 2016 physician orders shows "assist with repositioning in wheelchair/bed at least every 2 hours. R3's April 22, 2016 physician orders shows-change urinary catheter as needed, diagnosis: pressure ulcer.

On May 11, 2016 at 11:50 AM, E2 said rounds should be done by a CNA every two hours and include checking for continence, and turning and repositioning the resident. E2 said repositioning would be moving from side to side, or from side to back to side. E2 said a resident should be repositioned for a minimum of 30 minutes each time. E2 said R3 is high risk because of her pressure ulcers and should be repositioned hourly.

The facility November, 2013 Repositioning policy shows:
Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief.
Reposititioning is critical for a resident who is immobile or dependent upon staff for

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repositioning.
Residents who are in bed should be on at least an every two hour repositioning schedule.

R11 ' s head to toe facility admission assessment dated January 23, 2016 shows no pressure ulcers to his buttocks. R11 ' s Discharge Summary from a local hospital dated January 23, 2016 shows he was admitted to this facility to rehabilitate after a surgical repair of a fractured right femur. This summary shows R11 ' s plan is to return to an assisted living facility after his stay. It also recommends that R11 be up in the chair daily for short periods and to utilize decubitus precautions.
On May 12, 2016 R11 was in his wheelchair at 7:15 AM, 7:25 AM, 7:30 AM, 7:40 AM, 7:50 AM, 8:00AM, 8:05 AM and 8:15 AM. On May 12, 2016 at 8:15 AM, R11 ' s call light was answered by E14 CNA (Certified Nursing Assistant). R11 requested to use the urinal and was assisted to his feet by E14. R11 voided per the urinal. R11 ' s buttocks were reddened with healing Stage II uncovered wounds to both left and right buttocks. R11 sat back into the wheelchair after using the urinal. R11 was sitting in his wheelchair at 8:20 AM and at 8:25 AM R11 was pushed into the therapy department at 8:30 AM and stayed until 9:45 AM. At 9:10 AM, R11 was in the therapy room seated in the wheelchair with his eyes closed. R11 was seated in his wheelchair at 9:50 AM, 10:00 AM and on the toilet at 10:15 AM. R11 was in the wheelchair at 10:30 AM, 10:50 AM,10:55 AM, 11:15AM, 11:30 AM, 11:40 AM, 11:45 AM, 11:50 AM, and 12:10 PM.. On May 12, 2016 at 10:50 AM, Z1 (occupational therapy aide)

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F 314	Continued From page 8 said R11 did not get out of the wheel chair during any therapy sessions today. R11 was not offered assistance to reposition during these observations. On May 12, 2016 at 8:45 AM, E2 DON (Director of Nursing) said she expects pressure relieving interventions to be implemented as recommended and repositioning should occur every two hours. E12 RN (Registered Nurse) said she expects pressure relieving intervention and skin care procedures are implemented by all staff when residents are high risk. On May 13, 2016 at 9:00 AM, E3 said staff NOW know to let her know if a resident has any skin concerns (ie; reddened or open areas). .On May 12, 2016 at 9:50 AM, E12 said there is a lay down list on each unit that communicates which residents need to be laid down after meals. E12 said R11 is NOT on the list. On May 13, 2016 at 9:00 AM, E3 said a resident should have pressure relieved for at least 30 minutes at a time for it to be sufficient. E3 said after seeing so many wounds I get the left and right sides mixed up and I am not certified in wound care. After referring to some notes E3 said R11 ' s right buttocks pressure injury was first noted on April 15, 2016 and the left buttock pressure injury was first noted on May 5, 2016. E3 said pressure relieving interventions should be communicated to the nurse. . E3 said there has been no new pressure ulcer prevention interventions implemented since the care plan was initiated on April 4, 2016 although R11 has two facility acquired pressure injuries. E3 said I did not know I had to put my interventions on the care plan. I ' m learning as I go. R11 ' s April 23, 2016 MDS (Minimum Data Set) shows extensive assistance is required for transfers, dressing, hygiene, bathing, toilet use and bed mobility.R11 ' s potential for skin	F 314		

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F 314	Continued From page 9 breakdown care plan was initiated on April 4, 2016. The interventions include: instruct/assist resident to shift weight in wheelchair every 15 minutes, the resident needs assistance to reposition, monitor, document and report any changes to skin status as needed, teach the resident/family of importance of changing positions and causes of skin breakdown. R11 ' s pressure sore weekly documentation shows two-Stage 2 pressure injuries at this time. There have been no updated care plan interventions to address pressure ulcer prevention since the care plan was initiated April 4, 2016.The facility ' s Repositioning Policy dated November 2013 shows to encourage and assist the resident in the chair to change positions or shift weight at least every 15 minutes for the purpose of pressure relief, circulation promotion and skin breakdown prevention. The nurse ' s note dated April 28, 2016 at 8:29 PM shows R11 is forgetful with cognitive issues, a poor historian and decision maker. The April 26, 2016 nurse ' s note shows R11 is dependent for ADL ' s (Activities of Daily Living). R11 ' s monthly summary note dated February 26, 2016 shows bottom excoriation. The March 20, 2016 monthly summary note shows no skin problems or pressure ulcers marked. The April 20, 2016 monthly summary note shows no skin problems or pressure areas marked (Stage II pressure injury was noted on April 15, 2016). R11 ' s pressure sore weekly flow sheet shows a Stage II ulcer was noted on April 15, 2016 to the right buttock and measured 0.1 cm X 0.1 cm and progressed to 3 cm X 2 cm on May 2, 2016. R11 ' s pressure ulcer healing chart shows on March 15, 2016 the wound was scored a " 2 " and on May 2, 2016 it increased to an " 8 " which indicates a decline. R11 ' s pressure sore weekly flow sheet shows a new Stage II noted on May 5,	F 314		

