

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

PRINTED: 07/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2015
NAME OF PROVIDER OR SUPPLIER ELLIOTT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 06/23/15 and concluded on 06/26/15 with deficiencies cited at the highest Scope and Severity of an "E".	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Centers for Medicaid and Medicare Services (CMS) Resident Assessment Instrument Use Manual Version 3.0, it was determined the facility failed to ensure the Comprehensive Care Plan	F 280	Elliott Nursing & Rehabilitation Center (ENRC) endeavors to provide the resident with a plan of care that is revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving. On 6/26/15 the IDCPT, with input from primary care givers, the plan of care for resident #7 was reviewed and revised to ensure that all current interventions were recorded including "not to go to room alone after supper, is to remain at nurses' station and to offer toileting or to lie down after supper". The IDCPT reviewed all other fall care plans for each resident, with review and input by primary caregivers on 7/9/15 to ensure that the plan of care included all current individualized interventions being utilized in order to achieve the highest practicable well-being. The DNS/RN Supervisor provided education to all nursing staff and the IDCPT related to importance of reporting and recording all current and appropriate interventions on the plan of care. This education will be completed by 7/31/15. The Director of Nursing Services will audit 5 care plans per week with input from direct caregivers to ensure plan of care is current and reflects all individualized interventions being utilized in order to achieve the highest practicable well-being. Audits will be conducted weekly for 8 weeks and at least monthly thereafter. Results will be forwarded to the monthly QAP committee for further review and continued compliance.	08/04/2015
LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 		TITLE Administrator		(X6) DATE 07/24/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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was reviewed and revised for one (1) of fifteen (15) sampled residents (Resident #7).

Resident #7's Comprehensive Care Plan was not revised to implement interventions for prevention of further falls after the resident sustained a fall on 10/29/14, which resulted in a Fracture of the Left Wrist and Left Hip.

The findings include:

Review of the facility's reference source related to Comprehensive Care Plans, CMS RAI User Manual Version 3.0, dated October 2011, revealed the care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident was receiving.

Review of Resident #7's medical record revealed the facility re-admitted the resident on 09/23/14, with diagnoses including Dementia and Diabetes Mellitus. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 11/13/14, revealed the facility assessed Resident #7 as having a Brief Interview for Mental Status (BIMS) score of seven (7) indicating severe cognitive impairment. Continued review of the Significant Change MDS Assessment revealed the facility assessed Resident #7 to require extensive assistance of two (2) staff for transfers, bed mobility and toileting, and to not have ambulated. Further review of the MDS revealed the facility assessed Resident #7 to have had no falls since the last assessment. Review of the Quarterly MDS Assessment dated 04/22/15, revealed the facility assessed Resident #7 to have a BIMS score of thirteen (13), which indicated the resident was cognitively intact, and to require extensive assistance of two (2) staff for

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transfers, bed mobility and toileting, and to have not ambulated. Further review of the Quarterly MDS Assessment revealed the facility assessed Resident #7 to have had no falls since the last assessment.

Review of Resident #7's Comprehensive Care Plan dated 09/13/14, revealed the facility had care planned the resident as at risk for falls due to decreased mobility, weakness, pain and a history of falls. Continued review of the falls risk care plan revealed the goal stated Resident #7 would have no unidentified complications related to being at risk for falls. Further review revealed interventions which included: assist of one (1) staff for all ambulation; remind to ask for assist with ambulation; monitor for changes in condition that might warrant increased supervision and assistance; use a wheelchair for long distances; provide assistance with toileting; and sensor pad to bed and wheelchair at all times.

Review of the Departmental Note dated 10/29/14 at 5:53 PM, documented by Licensed Practical Nurse (LPN) #1, revealed Resident #7 was yelling from the bathroom while the nurse was on the phone with the Physician. According to the Note, another nurse and a Certified Nursing Assistant (CNA) went to check on Resident #7, and when she got off the phone she also went to check on the resident. Per the Note, Resident #7 was lying on the floor on her/his back in the bathroom beside the toilet. The Note revealed Resident #7's left foot was turned outward and the resident moaned in pain upon palpation of the leg and the hip. Continued review revealed Resident #7 was also complaining his/her left wrist hurt, and the wrist looked like it was "swelling". Further review revealed the Physician was notified, and the other

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nurse called for an ambulance and notified the resident's sister.

