STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 19, 20, 21, 24, 25 and 26, 2020 Facility number: 000038 Provider number: 155095 AIM number: 1000274830 Census Bed Type: SNF/NF: 141 SNF: 16 Total: 157 Census Payor Type: Medicare: 9 Medicaid: 109 Other: 39 Total: 157 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. QR completed February 28, 2020.	F 0000	Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. **This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review**	

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

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			on or after March 27 , 2020.	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview, and record review the facility failed to ensure assessments were accurately completed for 4 of 5 residents reviewed. (Resident 162, Resident 127, Resident 82, and Resident 122) Findings include: 1. Review of the clinical records for Resident 162 on 2/26/20 at 9:30 a.m., indicated the following diagnoses, dementia, muscle weakness, atrial fibrillation, hypertension, peripheral vascular disease, Parkinson's disease, and osteoarthritis. Review of Resident 162's MDS (Minimal Data Set) Assessments dated 01/05/2020 indicated an Entry/Discharge reporting was coded 10, which indicated the assessment was for a Discharge, and a return to the facility was not anticipated. The MDS Assessment Discharge Status was coded 03, which indicated the resident was discharged to an Acute Hospital on 01/05/2020. Review of Resident 162's Progress Notes indicated the following: A Social Service Note dated 1/3/20 at 9:13 a.m., indicated the resident was being discharged home on 1/5/20. A Nursing Note dated 01/05/20 at 1:56 p.m., indicated the resident was discharged from the facility to home, all appropriate paperwork was sent with the resident, and was transported via a family vehicle.	F 0641	**F641** It is the practice of this facility to ensure assessments are accurately completed. However; based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:** ·Resident #162: The MDS Discharge Assessment was modified ·Resident #127: The MDS Admission Assessment was amended to indicate receiving dialysis treatments ·Resident #82: A modification for the miscoded MDS was completed to reflect dialysis treatment The MDS Significant Change Assessments dated 9/24/19 and 12/27/19 were modified to reflect Active Diagnoses in Section I. ·Resident #122: The MDS	03/27/2020

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	Review of Resident 162's Transition of Care/Discharge Summary, which was provided by Medical Records on 02/26/20 at 10:50 a.m., indicated a Discharge Date of 01/05/20 and the Discharge Destination was documented, the resident went back to their apartment on their own. Review of Resident 162's Indiana State Form, Notice of Transfer or Discharge, which was provided by Medical Records on 2/26/20 at 10:50 a.m., indicated the Resident was being transferred to a private residence. An interview with the MDS Coordinator on 02/26/20 at 10:57 a.m., indicated, while she reviewed Resident 162's MDS Assessments, the discharge assessment must have been coded wrong. The MDS Coordinator reviewed the resident's records to make sure the Resident had not gone to the hospital before being discharged from the facility. She indicated Resident 162 was discharged to their home and the MDS Discharge Assessment was coded wrong.2. The record review for Resident 127 began 2-21-2020 at 12:41 p.m. Diagnoses included but were not limited to, disorders of calcium metabolism, non pressure chronic ulcer of skin, chronic pain, diabetes, end stage renal disease, and dependence on renal dialysis. The corrected MDS (Minimum Data Set) admission assessment dated 1-24-2020 for Resident 127 indicated in Section O Special Treatments, Procedures, and Programs, to check all of the following treatments, procedures, and programs that were performed during the last 14 days. The box for "dialysis while a resident" was not marked.		Quarterly Assessment was modified to correct the Coronavirus Infection coding error **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·Residents residing in the facility receiving hemodialysis, residents with an active infection and residents discharging from the facility have the potential to be affected by the alleged deficient practice ·No other residents were found to have been affected by the alleged deficient practice ·The MDS Department has been re-educated on the identifying factors for residents receiving hemodialysis while residing in the facility, correct infection diagnoses and discharge destinations. Education includes but is not limited to reviewing the resident physicians' orders, Medical Record, Care Plans and resident interviews prior to submitting MDS assessments. ·The MDS Department was educated on March 10, 2020 by the Home Office RAI Specialist. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:**	

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	A review of the current physician orders for Resident 127 indicated the dialysis center name and dialysis days of Tuesday, Thursday, and Saturday while a resident, during the assessment period. An interview with MDS Nurse 12 on 2-25-2020 at 9:30 a.m., indicated for the 2-24-2020 a corrected MDS admission assessment in Section O, "dialysis while a resident" should have been marked. 3. A review of Resident 82's record on 2/24/2020 at 10:55 a.m., indicated a BIMS (Brief Interview of Mental Status) score of 15, meaning the resident was cognitively intact. The score was obtained from the MDS (Minimum Data Set) Significant Change Assessment, dated 12/27/2019. Diagnoses included, but were not limited to: diabetes, heart disease, kidney disease, anxiety, depression, and psychotic disorder. The MDS (Minimum Data Set) Significant Change Assessment, dated 7/7/2019, was not coded for dialysis under Section O. Resident 82 had been receiving dialysis treatments 3 times weekly since admission on 1/23/2019. A Care Plan for Mental Illness, dated 9/27/2019, had indicated Resident 82 had diagnoses of schizophrenia and psychotic disorder. The MDS Significant Change Assessment, dated 9/24/2019, was coded Yes to Serious Mental Illness under Section A 1500/1510. Serious Mental Illness diagnoses, psychotic disorder or schizophrenia were not documented under Section I, Active Diagnoses. The MDS Significant Change Assessment, dated 12/27/2019, was coded Yes to Serious Mental Illness under Section A 1500/1510. Serious		·The MDS Department has been re-educated on the identifying factors for residents receiving hemodialysis while residing in the facility, correct infection diagnoses and discharge destinations. Education includes but is not limited to reviewing the resident physicians' orders, Medical Record, Care Plans and resident interviews prior to submitting MDS assessments. ·The MDS Department was re-educated on March 10, 2020 by the Home Office RAI Specialist. ·The MDS Co-ordinator/Designee is responsible for oversight. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur:** ·QAPI Monitoring Tools titled "Discharge Destination", "Hemodialysis Coding" and "Active Psychiatric Dx" will be utilized every week x 4, monthly x 6 and quarterly thereafter. ·Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed ·Non-compliance with facility procedure may result in disciplinary action up to and including termination.	

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	Mental Illness diagnoses, psychotic disorder or schizophrenia were not documented under Section I, Active Diagnoses. During an interview on 2/26/2019 at 10:50 a.m., MDS Coordinator 12 indicated Resident 82 should have been coded for dialysis, and she would complete a modification. 4. A review of Resident 122's record on 2/21/2020 at 10:11 a.m., indicated the resident had a BIMS score of 6 out of 15, meaning severe cognitive impairment. The score was obtained from the MDS Quarterly Assessment, dated 1/15/2020. Diagnoses included, but were not limited to: sepsis (infection in the blood and/or tissue), viral pneumonia, elevated white blood cell count, and Coronavirus infection. During an interview on 2/21/2020 at 10:30 a.m., the Infection Control Nurse indicated she had not realized the resident had a diagnosis of the Coronavirus. A review of an Infection Control Event Report for Respiratory Infection, dated 10/11/2019, and provided by the Infection Control Nurse on 2/21/2020 at 11:30 a.m., indicated Resident 122 was on an antibiotic for Rhinovirus/pneumonia. During an interview on 2/21/2020 at 11:05 a.m., the MDS Coordinator 12 indicated the Coronavirus infection diagnosis was an MDS coding error. She further indicated that she was not to familiar with the ICD-10 MDS codes and no formal training on the codes. During an interview on 2/26/2020 at 10:50 a.m., the MDS Coordinator 12 indicated the facility had no policy for the MDS coding and they referred to			

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	the RAI (Resident Assessment Instrument) manual. No State Rule.			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview, and record review, the facility failed to ensure a Care Plan was updated for 1 of 3 residents reviewed for Care Plans. (Resident 82)	F 0657	**F657** It is the practice of this facility to ensure Care Plans are updated based on changes in resident	03/27/2020

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	Findings include: A review of Resident 82's record on 2/24/2020 at 10:55 a.m., indicated a BIMS (Brief Interview of Mental Status) score of 15, meaning the residnet was cognitively intact. The score was obtained from the MDS (Minimum Data Set) Significant Change Assessment, dated 12/27/2019. Diagnoses included, but were not limited to: diabetes, heart disease, and kidney disease. A Physician's Order, dated 11/20/2019, indicated Resident 82 was on a Potassium restricted, NCS (no concentrated sweets), and fortified pudding with lunch. An intervention, dated 2/4/2019, on the Weight Loss Care Plan, indicated the resident was to be given a Regular Diet. A review of the Diet Order and Communication form, dated 1/23/2019, and provided by the DNS (Director of Nursing Services) on 2/24/2020 at 3:25 p.m., indicated the facility was to follow a diet order for controlled carbohydrates, and low potassium. During an interview on 2/19/2020 at 2:37 p.m., Resident 82 indicated at times she would get food on her meal tray that she was unable to eat because of her special dialysis diet. During an interview on 2/24/2020 at 3:54 p.m., the DNS indicated the regular diet was an error on the Care Plan, and the Care Plan should have reflected the Physician's Order. During an interview on 2/26/2020 at 10:50 a.m., MDS Coordinator 12 indicated the Dietician was responsible to update the Care Plans and they just		assessment/condition. However; based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:** ·Resident #82: The residents' Care Plan was updated to reflect the current physicians order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·Residents receiving a therapeutic diet in the facility have the potential to be affected by the alleged deficient practice. ·A facility audit reflected no other residents affected by the alleged deficient practice ·The newly employed Dietician has been educated on updating requirements/expectations for resident diets. Education includes but is not limited to daily dietary order audits, updating tray tickets, updating care plans with physicians' orders and specialty diets offered at the facility. ·Education provided March 10, 2020 by the Regional ASC Dietician. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice**	