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F 314	Continued From page 10 2016 to his left buttock measuring 1 cm X 0.9 cm. R11 ' s behavior charting from January 2016 through May 11, 2016 show rejection of care occurred once during this time period. There were no other behaviors documented. There were no new pressure ulcer preventative interventions since the date of initiation (April 4, 2016) in spite of R11 sustaining two new facility acquired Stage II pressure injuries. Interdisciplinary Progress notes from March 31, 2016 through May 5, 2016 show R11 being cooperative with care.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, 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, interview and record review the facility failed to have a medical diagnosis for an indwelling urinary catheter. This applies to 1 of 3 residents (R5) reviewed for indwelling urinary catheters in the sample of 17. The findings include: On May 10, 2016 at 9:00 AM, on initial tour of the facility, R5 was lying in bed sleeping and had a catheter drainage bag on the side of the bed in a	F 315		

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F 315	Continued From page 11 dignity bag. The May 2016 physician order sheet documents an order for indwelling urinary catheter dated February 5, 2015. The February 5, 2015 physician progress note documents R5 and her family requested a chronic indwelling catheter due to her incontinence and discomfort as a result of the incontinence. The physician notes the assessment and plan include a history of recurrent urinary tract infections and overactive bladder. The facility indwelling catheter assessment for justification for use of catheter has no diagnosis indicating the need for the catheter. The nurses notes for R5 dated February 5, 2016 document the nurse and physician spoke with the power of attorney regarding (R5), who wishes to have a catheter placed back in for dignity issues. No medical diagnosis was listed for placement for the indwelling catheter. On May 11, 2016 at 2:00 PM, E2 DON (Director of Nursing) stated a resident must have a medical reason for an indwelling catheter such as urinary retention, pressure ulcers or a terminal illness. E2 stated no resident should have a catheter because they request or wish to have it placed. E2 stated an overactive bladder is not a diagnosis to have a catheter. The February 20, 2016 care plan for R5 documents she has an indwelling catheter due to overactive bladder.	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	F 318		

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(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 318	Continued From page 12 range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident had a supportive device in place to sit upright in a wheelchair. This applies to 1 of 14 residents (R3) reviewed for positioning in the sample of 17. The findings include: R3's May, 2016 POS (Physician Order Sheet) shows R3 has diagnoses to include dementia and muscle wasting and atrophy. The MDS (Minimum Data Set) of February 9, 2016 shows R3 has severe cognitive impairment, and requires extensive assistance with bed mobility, transfers, dressing, hygiene, and bathing. The MDS shows R3 has impaired range of motion to her upper extremity. On May 10, 2016 at 12:30 PM, R3 was sitting in a wheelchair at the dining room table. R3 was leaning to the right side, and her right elbow was resting on the cushion of her wheelchair, while staff was assisting her with lunch. R3 did not have any assistive positioning devices in place to help her sit upright. On May 11, 2016 at 12:00PM, E6 CNA (Certified Nurse Assistant) was assisting R3 with lunch. R3 was sitting in her wheelchair, with her upper body leaning to the right, and her head leaning all the way over to the	F 318		

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F 318	Continued From page 13	F 318		

right. E6 said R3 "always leans to the side" and we try to sit her up but she moves back. On May 12, 2016 at 7:50 AM, R3 was sitting in her wheelchair, at the dining room table, leaning to the right side, with her right elbow resting on the wheelchair, seat cushion. E14 (CNA) was assisting R3 with breakfast, and said R3 always leans to the side. E14 said she thinks R3 has a cushion that sits in her chair to help hold her up.

On May 12, 2016 at 9:00 AM, E2 DON (Director of Nursing) said R3 has a supportive cushion that should be in place to her right side every time she is up in the wheelchair. E2 said the supportive cushion is used to hold R3 upright while she is in the chair.

R3's fall care plan dated December 9, 2013 shows "instruct the resident in the proper use of any appliance or device to aid in balance...

R3's Restorative Nursing Assessment/Reassessment/Progress Notes dated February 9, 2016 shows Requires extensive to total assist with Activities of Daily Living (ADL)...has a score of mild to severe decreased range of motion and needs assistance with complete full range." R3's February 9, 2016 ADL assessment shows R3 requires extensive assistance to sit unsupported.