Review of the Departmental Note dated 10/30/14 at 2:24 AM, revealed the nurse talked with a nurse at the hospital and was told Resident #7 had been admitted to the hospital with a left hip fracture and a left wrist fracture.

Review of the Hospital Discharge Summary, dated 11/04/14, revealed Resident #7 was discharged back to the facility with diagnoses which included Closed Fracture of the Distal End of the Radius (Wrist Fracture), Closed Intertrochanteric Fracture (Hip Fracture), Acute Blood Loss Anemia and a Urinary Tract Infection (UTI) "after immobility".

Review of the facility's "Resident Incident Report", dated 10/30/14, revealed Resident #7 sustained a fall on 10/29/14 at 5:45 PM, while taking self to the bathroom. Per the Report, Resident #7's left lower extremity had external rotation and the resident's left wrist looked edematous. Continued review revealed Resident #7 was transported to the hospital, and the Physician and family were notified of the fall and injuries. Review of the Report section titled, "Resident Condition at Time of Incident" revealed no documented evidence it was completed to include: physical restraints; bed rails; medications taken during the last eight (8) hours; mobility; medical risk factors possibly related to incident; or fall history. Further review also revealed no documented evidence of information related to equipment used at the time of the fall or if the equipment was functioning at the time of the fall, such as, alarms. Review of the "Post Incident Actions", dated 10/30/14, which was not signed by staff, revealed Resident #7

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"already" had a sensor pad, and "would encourage staff not to let" the resident come back to the room alone after meals. Further review of the Incident documentation revealed no documented evidence of further investigation related to the fail to include: witness statements; evidence of a fail huddle to help in investigating the circumstances of the fall; an Interdisciplinary Team (IDT) meeting to review to summarize the team recommendations for interventions; or revision of the care plan to prevent further falls.

Interview with LPN #3 on 06/24/15 at 4:50 PM, revealed she was at the nurse's station when Resident #7 experienced the fall and heard the resident "hollering" and also heard his/her sensor alarm going off. She revealed she found Resident #7 on the floor lying on the bathroom floor on his/her side and knew the resident was hurt. LPN #3 stated she left Resident #7 lying on the floor and called 911 immediately and sent the resident to the emergency room. Further interview revealed staff knew now to offer Resident #7 assistance to the bathroom or the bed when they saw him/her coming back to the unit to his/her room after supper.

Interview with CNA #7 on 06/24/15 at 4:30 PM, revealed she was coming back from the dining room and was told by someone Resident #7 had fallen. She stated when she went to Resident #7's room where a nurse was assessing the resident, checking his/her hips and legs. She further stated the resident's bowels had moved apparently, as there was feces on the toilet.

Interview, on 06/24/15 at 4:20 PM, with CNA #8 revealed she was assigned to Resident #7 on the day of the fall, and had toileted the resident

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before supper that day. Per interview, Resident #7 was in the dining room the last time she saw the resident before the fall, and he/she must have wheeled himself/herself back to the unit after supper. She stated she was told the resident fell in the bathroom after returning to his/her room after supper. Continued interview revealed Resident #7 would normally let staff know when he/she needed to be toileted; however, the resident was not on a routine toileting schedule. CNA #8 further stated, now staff ensured Resident #7 stayed at the nurse's station and did not go back to his/her room until staff could assist the resident to lie down in order to prevent further falls.