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	had a new Dietician start a few days ago. A policy, IDT (Interdisciplinary Team) Comprehensive Care Plan Policy, dated 10/2019, indicated the following: "...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input..." A form, IDT Care Plan Review Guidelines, dated 10/2019, indicated the following: "...Dietary to review diet orders, preferences, weight, weight goal..." 3.1-35(c)(2)		**does not recur:** ·The newly employed Dietician has been educated on updating requirements/expectations for resident diets. Education includes but is not limited to daily dietary order audits, updating tray tickets, updating care plans with physicians orders and specialty diets offered at the facility. ·Education provided March 10, 2020 by the Regional ASC Dietician. ·The Nutrition at Risk Interdisciplinary Team is responsible for oversight during routine dietary care plan audits. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur:** ·A QAPI Monitoring Tool titled "Resident Diets" will be utilized every week x 4, monthly x 6 and quarterly thereafter. ·Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed ·Non-compliance with facility procedure may result in disciplinary action up to and including termination.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation , interview and record review, the facility failed to ensure tube feedings were monitored for 2 of 2 residents reviewed. (Resident 101, and Resident 17) Findings include: 1. On 2/21/2020 at 10:00 a.m., the record of Resident 101 was reviewed. Diagnoses included, but were not limited to, the following: dysphagia (difficulty swallowing) following stroke, type 2 diabetes mellitus and dementia. The significant change Minimum Data Set (MDS) assessment, dated 1/1/2020 included the following: severely impaired cognition and no weight loss. A physician order, dated 1/3/2020, indicated to give an enteral feeding: flush tube with 300	F 0693	**F693** It is the practice of this facility to ensure residents receiving enteral nutrition are monitored. However; based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:** ·Resident 101: The resident continues to receive Glucerna @65cc/hr via G-Tube. She also receives a 300cc flush every 4 hours per physician's order. Her Kangaroo Pump volume was adjusted to a louder setting. ·Resident 17: The resident	03/27/2020

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	milliliters (ml) water every 4 hours (hrs) every shift: A physician order, dated 1/8/2020, indicated to give an enteral feeding: continous feeding formula glucerna 1.5, rate 65 ml/hr every shift, 6;00 a.m. - 2:00 p.m; 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. A significant change registered dietician review, recorded as a late entry on 1/3/2020 at 5:46 p.m., indicated Resident 101 was NPO (nothing by mouth) and received enteral nutrition through G-tube (gastrostomy tube inserted through abdomen to stomach to provide nutrition) of Glucerna 1.5 at 55 ml/hr. The resident required higher caloric and protein needs due to pressure ulcer being present, had been experiencing significant weight loss of 11.9% in 180 days, and weights had been reported of 133 lbs (pounds) 12/27/2019 and 151 lb 7/7/2019. The Dietician recommend increasing the enteral feeding rate due to continued weight loss. The recommendation was for: Glucerna 1.5 at 65 ml/hr. A review of the current February 2020 treatment administration record indicated the resident did not currently have a pressure area. A vitals report reviewed on 2/21/2020 at 1:30 p.m., indicated the most recent weights dated 2/14/2020 was 142 lbs; on 2/7/2020- 139 lbs. A Food and Nutrition Dietician Review dated 2/21/2020 at 2:00 p.m., indicated estimated Kcal (kilocalorie) needs: 1300-1700; estimation factor used, kcals/kg was 20-25. An Registered Dietician (RD) note dated 2/21/2020 at 2:16 p.m., indicated the following: Resident 101		continues to receive Jevity 1.2 @55cc/hr via G-Tube x 18 hours with a 240cc water flush every 4 hours per physician's order. ·Neither of the residents had any adverse effects based on the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·Residents requiring nutritional needs to be met via G-Tube have the potential to be affected by the alleged deficient practice. ·No other residents were found to have been affected. ·Kangaroo Pumps in the facility have been re-certified to ensure function of each pump is accurate. No concerns were identified. ·Licensed staff have been re-educated on nutritional intake via G-Tubes. Education includes but is not limited to appropriate labeling of Formula Bottles and Water Bags instilling flushes, timeliness initiating tube feedings, clearing the pump when a new bottle or water is added for infusion and documenting physician orders at the end of their shift. Kangaroo Pump education was provided using the written manufacturer recommendations. This education includes but is not limited to how to clear the pump, how to adjust volume, not turning volume down for alarms and	

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	had significant weight gain. Most recent weight was 142 lb. Usual body weight since admission usually 140s, was returning to normal weight, but had recent weight loss over 2 months. Patient received Glucerna 1.5 at 65 (sic) with 300 (sic) every 4 (sic) water flush. The resident currently received a tube feeding at goal rate. The tube feeding was meeting nutritional intake goals. The report indicated the RD would continue to monitor weight and adjust tube feeding accordingly. A plan of care, titled Nutritional Status, last reviewed/revised on 2/21/2020, indicated the following problem: The resident was NPO (nothing by mouth), related to diagnosis of stroke with dysphagia (difficulty swallowing); history of significant weight gain, but now had significant weight loss in 90/180 days (January 2020). The therapeutic formula was related to the diagnosis of diabetes mellitus type II. The goal was to have no further significant weight changes thru next review target date of 5/11/2020. The approaches included NPO- glucerna enteral feeding and flushes per orders. The current February 2020 MAR was reviewed on 2/24/2020 at 1:04 p.m. Documentation from RN 13 for 2/24/2020 for 2:00 p.m. - 10:00 p.m. shift, indicated the resident received continous feeding at 65 ml/hr. A copy of the current Medication Administration Record (MAR) for February 2020 was received on 2/26/2020 at 1:04 p.m. from the DNS. The following entries had been documented by LPN 11 as having been completed: Enteral Feeding: continuous feeding formula glucerna 1.5, rate 65 ml/hr and enteral feeding: flush tube with 300 ml water every 4 hours. The time frame for the orders for the enteral feeding and the flush were 6:00 a.m.		troubleshooting alarms. ·Education provided by Director of Nursing Services and Clinical Education Co-ordinator March 11, 2020 ·Unit Managers are responsible for oversight. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** ·Licensed staff have been re-educated on nutritional intake via G-Tubes. Education includes but is not limited to appropriate labeling of Formula Bottles and Water Bags instilling flushes, clearing the pump when a new bottle or water is added for infusion and documenting physician orders at the end of their shift. Kangaroo Pump education was provided using the written manufacturer recommendation. This education includes but is not limited to how to clear the pump, how to adjust volume and troubleshooting alarms. ·Education provided by Director of Nursing Services and Clinical Education Co-ordinator March 11, 2020 ·Unit Managers are responsible for oversight during routine unit rounds. The DNS/Designee will round each shift to ensure feeding tubes are operating per physician's order.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	to 2:00 p.m. On 2/26/2020 at 12:45 p.m., the DNS provided an undated, untitled note signed by RD 17. The DNS was made aware there was no date on the note and she indicated RD 17 had just documented the note on 2/26/2020. She was observed to write this date on the document. The note included, but was not limited to, the following: Resident kcal needs determined by 20-25 kcal/kg. Rounding up and using the most recent weight of 142 lb. This results in a kcal need of 1300-1700 kcals daily. Using these numbers to achieve the higher end of the kcal needs 1700. One would need a rate of 47 ml/hr. The note indicated, using clinical judgement, they often roundd up. The resident had been at rates of 45 - 65 ml/hr since admission. the note indicaated they found a rate of 55 ml/hr to be a rate that would provide optimal nutrition, and would provide 1980 kcal and 108 g protein. On 2/19/2020 at 10:57 a.m., Resident 101 was observed in her room. The tube feeding pump was observed to have an infusion rate of 65 ml/hr. The screen on the pump, indicated a total intake of feeding to be 1040 ml. A total of 500 ml was observed hanging in the tube feed bottle of Glucerna 1.5, with a total capacity observed on the bottle of 1000 ml. The tube feeding bottle was dated 2/18/2020 at 7:00 p.m. At an infusion rate of 65 ml/hr for 16 hours (2/18/2020 at 7:00 p.m. to 2/19/2020 at 11:00 a.m.) a total of 1040 ml would have been infused. At this time, a total of 500 ml was observed left in the bottle of tube feed. On 2/19/2020 at 10:58 a.m., the tube feeding pump screen indicated a total intake of flush to be 1200 ml. The flush was programmed to infuse 300ml every 4 hours. The level of water in the flush bag was observed to be barely 25 ml in the bottom of		**How will the corrective action(s) be monitored to ensure the deficient practice will not recur:** ·A QAPI Monitoring Tool titled "Enteral Nutrition" will be utilized every week x 4, monthly x 6 and quarterly thereafter. ·Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed ·Non-compliance with facility procedure may result in disciplinary action up to and including termination.	