The November, 2013 facility Repositioning policy shows: check the care plan, assignment sheet or the communication system to determine resident-specific positioning needs including special equipment...

The facility November, 2013 facility Rehabilitative Nursing Care policy shows

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F 318	Continued From page 14 Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes, but is not limited to: Maintaining good body alignment and proper positioning...	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, interview and record review the facility failed to safely transfer a resident with a mechanical lift. This applies to 1 of 17 residents (R4) reviewed for transfers. The findings include: On May 10, 2016 at 1:00 PM, E11 and E10, both CNA's (Certified Nursing Assistants) transferred R4 from her wheelchair to the bed using a mechanical lift so R4 could use the bedpan. R10 left the room after the transfer due to her shift being over. E11 left the room while R4 used the bed pan to find another staff to help her transfer R4 back to wheelchair. E11 returned with E13 (activity aide). E11 applied lift belts to R4 and lifted her up off bed. E11 moved R4 to hover over the wheelchair. E11 lowered R4 to the	F 323		

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F 323	Continued From page 15 wheelchair by herself. R4's buttocks were on the edge of the wheelchair seat with her legs dangling over the foot rest of her wheelchair. E11 removed the lift straps for R4 and pulled the lift away from R4. E13 moved forward to help E11 lift R4 into her wheelchair better. E11 and E13 pulled R4 up by lifting her under her arms and pulling on the back of R4's pants. On May 11, 2106 at 10:45 AM R4 stated that there are times when she feels like she will fall out of her chair after a transfer. On May 10, 2016 at 2:10PM E11 stated this was her first week here at facility and was told she can ask anyone to help her with a transfer. E11 stated one staff is to drive the lift and another is to guide resident into chair. E11 stated she did not feel like she could give the controls of the lift to E13 or have her guide the resident into the wheelchair. R11 stated she thought maybe all staff was certified. On May 10, 2016 at 2:15PM E13 said she was not a certified nursing assistant. E13 stated she is only allowed to watch a transfer with a mechanical lift and not allowed to touch the residents. On May 10, 2016 at 2:31PM, E8 LPN (Licensed Practical Nurse) said she would expect the CNA's to ask another CNA or nurse to help with transferring a resident with a mechanical lift. On May 11, 2016, at 11:00AM E2 DON (Director of Nurses) stated any staff can help with a transfer using a mechanical lift. E2 stated activity staff cannot run the lift but are there in case of an emergency. On May 12, 2016, at 8:50 AM E2 stated R4 can only help in the transfer process by crossing her arms over her chest. On May 12, 2016, at 9:15AM E16 (Activity Director) stated her staff are not allowed to touch	F 323		

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F 323	Continued From page 16 a resident. She would expect her staff to help only as a last resort. On May 12, 2016, at 10:15AM, E17 (Activity Aide), said she was trained only to watch a transfer. E17 stated the CNA's will ask for help only if no other CNA's are available. R4's care plan dated December 10,2015 shows transfer with mechanical lift and decreased mobility skills related to past stroke. The facility policy on Safe Lifting and Movements of Residents, dated November 2013 shows that manual lifting of residents shall be eliminated when feasible. The policy also states the staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices. The facility policy on Lifting Machine, Using A Portable, dated November 2013 states that the Portable lift can be used by one nursing assistant if the resident can participate in the lifting procedures. If not, two nursing assistants will be required to perform the procedure.The MDS (Minimum Data Set) dated March 1, 2016 shows R4 is unable to ambulate and requires extensive assist with transfers. M.D.S. also shows R4 has limited range of motion to her left side.	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	F 332		

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F 332	Continued From page 17 review the facility failed to administer medications as ordered. There were 29 opportunities with 2 errors resulting in a 6.8% error rate. This applies to 1 of 4 residents (R21) observed in the medication pass. On May 11, 2016 at 7:40 AM, E8 LPN (Licensed Practical Nurse) crushed R 21 ' s Prilosec delayed release tablet and Potassium extended release tablet before administration. The medications were given to R 21 mixed with her other medications in applesauce. On May 11, 2016 at 7:45 AM, E8 said she crushed all of R 21 ' s tablets before administering them. On May 12, 2016 at 8:45 AM, E2 DON (Director of Nursing) said there is a Do Not Crush list of medications at each nurse ' s station and it is her expectation that meds on the list are not crushed. On May 12, 2016 at 9:50 AM, E12 RN (Registered Nurse) said you should not crush medications that are delayed release or extended release as the drug would not be released as intended and may harm the resident. R21 ' s POS (Physician Order Sheet) for the month of May 2016 shows a current order for Prilosec 20.6 mg delayed release tablet and Potassium Chloride extended release 20 meq tablet. The January 2014 recommendations from ISMP (Institute for Safe Medication Practices) shows Prilosec OTC delayed release tablets and potassium extended release tablets should not be crushed. The facility ' s November 2013 Crushing Medications Policy shows medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders. The NIH (National Institute of Health) recommendations for both Prilosec OTC delayed release tablets and Potassium extended release tablets show both medications should not be crushed.	F 332		

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