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Interview with LPN #1 on 06/25/15 at 11:00 AM, revealed she was assigned to Resident #7 at the time of the fall, and had written the Departmental Note related to the fall. She stated Resident #7 had tried to toilet on his/her own without assistance, and fallen in the bathroom where LPN #3 had found the resident lying on the floor. Per interview, she was on the phone at the time, and LPN #3 had already assessed the resident before she got to the resident's room. LPN #1 revealed usually there were two (2) nurses and three (3) aides who stayed on the unit during supper and normally Resident #7 would let them know when he/she needed to go to the bathroom. Further interview revealed staff now knew, since the fall, not to let Resident #7 go to his/her room alone after supper until it was bedtime and staff were present to assist the resident.

Further review of Resident #7's Comprehensive Care Plan revealed no documented evidence it was revised or updated with the interventions staff interviews had revealed, such as, offering

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F 280	<p>Continued From page 6</p> <p>toileting, keeping the resident by the nurse's station in sight after supper or assisting Resident #7 to bed after supper and not allowing him/her to go to his/her room alone. Also, review of the Comprehensive Care Plan revealed no documented evidence of the Post Incident Action intervention dated 10/30/14, regarding not allowing Resident #7 back to his/her room after meals, was added to the care plan.</p> <p>Interview, on 06/25/15 at 1:30 PM, with the Director of Nursing (DON), revealed she had only been at the facility for two (2) weeks; however, the facility had already recognized falls were not being investigated thoroughly. She stated now through the facility's Quality Assessment Performance Improvement (QAPI) process the facility was implementing a "fall huddle" again, because from her understanding they had not been doing the fall huddles for a while. Continued interview revealed the facility was in the process of implementing a Falls Committee in order to better investigate falls. The DON revealed she received a shift report from each unit every morning which would indicate if a resident had experienced a fall, she printed off Incident Reports from the computer each morning related to falls and all of the information was taken to the facility's morning meeting. Per interview, the morning meeting started off with all department heads present including the Administrator, MDS Nurses, and herself. The DON stated then another meeting was held after the first meeting with those staff involved in care and falls were discussed. According to the DON, during that meeting the staff present were looking at the circumstances surrounding the residents' falls to see what they could do different to prevent further falls, and to add any new interventions</p>	F 280		
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necessary to the resident's care plan. Further interview revealed Resident #7's fall should have been investigated thoroughly in order to update the care plan with any additional interventions to prevent further falls.

Interview with MDS Coordinator #1 on 06/25/15 at 2:07 PM, revealed she revised residents' Comprehensive Care Plans and sometimes the nurses on the floor would also revise the care plans. She stated she learned about the falls which occurred in the facility during the morning meeting where the falls were discussed; however, she did not remember discussing Resident #7's falls. The MDS Coordinator stated she updated Resident #7's care plan after the fall related to the resident's risk for increased pain from the left hip fracture and left wrist fracture, but did not see where the falls care plan was updated or revised with any new interventions to prevent further falls. After reviewing Resident #7's fall investigation, she stated the investigation was not complete lacked the information necessary to revise the care plan with effective interventions. Continued interview revealed she did not know staff had implemented keeping Resident #7 by the nurse's station in sight after supper, or were offering the resident toileting or to lie down after supper. Per MDS Coordinator #1, she was also unaware of the Post Incident Actions, from the Incident Report, for staff not to allow Resident #7 to go back to the room alone after meals. Further interview revealed all of those interventions would be good to add to Resident #7's care plan however.

F 280

F 282 Elliott Nursing & Rehabilitation Center (ENRC) 08/04/2015

SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

endeavors to provide or arrange services in accordance with each resident's written plan of care.

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The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure services provided were in accordance with each resident's written Comprehensive Care Plan for one (1) of fifteen (15) sampled residents (Resident #4).

Resident #4's Comprehensive Care Plan stated the resident had a problem of constipation with interventions which included: evaluating for constipation and administering laxative or stool softener as ordered. Record review revealed Resident #4 experienced a bowel movement (BM) on 04/29/15; however, there was no documented evidence Resident #4 experienced BM's from 04/30/15 until 05/04/15, a five (5) days period. On 05/04/15, Resident #4 was admitted to the hospital and a Computerized Axial Tomography (CAT) Scan of the abdomen and pelvis showed a rectosigmoid fecal impaction. However, additional record review revealed no documented evidence nurses evaluated Resident #4 for constipation prior to the hospitalization or administered a laxative or stool softener as ordered as per the care plan interventions.