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	bag. There was no observed date or time on the 1000ml flush bag. On 2/24/2020 at 3:15 p.m., RN 13 was at Resident 101's bedside. The following was observed with RN 13: the Glucerna tube feeding bottle and the flush bag were both documented as having been hung on 2/24/2020 at 10:30 a.m. The level of tube feeding currently in the bottle was 850 ml. Tube feeding infusion rate was set at 65 cc/hr on the pump. The intake of feeding on the pump screen was 271 ml. The water flush was programed at 300 ml every 4 hours and the screen indicated 400 ml intake for the flush. The level of water in the flush bag was observed to be 775 ml. For 4.5 hours (10:30 a.m. to 3:00 p.m.) at a rate of 65 ml/hr a total of 292.5 ml feeding should have been infused. With the capacity of tube feeding being 1000 ml, minus 292.5 ml, a total of 708 ml should have been hanging, as compared to the 850 ml which was observed in the bottle. On 2/24/2020 at 4:15 p.m., Registered Dietician (RD) 8 was observed to go Resident 101's rm, and a repeated, beeping sound was heard. The source of the beepng sound was observed to be the feeding pump. The screen indicated "Hold error." The bottle of Glucerna 1.5 which was hanging, had documented on the label as hung 2/24/2020 at 10:30 a.m. The bag of flush water had a label documented hung on 2/24/2020 at 10:30 a.m. Observed was a level of 750 ml of flush water hanging. The total amount of feeding capacity of the bottle of feeding and the flush bag was 1000 ml. RD 8 calculated at 65 ml/hr for 5.5 hours (10:30 a.m. to 4:00 p.m.) a total of 357.5 ml should have been infused. With a total capacity of 1000 ml of feedng, minus 357 ml, a total of 643 ml should have remained. Observed was a total of 850 ml currently hanging in the Glucerna bottle. This was			

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	a difference of 207 ml. or 3 hours of feeding. RN 13 was observed standing down the hall at the medication (med) cart. On 2/24/2020 at 4:50 p.m., the med cart was observed where RN 13 had been standing whe Resident 101's alarm was sounding. The distance from the med cart to the door of Resident 101's room, was an approximate distance of 20 feet. On 2/26/2020 at 9:45 a.m., Resident 101 was observed in her room. The tube feeding bag was documented to have been hung on 2/26/2020 at 12:00 a.m. The tube feeding pump was observed to be set at 65 ml/hr for the feeding and the flush was set at 300 ml every 4 hours. The bag of flush had a date documented on it of 2/24/2020 at 10:30 a.m. A total of 575 ml was observed to be hanging in the tube feeding bag and a total of 100 ml water was observed to be hanging in the flush bag. From the time the tube feeding was hung at 12:00 a.m. on 2/26/2020 to the current time was 9.5 hours. With a rate of 65 ml/hr for 9.5 hours the total which should have been infused was 617.5 ml. With the tube feeding bottle capacity of 1000 ml minus the 617.5, which should have been infused, there should have been a remaining total of 382.5 ml, compared to the observed 575 ml hanging in the bottle. On 2/26/2020 at 9:55 a.m., the DNS was observed to go into Resident 101's room. There was observed to be a total of 900 ml of water in the flush bag. But there no documentation on the bag when the bag had been filled last. On 2/24/2020 at 3:10 p.m., RN 13 was interviewed. He indicated it was documented on the label when the bag/bottle of feeding and or flush water had been hung. He indicated, after he reviewed the			

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	MAR (Medication Administration Record), there was no documentation of the date/time the tube feeding and/or flush bag had been hung. He indicated the resident was to get 300 ml of flush every 4 hours. He indicated every 4 hours, the glucerna infusion was automatically shut off and then 300 ml of water flush was administered. He indicated he is not sure how long it takes to administer the 300 ml of flush water every 4 hours. He indicated the feeding pump automatically resumed the feeding after the flush was complete. He indicated on the feeding pump there was a place on the screen that had the total amount infused of feeding and flush infused. He indicated he would collect these totals at the end of his shift. He indicated he didn't document the amount of tube feeding infused per shift in the resident's record, but did document the total on his own personal records. He indicated he cleared the pump totals at the end of his shift, which was at 10:30 p.m. On 2/24/2020 at 3:54 p.m., RD 8 and the DNS were interviewed. They indicated the resident had the tube feeding initiated in November 2019 and had been NPO since 11/18/2019. They indicated when the nurse signed off and initialed the physician order on the MAR (for the tube feeding and flush administration), this indicated the nurse verified the resident had received the ordered amount of tube feeding and flush. RD 8 and the DNS indicated it was not their policy to document the total mls infused but rather to sign off on the MAR, the physician's order had been followed. They indicated by having signed off the order on the MAR, this indicated the resident had received the total amount of tube feedng and flush, the physician had ordered. When queried regarding how they ensured the resident received the physican ordered amount of feeding and fluid, RD			

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	8 indicated she looked at the nutritinal indicators to make sure the resident received adequate nutrition and hydration. She indicated nutritinal indicators included, but were not limited to, condition of skin, labs, etc. On 2/24/2020 at 4:25 p.m., RN 13 was interviewed. He indicated the beeping of the feeding pump alarm in Resident 101's room was not able to be heard from the med cart. When he was asked about Resident 101's feeding pump, he provided a demonstration, on 2/24/2020 at 3:15 p.m., he had accidently put the pump on hold and didn't set the pump back on to infuse. On 2/24/2020 at 4:47 p.m., the DNS was interviewed. She indicated RN 13 was unable to hear the alarm of the pump in the room from his cart in the hall. The DNS indicated they were trying to find out how to increase the level of the alarm on the pump. On 2/26/2020 at 9:40 a.m. LPN 11 was interviewed. She indicated she did not document anywhere in the resident's record the date and/or time she hung a bag/bottle of tube feeding and/or flush water. She indicated the tube feeding and/or flush order in the resident's MAR, for the flush and tube feeding, only told her the rate and the time frame each should infuse. She indicated when she signed off on the MAR for the flush and tube feeding, she was indicating the resident had received this amount. She indicated the feeding and flush were automatic as programed into the tube feeding pump. She indicated she does not look at the water or feeding level of the fluids in each bag as the rate was programmed into the tube feeding pump. She indicated she only looks at the water level to make sure there was enough water in the bag but does not check the level of			

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	the bag to ensure the correct amount had infused on her shift. She indicated if should would hang a new bag or bottle, she would clear the totals on the pump of the flush and feeding intakes. On 2/26/2020 at 9:56 a.m. the DNS was interviewed. She indicated the feeding pump was programmed so the Glucerna infused for 4 hours, then the Glucerna flow automatically stopped and the flush water infused (a total of 300 ml). The DNS indicated it took the flush approximately 10-15 minutes to infuse, then the Glucerna automatically resumed infusion. The DNS indicated the RD calculated the the resident's nutritional needs and the resident received 10 ml/hr per hour over the recommended amount. The DNS indicated this 10 ml/hr over the calculated rate was to compensate and/or account for the time the tube feeding was not infusing. On 2/26/2020 at 10:10 a.m., the DNS, ED, RD 18 and RD 17 were interviewed. RD 18 indicated the pump was programmed to infuse 300 ml of water flush every 4 hours. She indicated at 4 hour intervals, the 300 ml of water flush is infused via the pump similar to a bolus. RD 18 indicated the water flush took approximately 8-10 minutes to infuse. The DNS indicated the facility does not documented the amount of water flush that was infused. The DNS indicated it would depend on the total on the screen for how much feeding and flush the resident received. The DNS, ED, RD 17 and RD 18 were made aware of the observations of the amount of feeding and flush that were ordered to have been administered were not what was observed to have been administed. RD 17 indicated the resident only required a rate of 55 ml/hr for her feeding but was currently at the rate of 65 ml/hr to compensate for tube feeding being off, for medication administration or various			

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	reasons. On 2/26/2020 at 10:20 a.m., Unit Manager 5 and Unit Manager 6 were interviewed in Resident 101's room by the tube feeding pump. They provided a full bottle of unopened tube feeding to use as a demonstration. They turned the tube feeding bottle upside down as though it were hanging from the tube feeding pump. The level of the tube feeding was over the level of the 1000 ml mark on the bottle. Both Unit Managers indicated it appeared as the level of the tube feeding was approximately 50 ml over the 1000 ml hash mark. They indicated the intake totals for the feeding and the flush were to be cleared when a new bottle of tube feeding and flush bag were hung. They were queried regarding how they would ensure the resident received the ordered amount of tube feeding and flush. They indicated the Dietician sets the tube feeding and flush rate according to the resident's nutritional needs. They indicated the rate took into account the resident's weight, lab results, when the feeding pump would be on hold and/or if the resident would have the tube feeding turned off for a transfer or some other reason. They indicated they do not look at the totals on the screen of the feeding pump. On 2/26/2020 at 12:10 p.m., the DNS was interviewed. She indicated RD 17 indicated to her, documentation was lacking of the resident only requiring a tube feeding rate of 55 ml/hr. On 2/26/2020 at 12:15 p.m., RN 3 was interviewed. She indicated to administer medications to a resident via a G-tube, it would take approximately 15 minutes. On 2/26/2020 at 2:15 p.m., the Executive Director			

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	(ED) and Director of Nursing Service (DNS) were interviewed. A full 1000 ml bottle of tube feeding was observed. The bottle of tube feeding was turned in the position it would hang from a pump. The level of tube feeding was over the level of the hash mark labeled 1000 milliliters (ml). Both the ED and the DNS indicated the amount of tube feeding over the 1000 ml hash mark was approximately 50 ml. They were made aware even with reading the level of tube feeding on the bottle and considering a variance of 50 ml, the amount ordered to be infused was not the amount observed to have been infused. The DON was made aware the copy of the current MAR for Resident 101 was received on 2/26/2020 at 1:04 p.m. LPN 11 had already documented the order for the glucerna to infuse at 65 ml/hr continous and the flush to infuse at 300 ml every 4 hours as completed on the MAR, prior to 1:04 p.m. The DON indicated LPN 11 should have waited until the completition of her shift to sign off the order for the glucerna and flush, instead of nearly an hour prior to the end of her shift. The DNS indicated by the nurse signing the MAR for the glucera and flush infusion, this indicated the rate and time frame the tube feeding and flush had infused per physician order. The ED and DNS indicated there was no place on the MAR to document the amount of feeding and/or flush infused via the pump. The DNS indicated the RD 17 indicated the minimum tube feeding rate the resident required based on her needs was 55 ml/hr but the resident actually received a rate of 65 ml/hr. The DNS indicated the physician orders should be followed. 2. On 2/21/2020 at 2:30 p.m., the record of Resident 17 was reviewed. Diagnoses included, but were not limited to, the following: cerebral palsy.			