In addition, the facility failed to provide documented evidence Resident #4 experienced bowel movements for periods ranging from five (5) to six (6) days on five (5) subsequent occasions in May and June 2015. Also, there was no documented evidence the care plan

F 282 The bowel habits for Resident #4 and Resident #9 were reviewed by the RN Supervisor on 7/20/15. The results were reported to the MD on 7/20/15 and changes were made to each resident's bowel protocol on 7/20/15. New orders were received and implemented by the Charge Nurse on 7/20/15. The bowel habits for each resident will be reviewed by the DNS/RN Supervisor by 7/27/15 for the prior 30 days. Any resident requiring bowel care more than one time in the last 30 days will be referred to the MD for a bowel protocol review. Any new orders will be implemented as directed.

On 7/16/15 the system for administration of prn bowel protocols were revised. The prn medications have been added to the Electronic Health Record and follow up documentation will "fire" at the end of the shift. Effective or non-effective will be required and will alert the nurse if interventions have not been effective. All licensed nursing staff will receive education by the DNS/RN Supervisor by 7/31/15 regarding the revised system for tracking and follow up on bowel protocol interventions.

The DNS will audit the No Bowel Movement Report each morning (Monday through Friday) and review each resident record to ensure that bowel interventions have been implemented and follow up has occurred as required. Results will be forwarded to the monthly QAPI committee for further review and continued compliance.

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interventions for nurses to evaluate Resident #4 for constipation and administered a laxative or stool softener as ordered were implemented during the five (5) subsequent time periods of no BM.

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The findings include:

Interview with the Director of Nursing (DON) on 06/26/15 at 3:00 PM, revealed she was unaware of the facility having a policy related to staff following residents' care plans; however, it was the expectation and all the nurses' responsibility to ensure residents' care plans were followed.

1. Review of Resident #4's medical record revealed the facility admitted the resident on 10/07/13, with diagnoses which included Multi-Infarct Dementia, Depression, Parkinson's Disease and Cerebral Vascular Accident (CVA) with Hemiplegia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 04/28/15, revealed the facility assessed Resident #4 as: having both short and long term memory loss; requiring extensive assistance of two (2) persons for toileting; urinary incontinence not rated; and as always incontinent of bowel.

Review of Resident #4's Comprehensive Care Plan, dated 10/07/13, revealed the facility had care planned the resident with a problem of constipation and the goal stated he/she would achieve regular bowel movements. Continued review of the care plan revealed the interventions included: to evaluate the resident's bowel pattern; evaluate for constipation; assist of two (2) with toileting needs; assess his/her bowel sounds as needed; and administer laxative or stool softener as ordered.

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F 282:

Review of the Physician's Orders for May and June 2015, revealed the following orders: Bisacodyl (a laxative medication) 10 milligram (mg) suppository per rectum every day prn (as needed) constipation; Milk of Magnesia (MOM, a laxative medication) 30 milliliters (ml) every day prn constipation; and Fleets Enema (a solution introduced into the rectum to promote evacuation of feces) use as directed per rectum for constipation.

Review of the "Bowel Movement Validation Report" (BMVR) for Resident #4, revealed the resident had a BM on 04/29/15. Continued review of the BMVR, revealed however, no documented evidence of Resident #4 experiencing a BM from 04/30/15 until 05/04/15, a five (5) day period.

However, review of Resident #4's Medication Administration Record (MAR) revealed no documented evidence the Bisacodyl, MOM or Fleets Enema were administered for constipation from 04/30/15 through 05/04/15. Also, review of the Departmental Notes from 05/01/15 through 05/04/15, revealed no documented evidence Resident #4's BM's were being evaluated or of the resident having no BM during that timeframe.