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A significant change MDS dated 11/15/19, indicated the resdient had severe cognitive impairment, no weight loss and percent of intake by artificial route was 51% or more.

A plan of care with a revision date of 2/2020, titled Nutritional Status, indicated the resident required enteral nutrition to meet nutrient needs related to: refusal to consume adequate nutrition orally, weight continued to fluctuate. Approaches included the following: Provide enteral feeding per MD (medical doctor) order.

A dietary progress note, dated 2/21/2020 at 8:59 a.m., indicated the following: Resident's guardian was requesting tube feeding be disconnected while up in chair. Resident currently received Jevity 1.2 at 48 ml/hr for 22 hours (off from 6:00 a.m. to 10:00 a.m.) each day. Resident was NPO but could have thin liquids and pleasure feedings as desired. Resident was experiencing weight loss at 6 pounds (4.5%) in 24days and 23 pounds (15.4%) in 91 days. Most current weight was 126 lb. The note recommended administering tube feed Jevity 1.2 at 55 ml/hr for 18 hours (off 8 a.m. to 2 p.m.).

A copy of the physician order dated 2/21/2020, indicated to give the following: Jevity 1.2 at 55 ml/hr for 18 hours (off at 8:00 a.m. - start at 2:00 p.m.), twice a day; 6:00 a.m., 2:00 p.m.

The current February 2020 MAR indicted the following: a physician order, dated 2/21/2020, for Jevity 1.2 at 55 ml/hr for 18 hours (off at 8:00 a.m. - start at 2:00 p.m.). The area of the MAR to document this order indicated for 2/24/2020 time: "6:00 a.m. off" and "2:00 p.m., on."

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	On 2/24/2020 at 11:46 a.m., the DNS was interviewed. She indicated the resident had been weighed and her weight was 131 lb. Compared to the previous weight on 2/14/2020 of 126 lb, this was an increase. On 2/24/2020 at 4:25 p.m., the resident was observed in bed with the tube feeding pump at bedside. The label on the Jevity 1.2 tube feeding bottle indicated the bottle had been hung at 2:45 p.m. on 2/24/2020. The level of the tube feeding was observed to be over 1000 ml mark at the top of the feeding bottle. The screen displayed the pump had been programmed to infuse the feeding at 55 ml/hr. The screen indicated "zero" ml feeding and "zero" ml flush had been infused. The flush bag had a capacity of 1000 ml but had water over the level of the 1000 ml mark. On 2/24/2020 at 4:30 p.m., RN 13 was interviewed. He indicated he had not hung the resident's Jevity and/or flush bag at 2:45 p.m, another nurse had hung it. On 2/24/2020 at 4:35 p.m., the resident was observed with RD 8. The level of Jevity was observed to be over the 1000 ml mark in the bottle. RD 8 indicated it looked like they overfilled the bottle, as it was still over 1000 ml. The rate was programmed at 55 ml/hr and the screen indicated "zero" fed and "zero" flush. RD 8 indicated this was a problem, that the amount of Jevity which was to have been infused (100 ml), was not infused. On 2/24/2020 at 3;59 p.m., the DNS provided a current copy of the policy and procedure for "Enteral Therapy" dated 1/2016. The policy included but was not limited to, the followng: "...policy of this facility...licensed nurse...must			

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	carefully monitor the resident's response to the enteral feedings and feeding techniques to ensure the attainment of therapeutic goals..." The procedure included but was not limited to, the following: A licensed nurse will take, note and implement physician orders for enteral therapy; the followng orders should be obtaned when enteral therapy is being impleted or changed: type of formula and amount and frequenc of water flushes; and a licensed nurse will communicate enteral therapy orders, to the Dietary Department. 3.1-47(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure fluid intakes were accurately monitored for 2 of 2 residents reviewed. (Resident 119 and Resident 127) Findings include: 1. The record review for Resident 119 began on 2-21-2020 at 1:00 p.m. Diagnoses included, but were not limited to, encounter for orthopedic aftercare following surgical intervention, diabetes with neuropathy, end stage renal disease, dependence on renal dialysis, anxiety, noncompliance with other medical treatment and regimen, chronic obstructive pulmonary disease, depression, fluid overload, and chronic pain	F 0698	**F698** It is the practice of this facility to ensure fluid intakes are accurately monitored for residents requiring fluid restrictions. However; based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:** ·Resident #119: The physician determined due to the residents continued non-compliance with	03/27/2020

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	syndrome. The most recent MDS (Minimum Data Set) admission assessment, dated 1-22-2020, indicated the resident's BIMS (Brief Interview for Mental Status) was 15/15 which indicated the resident was cognitively intact. The PHQ-9 (Patient Health Questionnaire) score was 10 for the resident which indicated moderate depression. The resident required an extensive assist of 2 staff for bed mobility and for transfers. Walk in room/corridor did not occur. The resident required an extensive assist of 1 person for locomotion on/off unit, dressing, toilet use and personal hygiene. For eating, the resident required supervision with set up help and was dependent on 1 person for bathing. The resident had impairment on one side of her lower extremities and had scheduled and prn (as needed) pain medications for frequent, severe pain. Dialysis was marked as being received during the last 14 days while a resident of the facility. A review of the current physician orders for Resident 119 indicated the following: Dialysis Tuesday, Thursday, & Saturday with hook up time at 6:45 a.m. and special instructions to complete dialysis event, appointment transportation, and paperwork dated 2-12-2020. Dialysis order dated 2-18-2020 indicated a 1500 ml (milliliters) fluid restriction with 240 ml amount allowed with meals and from nursing 300 ml on first shift, 240 ml on second shift and 240 ml on third shift. A dialysis order dated 1-3-2020 indicated a 1500 ml fluid restriction in a 24 hours period with 240 ml		recommended fluid consumption- the restriction on her fluids was discontinued. ·Resident #127- This resident remains at the hospital **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·Residents with a physicians' order for restricted fluid intake have the potential to be affected by the alleged deficient practice. ·No other residents were identified to be affected by the alleged deficient practice. ·Nursing staff have been educated on the documentation requirements of residents with a fluid restriction ordered by their physician. Education includes but is not limited to visual assessment of fluid intake, not providing a water pitcher at bedside, accurate documentation of fluids consumed and physician notification of non-compliance. Education also includes types of diets offered at the facility. ·Education provided by Director of Nursing Services/Clinical Education Co-ordinator on March 11, 2020. ·The Registered Dietician has been educated on updating tray tickets to reflect Dietary Fluid Restrictions for residents with a physicians' order for restricted fluids and updating diet	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	allowed with meals and for 300 ml on first shift, 300 ml on second shift and 180 on third shift. Diet orders dated 12-28-2019 indicated to document in milliliters all fluids taken with medications (8 hour shifts) on every shift. A review of the February 2020 MAR (Medication Administration Record) indicated the fluid intakes for the above orders were documented with the nurse initials on the orders for their respective shifts. The amounts of the fluids were not entered each shift. A review of the dietitian notes dated 1-22-2020 indicated Resident 119 was on a consistent carbohydrate, 3 gram sodium diet with potassium restricted foods and a 1500 ml fluid restriction. Resident 119 had experienced significant weight fluctuations over past couple months with reported weights of 209 pounds on 1-21-2020, and 216 pounds on 1-7-2020 and 12-31-2019. The dietitian indicated the resident was at risk for further weight fluctuations due to the diagnosis of end stage renal disease and dependence on dialysis. The fluid restriction was in place to promote fluid control and the dietitian recommended continuing with current nutrition plan. The DNS (Director of Nursing services) provided the diet communication form for Resident 119 on 2-24-2020 at 4:40 p.m. The form indicated the resident's diet was marked consistent carbohydrate, no added salt, renal with a 1500 ml fluid restriction. A copy of the tray card for Resident 119 was provided by Nurse Unit Manager 5 on 2-21-2020 at 2:38 p.m.		changes/careplans per physician orders. Education includes but is not limited to entering each meal fluid restriction detail on the residents' meal tray card and specific diets per physicians order. ·Education provided on March 11, 2020 by the ASC Dietician. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** ·Nursing staff have been educated on the documentation requirements of residents with a fluid restriction ordered by their physician. Education includes but is not limited to visual assessment of fluid intake, not providing a water pitcher at bedside, accurate documentation of fluids consumed and physician notification of non-compliance. Education also includes types of diets offered at the facility. ·Education provided by Director of Nursing Services/Clinical Education Co-ordinator on March 11, 2020. ·The Registered Dietician has been educated on updating tray tickets to reflect Dietary Fluid Restrictions for residents with a physicians' order for restricted fluids and updating diet changes/careplans per physician orders. Education includes but is not limited to entering each meal	

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	The meals for 2-22-2020 were listed on the card with the consistent carbohydrate diet and with 8 ounces of water at each meal, 8 ounces of beverage choice for breakfast, 8 ounces of 2% milk and 8 ounces of iced tea for lunch and 8 ounces of iced tea for dinner. (8 ounces of fluid equals 240 ml.) An interview with Regional Dietitian 8 on 2-24-2020 at 4:06 p.m., indicated Resident 119's tray card was corrected for 8 ounces of a beverage for each meal. A review of the care plans for Resident 119 indicated the following: A nutrition care plan dated 1-25-2020 indicated the resident required a therapeutic diet due to diabetes, end stage renal disease and dependence on dialysis treatments. There was risk for weight fluctuations due to the end stage renal disease and dialysis treatments and the resident having experienced weight fluctuations over the past 2 months. The approaches included but were not limited to, monitor food/fluid intake at meals, provide diet per MD (Medical Doctor) order and 1500 ml fluid restriction. A care plan dated 12-29-2020 and last revised on 2-10-2020 indicated the resident was receiving hemodialysis and was at risk for complications such as fluid imbalance, bleeding or infection. The approaches included but were not limited to, monitor fluid intake, 1500 ml fluid restriction and observe for symptoms of fluid volume deficit or fluid volume excess, document and notify physician and dialysis center. A care plan dated 12-29-2019 last reviewed/revised on 1-28-2020 indicated the resident was at risk for fluid imbalance related to end stage renal disease with dialysis fluid		fluid restriction detail on the residents' meal tray card and specific diets per physicians order. ·Education provided on March 11, 2020 by the ASC Dietician. ·Residents who have an order for fluid restrictions will be monitored to ensure fluid intakes are documented and reviewed by DNS/Designee. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur:** ·A QAPI Monitoring Tool titled "Fluid Restriction" will be utilized every week x 4, monthly x 6 and quarterly thereafter. ·Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed ·Non-compliance with facility procedure may result in disciplinary action up to and including termination.	

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restrictions and required assistance with food and fluids. The approaches included but were not limited to, encourage to consume fluids offered per restrictions and record intake.

A care plan dated 2-10-2020 last reviewed/revised on 2-19-2020 indicated the resident was making unsafe decisions and was refusing to follow the fluid restriction order as manifested by getting and keeping water pitchers in her room.

A review of the fluid intakes documented for meals in the point of care program used by the CNAs, indicated there was missing fluid intake documentation for Resident 119 on 2-23-2020, 2-21-2020, 2-10-2020, 2-7-2020, 1-31-2020, and 1-26-2020.

The Fluid Restriction Worksheets for Resident 119 for February 2020 were provided by Nurse Unit Manager 5 on 2-24-2020 at 1:42 p.m. There were 7 dates the resident was not in the facility during breakfast and the fluid intakes were documented at 240 ml. There were 2 dates where the resident was not in the facility for breakfast or lunch becasue she was at dialysis and the fluid intakes for breakfast and lunch were documented at 240 ml each. Also, the fluid amounts taken in between meals were documented between breakfast and lunch and lunch and dinner. The amount of fluid intake documented was exactly the same amount as allowed on all dates for meals and in between meals except for 2-19-2020 third shift. The fluid intakes were also documented for 2-24-2020 third shift (10 p.m.to 6 a.m.). There was also 240 ml of fluids documented for the lunch meal on 2-21-2020 when the resident did not drink any of the liquids offered by the facility.

The nurse progress notes for Resident 119 were

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	provided by Medical Records on 2-25-2020 at 9:36 a.m. The progress notes from admission of were reviewed. There was no mention of the resident taking in fluids, not by what family brought in or what resident obtained herself. A progress note dated 2-11-2020 at 8:27 a.m., indicated the Dialysis center contacted the facility regarding Resident 119 having excess fluid and requiring an additional dialysis session on Wednesday from 4:30 p.m. - 6:30 p.m. An interview with Resident 119 on 2-19-2020 at 11:07 a.m., indicated she was on a low sodium and diabetic diet with a 1500 ml fluid restriction. The resident indicated the staff filled a water pitcher in her room to about 500 ml each shift with ice. At this time, a pitcher of ice water was observed to be filled to 300 ml and the resident was observed to drink from container twice during the interview. The resident indicated she was aware she was on a fluid restriction and indicated she tried to watch how much fluid she takes in. An observation of Resident 119's room on 2-20-2020 at 9:57 a.m., indicated there was a water pitcher on her overbed table with 450 ml water and ice. The resident was out for her dialysis appointment. An observation of Resident 119 on 2-20-2020 at 12:22 p.m., indicated the resident had returned from dialysis. Nurse 2 was observed to obtain her blood pressure and administer the resident her medications with a small amount of water the nurse brought in with her. The resident's water pitcher with 450 ml of ice and water remained on the overbed table. An observation of Resident 119 in her room on			

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	2-21-2020 at 12:52 p.m., indicated the resident had been eating her lunch. On the meal tray, an 8 ounce glasses of iced tea, water and a carton of milk (half pint = 8 ounces) was observed. An interview with the resident at this time indicated she did not usually drink all the fluids they served her. The resident was observed with a 20 ounce bottle of soda pop on her overbed table and a pitcher of 450 ml of water. An observation of Resident 119's room on 2-21-2020 at 12:59 p.m., indicated her meal tray was removed by the Nurse Unit Manager 5. The full glass of water, tea and the unopened carton of milk were removed from the resident's room. Nurse Unit Manager 5 indicated the resident had requested the alternate meal so the meal tray lacked a tray card. An observation of Resident 119's meal tray on her overbed table on 2-24-2020 at 1:22 p.m., indicated there was an opened empty carton of milk (1/2 pint) 240 ml and a full glass of orange drink she did not drink. An interview with Resident 119 in her room on 2-24-2020 at 10:04 a.m., indicated the facility staff did not fill her water pitcher this morning which was observed on the over bed table empty. The resident indicated her daughter brought her a large drink from a fast food restaurant the day before and that drink lasted her 2 days. An interview with CNA 6 (Certified Nurse Aide) on 2-24-2020 at 1:20 p.m., indicated it was her responsibility to record the intakes, both food and fluids for the residents that ate their meals in their room.			

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	An interview with Nurse 7 on 2-24-2020 at 1:35 p.m., indicated the nursing staff monitored how much fluid the resident consumed between meals and if they had a pitcher of water, they monitored the water intake. The nurse indicated the resident had a right to drink the fluids, but they do not encourage it with a resident on fluid restrictions. The nurse indicated they also keep track of the fluids taken during the medication pass and the amounts for the meals and in between meals were recorded on the Fluid Restriction Worksheet located in the Narcotic book. An interview with Nurse Unit Manager 5 on 2-24-2020 at 1:40 p.m., indicated she did not know if the Fluid Restriction Worksheets were a part of the resident's clinical record or not. She indicated when they are completed, they were sent to medical records. An interview with Resident 119 on 2-24-2020 at 3:10 p.m., indicated the facility did not provide her with breakfast before she left for dialysis. She indicated the facility provided her a meal to take to dialysis, usually with a small container of cranberry juice. She indicated the facility did not ask her whether she drank the cranberry juice at dialysis. An interview with the Regional Dietitian 8 on 2-24-2020 at 4:06 p.m., indicated the fluid restriction order should have the fluid distribution for each meal and in between meals. The Regional Dietitian 8 indicated there should be a Dietary Communication form for the resident on fluid restrictions. She indicated they just fixed Resident 119's diet card to reflect an 8 ounce (240 ml) drink for each meal. An interview with the DNS (Director of Nursing			

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	Services) on 2-24-2020 at 4:12 p.m., indicated on the Fluid Restriction Worksheet, the fluids monitored were only what the facility provided to the resident. She indicated if the family or resident obtained more fluids, the facility did not include those amounts in the fluid intake documentation. She indicated the facility could not keep track of how much the resident consumed in fluids for amounts not provided by the facility. She indicated this resident was non-compliant and the nephrologist did not want to remove the fluid restriction. When asked about fluid intakes at meals when the resident was out of the building for dialysis and how did the facility know how much fluid the resident consumed, the DNS indicated the resident probably would not get a drop of water from the dialysis facility. The DNS was made aware of the 2-21-2020 lunch meal, when the tray was observed with a carton of milk, a glass of tea and a glass of water not consumed and the recorded intake of 240 ml of fluid at lunch. The DNS indicated it was probably from the water pitcher she had in her room. The DON was made aware water pitcher intake was documented as between meal intakes per nursing interviews. An interview with Nurse 1 on 2-24-2020 at 5:02 p.m., indicated during her shift, the CNA would record the fluid amount taken for supper and she would record fluids taken with medications and any other fluids she may have observed in the room. When asked if she would include fluids that were in a fast food cup, she indicated she would and she would ask the resident how much was in the cup and estimate the amount that the resident would show by using her fingers to measure the amount in the cup. She indicated she would record her amounts on the Fluid Restriction worksheet which was located the narcotic book on the medication cart.			

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An interview with Nurse 2 on 2-25-2020 at 8:44 a.m., indicated Resident 119 did get a breakfast before leaving for dialysis and she had drank 240 ml of liquid. The nurse indicated the nurse documented the fluid intakes for the resident's on fluid restrictions. She indicated she will keep track of the fluids the resident takes between meals and with medication pass and she will chart the amount of fluids at the end of her shift. She indicated the resident was provided a lunch to take with her and it had 240 ml of fluid, but if the resident arrived back to the facility before the facility served lunch, she would usually eat the lunch provided at the facility. At 8:47 a.m., Nurse 2 indicated they only document the fluid intakes from what the facility provided the resident on the Fluid Restriction Worksheets, but if the resident had fluids brought in such as a drink from a fast foot restaurant, it would be noted in the nurse progress notes.

An interview with CNA 9 on 2-25-2020 at 8:46 a.m., indicated for Resident 119, he would let the nurse know how much fluid intake the resident had at meals, and he would also document the amounts in the Point of Care system for the CNAs..

2. The record review for Resident 127 began 2-21-2020 at 12:41 p.m. Diagnoses included but were not limited to,
disorders of calcium metabolism, non pressure chronic ulcer of skin, chronic pain, diabetes, end stage renal disease, and dependence on renal dialysis.