Review of the Departmental Note dated 05/04/15 at 2:42 PM, revealed Resident #4 had no urinary output present in the catheter drainage bag that shift, and the nurse attempted to flush the Foley catheter with sixty (60) cubic centimeters (cc's) of Acetic Acid as prescribed, but the Foley catheter obstructed. Continued review of the Note revealed the nurse changed Resident #4's Foley catheter, and the resident had less than 100 cc's

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NAME OF PROVIDER OR SUPPLIER ELLIOTT NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 282	Continued From page 11	F 282				
	<p>output of urine when the new catheter was inserted and the Physician was aware of the information.</p> <p>Review of the Physician's Orders dated 05/04/15, revealed orders to transfer Resident #4 to the hospital for evaluation and treatment for decreased urine output, fever and decreased orientation.</p> <p>Review of the Departmental Note dated 05/04/15 at 9:28 PM, revealed Resident #4 was being admitted to the hospital with Dehydration, Cystitis, Constipation and Altered Mental Status.</p> <p>Review of the Hospital Discharge Summary, dated 05/06/15, revealed Resident #4 had a CAT Scan of the abdomen and pelvis which showed a rectosigmoid fecal impaction. Further review revealed Discharge diagnoses which included Altered Mental Status, Uremia and Constipation.</p> <p>Also, review of the "Bowel Movement Validation Report" (BMVR), revealed Resident #4 had a BM on 05/11/15 with no documented evidence of another BM until 05/17/15, six (6) days later. However, there was no documented evidence on the MAR dated May 2015 of the prn laxatives or Fleets Enema administered during this time frame and no documented evidence in the Departmental Notes of reference to the resident having no BM or of an abdominal assessment done during this timeframe.</p> <p>Further review of the BMVR revealed Resident #4 had a BM on 05/20/15 with no documented evidence of another BM until 05/25/15, five (5) days later. Per the MAR, a Fleets Enema was administered on 05/25/15 (five (5) days later).</p>					

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F 282	<p>Continued From page 12</p> <p>Review of the Departmental Notes revealed no documented evidence of the resident having no BM or of an abdominal assessment during this timeframe.</p> <p>Review of the June 2015 BMVR revealed Resident #4 had a BM on 06/03/15 with no further BM until 06/08/15, five (5) days later. Per the MAR, there was no documented evidence of laxatives or Fleets Enema administered during that timeframe, and per the Departmental Notes, there was no reference to Resident #4 not having a BM and no reference to an abdominal assessment being performed.</p> <p>2. Continued review of the BMVR revealed Resident #4 had a BM on 06/10/15 with no further BM documented until 06/15/15, five (5) days later. Review of the MAR revealed no documented evidence of laxatives or Fleets Enema administered during this timeframe. Review of the Departmental Notes from 06/10/15 through 06/13/15, of nurses evaluating Resident #4 for constipation as per the care plan interventions. On 06/14/15 at 3:54 AM, there was documentation in the Departmental Notes of Resident #4's abdomen being soft and non tender with no distension; however, there was no reference related to the resident having had no BM during the timeframe.</p> <p>Review of the BMVR revealed Resident #4 had a BM on 06/16/15 with no further BM documented until 06/21/15, five (5) days later. Review of the MAR revealed no documented evidence of a laxative or Fleets Enema administered during the timeframe, as per the care plan interventions. Review of the Departmental Note on 06/16/15 at 4:35 AM, revealed Resident #4's abdomen was</p>	F 282		
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F 282	<p>Continued From page 13</p> <p>soft and nontender. However, further review of the Notes revealed no documented evidence of further documentation of an abdominal assessment, and no reference related to the resident not having a BM during the above timeframe to note the nurses had evaluated Resident #4's BM's as per the care plan.</p> <p>Interview, on 06/26/15 at 9:30 AM, with Licensed Practical Nurse (LPN) #2, revealed she was assigned to Resident #4 most days during May and June 2015. LPN #2 stated if a resident had no BM in three (3) days, MOM 30 ml was to be administered on the morning of the 4th day with no BM. Per interview, if the MOM was ineffective, the next shift was to administer a Bisacodyl Suppository 10 mg, and if the Bisacodyl Suppository was ineffective in twelve (12) hours, the nurse was to administer a Fleets Enema. LPN #2 explained the midnight shift ran a computer generated sheet which showed the residents who needed bowel care related to not having BM's in three (3) days. She stated the sheet was given to the day shift to follow up with administering the laxatives. LPN #2 reviewed the MAR for May and June 2015, and stated Resident #4 received a Fleets Enema on 05/25/15; however, no other laxatives were given during the two (2) month period. Continued interview revealed Resident #4 should have received laxatives on 05/03/15, 05/15/15, 05/24/15, 06/07/15, 06/14/15, and 06/20/15 on the 4th day without a BM, as per the care plan.</p> <p>Interview with the DON on 06/26/15 at 3:00 PM, revealed she had just started in her position at the facility two (2) weeks previously. The DON stated the Certified Nursing Assistants (CNA's) documented BM's in the facility's computerized</p>	F 282		
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F 282 Continued From page 14
documentation system, and the computer would print a list of residents who had not had a BM entered for three (3) days. Per interview, medical records staff printed the list Monday through Friday and brought it to the morning meeting which included the DON, Administrator, MDS Nurses, and a nurse from each resident hall. She stated anyone could print the list off on the weekends or at anytime. The DON stated the BM list was taken to the units and nurses communicated to the other nurses, as well as, the Certified Medication Technicians (CMT's) regarding which residents needed laxatives, the residents who had not had a BM in three (3) days, and the nurses were to administer laxatives as ordered for constipation to the residents. She stated Resident #4's care plan interventions should have been followed related to evaluating the resident for constipation and administering laxatives as ordered. The DON further stated it was each and every nurse's responsibility to ensure residents' care plans were followed.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=D
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of

F 282
F 309 Elliott Nursing & Rehabilitation Center (ENRC) 08/04/2015
endeavors to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The bowel habits for Resident #4 and Resident #9 were reviewed by the RN Supervisor on 7/20/15. The results were reported to the MD on 7/20/15 and changes were made to each resident's bowel protocol on 7/20/15. New orders were received and implemented by the Charge Nurse on 7/20/15.

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F 309 Continued From page 15
the facility's protocol, it was determined the facility failed to ensure necessary care and services were provided for resident's physical well beings for two (2) of fifteen (15) sampled residents (Resident #4 and #9).

Resident #4 had a documented bowel movement (BM) on 04/29/15; however, there was no documented evidence he/she experienced BM's after that from 04/30/15 until 05/04/15, five (5) days later. On 05/04/15, orders were received to transport Resident #4 to the hospital for decreased urine output, fever and decreased orientation. The resident was admitted to the hospital on 05/04/15 and underwent a Computerized Axial Tomography (CAT) Scan of the abdomen and pelvis which revealed the resident had a rectosigmoid fecal impaction.

Resident #4 also had periods ranging from five (5) to six (6) days of no documented BM's, after he/she returned from the hospital, during five (5) different timeframe's in May and June 2015, and no documented evidence of interventions or Physician's Orders implemented for possible constipation.

In addition, the facility failed to provide documented evidence Resident #9 experienced BM's for six (6) days from 05/23/15 to 05/29/15, and no documented evidence of interventions or Physician's Orders implemented for possible constipation.

There was no documented evidence the facility followed its bowel protocol regarding administration of laxatives as ordered by the Physician for Resident #4 and Resident #9.

F 309 The bowel habits for each resident will be reviewed by the DNS/RN Supervisor by 7/27/15 for the prior 30 days. Any resident requiring bowel care more than one time in the last 30 days will be referred to the MD for a bowel protocol review. Any new orders will be implemented as directed.