The Corrected MDS admission assessment dated 1-24-2020 for Resident 127 indicated the resident had a BIMS of 13/15, which meant the resident was cognitively intact. The required an extensive

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	assist of 2 for bed mobility, toilet use and bathing. The resident was totally dependent on 2 staff for transfers and bathing. The resident did not walk on the unit/corridor and required an extensive assist of 1 staff for locomotion on/off unit, for dressing and personal hygiene. The resident required supervision of 1 person for set up help for eating. The resident had impairment on one side of her lower extremity, had occasional pain rated moderate on a verbal scale and received as needed pain medications. The resident was 64 inches tall and weighed 246 pounds. The resident had MASD (Moisture Associated Skin Damage) and open lesions on her skin and was not marked for receiving dialysis while a resident A review of the current physician orders for Resident 127 indicated the following: A dialysis order dated 1-17-2020 for Fluid Restriction with 240 ml amount allowed during meals, and additional fluids, 300 ml on first shift, 240 ml second shift and third shift were the amounts allowed between meals (nursing). An order for check placement of fluid restriction band every shift ordered on 1-17-2020. Diet orders dated 1-31-2020 indicated the resident was on a consistent carbohydrate, renal diet with ground meat per resident request. A review of the February 2020 MAR (Medication Administration Record) indicated the fluid intakes for the above order were documented with the nurse initials on the orders for their respective shifts. The amounts of the fluids were not entered each shift. A review of the dietitian notes dated 1-24-2020 at			

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	5:20 p.m., indicated Resident 127 was on a consistent carbohydrate, renal friendly diet with a 1500 ml fluid restriction. The resident's weight remained stable since admission with a risk for significant weight fluctuations due to end stage renal disease and dependence on dialysis. A copy of the Diet Communication Form for Resident 127 was provided by the DNS on 2-24-2020 at 4:40 p.m. The form indicated a consistent carbohydrate diet was marked and other diet, renal diet was written on the form. The fluid restriction of 1500 ml was not entered on the form signed by a nurse on 1-17-2020. The tray card for Resident 127 was provided by the Nurse Unit Manager 5 on 2-21-2020 at 2:38 p.m. The tray card indicated the resident was on a consistent carbohydrate diet and was to receive 8 ounces of water with each meal. There was no mention of a renal diet or 1500 ml fluid restriction on the tray card. An updated tray card for Resident 127 was provided by the DNS on 2-21-2020 at 2:56 p.m. She indicated the home office dietitian corrected the tray cards to add the special instructions (1500 ml fluid restriction and 240 ml only at meals, serve ground meat) as the special instructions had not been on the tray cards prior to this time. A care plan dated 1-15-2020 and last reviewed/revised on 2-10-2020 for Resident 127 indicated the resident was on hemodialysis and was at risk for complications such as fluid imbalance. Approaches included but were not limited to, monitor fluid intake, observe for symptoms of fluid volume excess such as edema, shortness of breath, abnormal lung sounds, weight gain, and hypertension; to document			

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	findings and notify MD and dialysis center. A care plan for dehydration and fluid maintenance for Resident 127 was dated 1-15-2020 and last reviewed/revised on 2-10-2020. The care plan indicated the resident was at risk for fluid imbalance due to needing assistance with foods and fluids, receiving dialysis 3 times a week with a fluid restriction. Approaches included but were not limited to, record intake. A care plan for risk for altered nutritional status for Resident 127 related to history of a stomach bleed, diabetes, end stage renal disease, and dependence on renal dialysis was implemented on 1-28-2020 and last reviewed/revised on 2-4-2020. The approaches included but were not limited to monitor food/fluid intake at meals and provide consistent carbohydrate, renal friendly diet with ground meats and a 1500 ml fluid restriction. A review of the fluid intakes documented for meals in the point of care program used by the CNAs, indicated there was missing fluid intake documentation for Resident 127 on 2-21-2020, 2-20-2020, and 2-17-2020. Copies of the Fluid Restriction Worksheets for Resident 127 were provided on 2-24-2020 at 1:42 p.m. by Unit Manager 5. The fluid intakes recorded were the exact amounts the resident was allowed on each shift. Fluid amounts were entered when the resident was out of the building at dialysis. Fluid amounts were entered on 5 shifts after the resident was transferred to the hospital (and marked out) on 2-22-2020 at 11:29 a.m. per the transfer report. An interview with Resident 127 on 2-19-2020 at 4:51 p.m., indicated the resident was aware she			

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	was on a fluid restriction but did not know what amount. She indicated the facility staff filled this large pitcher that was observed on her overbed table with water each shift (pitcher size was about 32 ounces.) The resident indicated she did not drink it all. An interview with Resident 127 on 2-20-2020 at 10:00 a.m., indicated she was not feeling well and was not going to dialysis. She was observed to have a 16 ounce bottle of ginger ale with about of 1/4 of it gone. An observation of Resident 127's room on 2-21-2020 at 1:22 p.m., indicated the resident was not in her room. Staff indicated the resident was out for dialysis today as she was ill yesterday and did not go. An observation of Resident 127's room on 2-24-2020 at 10:45 a.m., indicated the resident's name was not on the room door. CNA 9 was interviewed at this time and he indicated the resident was sent to the hospital. On 2-24-2020 at 4:40 p.m., the DNS provided a Dialysis care policy and indicated the facility did not have any other policy regarding fluid restrictions as far as she knew. She indicated the only statement in the Dialysis policy was regarding physician orders to obtain for fluid restrictions if indicated. A current policy, "Dialysis Care" last revised on 11/2017 was provided by the DNS on 2-24-2020 at 4:40 p.m. The policy indicated, "...It is the policy of the named facility corporation to ensure that residents requiring dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care,			

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	and the residents' goals and preferences...1. Physician orders will be received at time of admission specific to the resident...fluid restrictions if indicated...8. All specific resident care areas will be addressed on the plan of care and profile as needed...." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure accuracy, monitoring and reconciliation of controlled substances for 1 of 2 residents reviewed. (Resident 119) Findings include: The record review for Resident 119 began on 2-21-2020 at 1:00 p.m. Diagnoses included but were not limited to, encounter for orthopedic aftercare following surgical intervention, diabetes with neuropathy, end stage renal disease, dependence on renal dialysis, anxiety, noncompliance with other medical treatment and regimen, chronic obstructive pulmonary disease, depression, fluid overload, and chronic pain syndrome. The most recent MDS (Minimum Data Set) admission assessment was dated 1-22-2020 for Resident 119. The resident's BIMS (Brief Interview for Mental Status) was 15/15 which indicated the resident was cognitively intact. The PHQ-9 (Patient Health Questionnaire) score was 10 for the resident which indicated moderate depression. The resident had impairment on one side of her lower extremities and had scheduled and prn (as needed) pain medications for frequent, severe pain. Dialysis was marked as being received during the last 14 days while a resident of the facility. A review of the current physician orders for Resident 119 indicated the following medication	F 0755	**F755** It is the practice of this facility to ensure controlled substances are monitored and reconciliation is accurate. However; based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:** ·Resident #119: Controlled substances are signed out on the Controlled Substance Record and also signed out in the EMAR to reflect the nurse taking the medication from the medication cart then initialing off the medication after resident administration. Resident is receiving medication per physician's order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·Residents receiving prn medications identified as a controlled substance have the potential to be affected by the alleged deficient practice. ·No other residents were found to have been affected by the	03/27/2020

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	was ordered for pain, Percocet (oxycodone-acetaminophen), a Schedule II narcotic, 5-325 mg (milligrams) tablet 2 tablets for pain rated 7-10 every 4 hours as needed by mouth. Percocet (oxycodone-acetaminophen) 5-325 mg 1 tablet for pain rated 4-6 every 4 hours as needed by mouth was also ordered. The dose of pain medication was not to exceed 4000 mg of acetaminophen from all sources in 24 hours. A physician's order indicated the resident may take 2 Percocet tabs (5-325 mg) to dialysis with her. A review of the February 2020 MAR (Medication Administration Record) for the Percocet 5-325 mg indicated 2 tablets were administered 22 times from 2-1-2020 to 2-21-2020. The pain medication was effective 15 times, somewhat effective 3 times, not effective twice and the resident was not in the building one time during the pain medication followup. The Percocet 5-325 mg 1 tablet was administered 5 times during the same time period and all were effective. The Controlled Substance Records for Resident 119 were reviewed from 2-1-2020 through 2-21-2020 for the Percocet (oxycodone-acetaminophen) 5-325 mg tablets. The February 2020 MAR lacked documentation of the Percocet (oxycodone-acetaminophen) 5-325 mg tablets signed out on the following Controlled Substance Records: On 2-1-2020, oxycodone 5-325 mg 2 tablets were signed out at 6:00 a.m. and 1 tablet was signed out at 8:00 (unable to determine if it was a.m. or p.m.) and were not documented on the MAR on 2-1-2020. On 2-3-2020, oxycodone 5-325 mg 2 tablets were signed out at 12:00 a.m., 4:00 a.m., and 8:30 a.m. and were not documented on the MAR for		alleged deficient practice. ·Licensed Staff have been re-educated on the expectation/requirement to administer controlled substances. Education includes but is not limited to signing out the medication on the Controlled Substance Record indicating the Licensed Nurse has pulled the medication out of the Narcotic Box. The Licensed Nurse then initials the medication off in the EMAR after administration to the resident. ·Education provided on March 11, 2020 by the Director of Nursing Services and the Clinical Education Co-ordinator. ·The Unit Managers are responsible for oversight with routine audits of prn controlled substance administration and corresponding documentation. . **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** ·Licensed Staff have been re-educated on the expectation/requirement to administer controlled substances. Education includes but is not limited to signing out the medication on the Controlled Substance Record indicating the Licensed Nurse has pulled the medication out of the Narcotic Box. The Licensed Nurse then	

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	2-3-2020. On 2-4-2020, oxycodone 5-325 mg 2 tablets were signed out at 12:00 a.m., 4:45 a.m., and 5:00 p.m. and were not documented on the MAR for 2-4-2020. On 2-5-2020, oxycodone 5-325 mg 2 tablets were signed out at 6:00 p.m. and was not documented on the MAR for 2-5-2020. On 2-6-2020, oxycodone 5-325 mg 1 tablet was signed out at 7:00 (a.m. or p.m. was not documented) and was not documented on the MAR for 2-6-2020. On 2-8-2020, oxycodone 5-325 mg 2 tablets were signed out at 1:30 a.m. and 6:00 a.m. and were not documented on the MAR for 2-8-2020. On 2-9-2020, oxycodone 5-325 mg 2 tablets were signed out at 4:15 a.m. and was not documented on the MAR for 2-9-2020. On 2-10-2020, oxycodone 5-325 mg 2 tablets were signed out at 12:00 a.m., 4:00 a.m., and 8:00 p.m. and were not documented on the MAR for 2-10-2020. On 2-11-2020, oxycodone 5-325 mg 2 tablets were signed out at 12:00 a.m., 4:00 a.m., 6:30 a.m., 4:00 p.m., and 11:30 p.m. and were not documented on the MAR for 2-11-2020. On 2-12-2020, oxycodone 5-325 mg 2 tablets were signed out at 4:30 a.m., and 5:30 (a.m. or p.m. were not designated) and were not documented on the MAR for 2-12-2020. On 2-13-2020, oxycodone 5-325 mg 2 tablets were signed out at 6:10 a.m., 5:00 p.m., and 11:30 p.m. were not documented on the MAR for 2-13-2020. On 2-14-2020, oxycodone 5-325 mg 2 tablets were signed out at 5:30 a.m., and 4:30 p.m. and were not documented on the MAR for 2-14-2020. On 2-15-2020, oxycodone 5-325 mg 2 tablets were signed out at 7:30 a.m. and was not documented on the MAR for 2-15-2020. On 2-16-2020, oxycodone 5-325 mg 2 tablets were		initials the medication off in the EMAR after administration to the resident. ·Education provided on March 11, 2020 by the Director of Nursing Services and the Clinical Education Co-ordinator. ·The Unit Managers are responsible for oversight. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur:** ·A QAPI Monitoring Tool titled "Controlled Substance Administration" will be utilized every week x 4, monthly x 6 and quarterly thereafter. ·Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed ·Non-compliance with facility procedure may result in disciplinary action up to and including termination.	

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	signed out at 12:00 a.m., 4:30 p.m., and 8:30 p.m. and were not documented on the MAR for 2-16-2020. On 2-17-2020, oxycodone 5-325 mg 2 tablets were signed out at 12:30 a.m., 4:30 a.m., 8:30 a.m., and 4:30 p.m. and were not documented on the MAR for 2-17-2020. On 2-18-2020, oxycodone 5-325 mg 2 tablets were signed out at 12:30 a.m. and 1 tablet was signed out at 4:30 a.m. and neither were documented on the MAR for 2-18-2020. On 2-19-2020, oxycodone 5-325 mg 1 tablet was signed out at 8:00 p.m. and was not documented on the MAR for 2-19-2020. On 2-20-2020, oxycodone 5-325 mg 2 tablets were signed out at 6:05 a.m. and 1 tablet was signed out at 8:00 p.m. and neither were documented on the MAR for 2-20-2020. On 2-14-2020, oxycodone 5-325 mg 1 tablet was documented on the MAR at 7:44 p.m., but was not signed out on the Controlled Substance Record. On 2-20-2020, oxycodone 5-325 mg 1 tablet was documented on the MAR at 12:29 a.m., but was not signed out on the Controlled Substance Record. A review of the bottom of each Controlled Substance Record for Resident 119 was the following statement, "...Note...Chart each dose administered...." An interview with Resident 119 on 2-19-2020 at 11:17 a.m., indicated she gets Percocet for pain as needed due to the chronic pain in her back. The resident indicated the pain medication will bring the pain down to a bearable state. An interview with Nurse 7 and Nurse 2 on 2-25-2020 at 1:45 p.m., indicated when a resident requested a prn pain narcotic medication, the			

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	nurse will sign it out on the Controlled Substance Record and then the nurse should document the administration of the medication on the MAR. An interview with Unit Manager Nurse 7 on 2-5-2020 at 1:53 p.m., indicated she did not reconcile the Controlled Substance Records for narcotics and the MAR to ensure that the narcotics that were signed out were also documented as administered on the MAR. An interview with the DNS (Director of Nursing Services) on 2-25-2020 at 2:04 p.m., indicated she was made aware of Resident 119's Controlled Substance Records for the Percocet 5-325 mg tablets were not all documented in the MAR from 2-1-2020 through 2-21-2020. The DNS indicated the facility did not have a process for reconciliation of the Controlled Substance Record medication sign outs with a resident's MAR to ensure all doses signed out were documented as administered on the resident's MAR. The DNS indicated the Controlled Substance Records were part of the medical record, showed the nurse signed the medication out and it was not necessary that administration of the medication was marked on the MAR. She indicated the documentation was on the Controlled Substance Record and was all in the resident's record. She indicated they had reviewed this information with the nursing staff at a staff meeting and the documentation was improving. A facility policy was requested for documentation of the administration of narcotic medications. An interview with the DNS on 2-25-2020 at 3:21 p.m., indicated the facility did not have anything in their pharmacy policies regarding documentation of narcotic medications in the MAR. She indicated their pharmacy policy only			

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	addressed the use of the controlled substance records for the declining inventory of the controlled substances. Nurse 11 was interviewed on 2-26-2020 at 8:44 a.m. The nurse was asked about the statement on the bottom of the Controlled Substance Record, "...Note...Chart each dose administered...." Nurse 11 indicated the statement meant the nurse was to document on the Controlled Substance Record (which included the date, time and number of the tablets removed, the quantity remaining and the nurse initials). The nurse indicated after administration of the medication, the nurse should document the administration of the narcotic in the electronic MAR. A current policy, "General Dose Preparation and Medication Administration" with a revised date of 1-1-2013 was provided by the DON on 2-26-2020 at 1:11 p.m. The policy indicated, "...5.5 Document the administration of controlled substance in accordance with Applicable Law...6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: Document necessary medication administration/treatment information...when medications are given...on appropriate forms...." 3.1-25			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.			

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	§483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview, and record review, the facility failed to ensure the proper route of medication administration was documented for 1 of 3	F 0756	**F756** It is the practice of this facility to ensure medication is administered	03/27/2020

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	residents reviewed. (Resident 25) Findings include: A review of Resident 25's record on 2/21/2020 at 12:25 p.m., indicated a BIMS (Brief Interview of Mental Status) was unable to be completed due to severe cognitive impairment. The BIMS result was obtained from the MDS (Minimum Data Set) Admission Assessment, dated 11/29/2019. Diagnoses included, but were not limited to: stroke, dysphagia (inability/difficulty swallowing), a tracheostomy (an incision in the windpipe), gastrostomy (a surgical opening into the stomach made for a tube to provide feeding) and muscle weakness. The Physician Orders indicated the following: Aspirin 81 mg (milligram), delayed release, enteric coated, orally daily, dated 1/16/2020, for stroke. Baclofen 5 mg orally, 3 times a day for muscle spasms, dated 1/10/2020. May crush appropriate medications and administer per G tube (gastric stomach tube). May substitute liquid medications as available. NPO, dated 11/22/2019. A review of the EMAR (Electronic Medication Administration Record) for the last 14 days indicated both Baclofen, and delayed release and enteric coated Aspirin as given per oral route. A review of the form, Common Oral Dosage Forms That Should Not Be Crushed, provided by the ADNS (Assistant Director of Nursing Services) on 2/21/2020 at 2:50 p.m., indicated enteric coated and/or delayed release Aspirin was not to be crushed. A review of the Monthly Pharmacy Review, for		via physicians order route. However; based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:** ·Resident #25: The residents enteric coated medication was discontinued. The physician ordered a chewable medication to allow G-Tube administration. The physician discontinued the Baclofen order po and wrote a new order for the Baclofen to be administered via G-Tube. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·Residents requiring medications be administered via G-Tube have the potential to be affected by the alleged deficient practice. ·No other residents were identified to have been affected by the alleged deficient practice ·The facility providing pharmacy conducted a full house audit to identify medications that are not to be crushed. ·Medication cards are marked with a sticker indicating “Do Not Crush” for easy identification. ·Licensed staff have been re-educated on medication	

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	Resident 25, dated 2/10/2020 indicated the following: "...See report for any noted irregularities..." A review of the Pharmacy recommendations indicated no documented concerns that regarded the two medications documented as administered orally or the enteric coated Aspirin crushed. A Care Plan, titled Resident at risk for fluid imbalance due to the resident was NPO, was dated 11/22/2019. An intervention indicated to administer medications as ordered. During an interview on 2/21/2020 at 1:45 p.m., RN (Registered Nurse) 3, indicated the resident received all medications through his G tube, they crushed the pills and some of the medications were liquid. During an interview on 2/21/2020 at 2:17 p.m., LPN (Licensed Practical Nurse) 19, indicated the resident received all of his medications through his G tube, indicated he had a combination of pills that were crushed prior to administration and liquids. She further indicated the resident was getting nothing by mouth, he was NPO. During an interview on 2/24/2020 at 10:17 a.m., the DNS (Director of Nursing Services) indicated the facility had no policy on following Physician Orders. During an interview on 2/24/2020 at 10:25 a.m., the Medical Records Coordinator indicated there was an administration note in the EHR (Electronic Health Record) that indicated may crush appropriate medications and administer per G-tube, and may substitute liquid meds as available, dated 11/25/2019 at 11:54 a.m.		administration via G-Tube, available information used to identify non-crushable medications and process to obtain a substitute medication from the physician. Education includes but is not limited to using the "Common Oral Non-Crush Medication List" available on each medication cart for Licensed Staff reference, utilizing "Do Not Crush" stickers provided by pharmacy, notifying the physician if a non-crushable medication is ordered for NPO residents for liquid form or a substitute medication and ensuring NPO residents have all medications ordered to be administered via G-Tube. ·Education provided by the Director of Nursing Services and Clinical Education Co-ordinator March 11, 2020 ·Medical Records Licensed Nurses are responsible for oversight. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** ·Medication cards are marked with a sticker indicating "Do Not Crush" for easy identification. ·Licensed staff have been re-educated on medication administration via G-Tube, available information used to identify non-crushable	

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	A current facility policy, General Dose Preparation and Medication Administration, dated 1/1/2013, and provided by the DNS on 2/26/2020 at 11:57 a.m., indicated the following: "...3.8 Facility staff should crush oral medications only in accordance with Pharmacy guidelines as set firth in Appendix 16: Common Oral Dosage Forms that Should Not be Crushed and/or Facility policy. 4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule..." 3.1-25(i)		medications and process to obtain a substitute medication from the physician. Education includes but is not limited to using the "Common Oral Non-Crush Medication List" available on each medication cart for Licensed Staff reference, utilizing "Do Not Crush" stickers provided by pharmacy, notifying the physician if a non-crushable medication is ordered for NPO residents for liquid form or a substitute medication and ensuring NPO residents have all medications ordered to be administered via G-Tube. ·Education provided by the Director of Nursing Services and Clinical Education Co-ordinator March 11, 2020 ·Medical Records Licensed Nurses are responsible for oversight during daily physician order audits to ensure medication orders include "Do Not Crush" when applicable. Unit managers ensure appropriate drug cards are labeled with "Do Not Crush" sticker identifiers. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur:** ·A QAPI Monitoring Tool titled " Medication Administration" will be utilized every week x 4, monthly x 6 and quarterly thereafter. ·Data will be submitted to the	

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			QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed ·Non-compliance with facility procedure may result in disciplinary action up to and including termination.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. Based on observation, interview, and record review, the facility failed to ensure medications	F 0761	**F761** It is the practice of this facility to	03/27/2020

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	were labeled, stored per pharmacy guidelines and secured for 2 of 5 medication carts observed. This had the potential to affect 38 residents residing on the units. (100 hall medication cart and 500 hall medication cart) Findings include: A review of the facility census indicated there were 26 residents residing on the 100 hall and 12 residents residing on the 500 hall. 1. An observation of the 100 hall medication cart which was located at the 100/200 hall intersection on 2-24-2020 at 4:58 p.m., indicated 3 medication cards and one 300 count bottle of multivitamin and minerals were out on top of the unattended medication cart. There was 1 tablet of acetaminophen 500 mg (milligrams) on a medication card and 2 tablets of spironolactone (a diuretic) 25 mg tablets on another card. The last card did not have any medications left. A resident was observed to wheel herself by the 100 hall medication cart to the 200 hall dining room. An observation of the 100 hall medication cart on 2-24-2020 at 5:00 p.m., indicated Unit Manager Nurse 5 walked by the unattended medication cart with the medications out on top. Unit Manager Nurse 5 was observed to enter room 111 and Nurse 1 was observed to come out of room 111 with the Unit Manager. An interview with Nurse 1 on 2-24-2020 at 5:03 p.m., indicated she just had pulled those cards out and was going to destroy the medications left in the cards. 2. An observation of the 100 hall medication cart with Nurse 2 on 2-26-2020 at 12:27 p.m., indicated		ensure medications are labeled, stored per pharmacy guidelines and secured. However; based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:** ·Medications on cart: The two medication cards with medications still in bubble wrap were destroyed by the Licensed Nurse and the bottle of multivitamins were immediately secured in the locked medication cart. The medication card with no medications was disposed of. ·Medications in cart: The Omeprazole, Vancomycin Powder, Insulin Vials x 3 and the Insulin Pen were disposed of. ·Unlocked Medication Cart: The cart was immediately locked by the Licensed Nurse. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·Residents residing in the facility have the potential to be affected by the alleged deficient practice. ·No residents were identified as being affected by the alleged practice. ·Licensed staff have been re-educated regarding storing, labeling and destroying	

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	155095	A. BUILDING 00 B. WING	02/26/2020

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	there was a 14 count box of omerprazole 20 mg tablets without a label to indicate to which resident this medication belonged. Nurse 2 indicated she did not know which resident the omerprazole belonged. There was a vial of vancomycin powder 1 gram for injection without a prescription label to identify the prescription for use, the resident name, the date or physician. Nurse 2 indicated there was not a resident with an order for vancomycin in her hall at this time. Further observation of the 100 hall medication cart, indicated there were 3 plastic bottle containers with unopened insulin vials inside. An unopened 10 ml (milliliter) vial of Lantus 100 units/ml was labeled with a resident name who was sent to the hospital on 2-22-2020 and was not currently in the facility. The prescription date was 2-19-2020 and a sticker was on the container which indicated "refrigerate." There was no other date written on the vial or the plastic container. An unopened 10 ml vial of Lantus insulin 100 units/ml was labeled with a prescription date of 2-20-2020 and a sticker was on the container which indicated "refrigerate." There was no other date written on the vial or the plastic container. An unopened 3 ml vial of Humulin R insulin with prescription date of 2-5-2020 and a sticker was on the container which indicated "refrigerate." There was no other date written on the vial or the plastic container. An unopened insulin Lispro 100 unit/ml pen was observed to be stored in the 100 hall medication cart with a prescription date of 2-19-2020. A label on the plastic bag which held the insulin pen		medications in the facility. Education includes but is not limited to locking the medication cart when unattended by a Licensed Nurse, appropriate labeling of all medications including prescription and over the counter medications, appropriate storage of unopened insulins and dating medications. Education also included using the "Insulin Storage Recommendations" available on every medication cart when unused insulins are taken out of the refrigerator and put in the medication cart. ·Education provided by Director of Nursing Services and Clinical Education Co-ordinator on March 11, 2020 ·Nurse Managers are assigned to each medication cart and are responsible for oversight. ·All medication carts were reviewed by DNS/Designee to ensure medications were labeled and stored per pharmacy guidelines. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** ·Licensed staff have been re-educated regarding storing, labeling and destroying medications in the facility. Education includes but is not limited to locking the medication	

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	indicated refrigerate until opened, then room temperature. Another sticker had refrigerate and was on the plastic bag. The nurse did not know how long each of the insulin vials or the insulin pen had been in the medication drawer. The nurse indicated she was going to put them in the refrigerator. There were no dates documented on the insulin vials or pen other than the prescription date to reflect when the 4 insulins were placed in the medication cart. An interview with the DNS on 2-26-2020 at 1:48 p.m., indicated the facility did not have a policy on medication labeling for prescription medications or over the counter medications. An interview with Nurse 4 on 2-26-2020 at 2:25 p.m., indicated when insulin pens or vials were delivered from the pharmacy, the unopened vials/pens would be placed in the medication room refrigerator. An interview with Unit Manager Nurse 5 on 2-26-2020 at 2:33 p.m., indicated for insulin pens/vials delivered by pharmacy, they should be stored in the medication room refrigerator. The Unit Manager indicated if the nurse saw that they would be using the vial/pen soon, they could place it in the medication drawer. The Unit Manager was asked how the nurse who opened the vial would know the correct expiration date for the unopened insulin stored in the medication cart drawer, as there was specific guidance by the pharmacy on the number of days the insulin vial/pen had to be used whether it was unopened or opened and stored at room temperature. The nurse indicated the nurse should then write the date the insulin vial/pen was placed in the		cart when unattended by a Licensed Nurse, appropriate labeling of all medications including prescription and over the counter medications, appropriate storage of unopened insulins and dating medications. Education also included using the "Insulin Storage Recommendations" available on every medication cart when unused insulins are taken out of the refrigerator and put in the medication cart. ·Education provided by Director of Nursing Services and Clinical Education Co-ordinator on March 11, 2020 ·Nurse Managers are assigned to each medication cart and are responsible for oversight. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur:** ·QAPI Monitoring Tools titled "Medication Cart Audit" will be utilized every week x 4, monthly x 6 and quarterly thereafter. ·Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed ·Non-compliance with facility procedure may result in disciplinary action up to and including termination.	

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	medication cart. A current copy of the pharmacy "Insulin Storage Recommendations" was provided by Nurse 3 on 2-26-2020 at 1:25 p.m. The form indicated for vials of insulin under refrigeration, the unopened vials could be used until expiration date. For unopened vials stored at room temperature, the Lantus storage time was 28 days and the Humulin R was 31 days before they were expired. The Lispro pen could be used until the expiration date when refrigerated and if stored at room temperature the storage time was 28 days. A current policy, "General Dose Preparation and Medication Administration" with a revised date of 1-1-2013 was provided by the DON on 2-26-2020 at 1:11 p.m. The policy indicated, "...3.9 Facility staff should not leave medications...unattended...3.11 Facility staff should enter the date opened on the label of medications with shortened expiration dates...insulin...7. Facility should ensure that medication carts are always locked when out of sight or unattended...."3. On 2/26/2020 at 2:20 p.m., the medication cart on the 500 hall was observed unlocked with no staff observed at or in view of the cart. At 2:20 p.m. a resident was observed to propel himself to his room, which was located right beside the unlocked, medication cart. On 2/26/2020 at 2:21 p.m., LPN 14 was observed to walk down the hall to the medication cart from the dining room. As she arrived at the unlocked medication cart, she was observed to lock the medication cart. On 2/26/2020 at 2:15 p.m., the DON and ADM were interviewed. They indicated they were made aware of the medication cart in the 500 hall being			

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	unsupervised and unlocked. The DON indicated the medication cart should be been locked when unattended. 3.1-25(j) 3.1-25(m)			