On 7/16/15 the system for administration of prn bowel protocols were revised. The prn medications have been added to the Electronic Health Record and follow up documentation will "fire" at the end of the shift. Effective or non-effective will be required and will alert the nurse if interventions have not been effective. All licensed nursing staff will receive education by the DNS/RN Supervisor by 7/31/15 regarding the revised system for tracking and follow up on bowel protocol interventions.

The DNS will audit the No Bowel Movement Report each morning (Monday through Friday) and review each resident record to ensure that bowel interventions have been implemented and follow up has occurred as required. Results will be forwarded to the monthly QAPI committee for further review and continued compliance.

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The findings include:

Interview with the Administrator on 06/25/15 at 5:00 PM, revealed the facility had no bowel policy; however, there was a protocol. Review of the protocol, undated, revealed Milk of Magnesia (MOM, a laxative medication) 30 milliliters (mls) was to be given every day prn (as needed) for constipation. Continued review of the protocol revealed a Bisacodyl suppository (a laxative medication) one (1) per rectum prn every day or every other day for constipation, and a Fleets Enema (a solution introduced into the rectum to promote evacuation of feces) prn for constipation were also to be given.

1. Record review revealed the facility admitted Resident #4 on 10/07/13, with diagnoses which included Depression, Parkinson's Disease, Cerebral Vascular Accident (CVA) with Hemiplegia and Multi-Infarct Dementia. Review of the Quarterly Minimum Data Set (MDS) dated 04/28/15, revealed the facility assessed Resident #4 to have short and long term memory loss, to require extensive assistance of two (2) staff for toileting, as always incontinent of bowel and his/her urinary incontinence was not rated. Record review revealed Resident #4 had a Foley catheter in place.

Review of the Comprehensive Plan of Care dated 10/07/13, revealed the facility had care planned Resident #4 for a problem of constipation with a goal to achieve regular bowel movements. Continued review revealed the interventions included: evaluate bowel pattern and evaluate for constipation as needed; assist of two (2) with toileting needs; assess bowel sounds as needed; and administer laxative or stool softener as

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ordered.

F 309

Review of Resident #4's Physician's Orders for May and June 2015, revealed the following orders related to bowel medications: Bisacodyl 10 milligram (mg) suppository per rectum every day prn constipation; 30 mls every day prn constipation; and Fleets Enema, use as directed per rectum per bowel protocol for constipation.

Review of Resident #4's computerized, "Bowel Movement Validation Report" (BMVR), revealed the resident had a BM on 04/29/15. Continued review of the BMVR revealed however, there was no documented evidence of a BM from 04/30/15 until 05/04/15, five (5) days later.

Review of Resident #4's April and May 2015, Medication Administration Record (MAR) revealed there was no documented evidence the resident had received the Bisacodyl, MOM or Fleets Enema from 04/30/15 through 05/04/15, as per the protocol. Review of the Departmental Notes from 05/01/15 through 05/04/15 revealed no reference to Resident #4 having no BM during the timeframe of 04/30/15 through 05/04/15.

Review of the Departmental Note dated 05/04/15 at 2:42 PM, revealed Resident #4 had not had any urinary output present in the catheter drainage bag for that shift and the nurse attempted to flush the resident's Foley catheter with Acetic Acid (a urinary bladder antimicrobial, acidifying irrigant) as prescribed, but the catheter was obstructed. Per the Note, the nurse changed the Foley catheter; however, Resident #4 had less than 100 cc's output when the new catheter was inserted, which the Physician was aware of.

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Continued review of the Physician's Orders dated 05/04/15, revealed orders to transfer Resident #4 to the hospital for evaluation and treatment for decreased urinary output, fever and decreased orientation. Continued review of the Departmental Note dated 05/04/15 at 9:28 PM, revealed Resident #4 was to be admitted to the hospital with Dehydration, Constipation and Altered Mental Status.

Review of the Hospital Discharge Summary, dated 05/06/15, revealed Resident #4 had received a CAT Scan of the abdomen and pelvis which shown the resident had a rectosigmoid fecal impaction. Further review revealed Resident #4's discharge diagnoses included Constipation and Altered Mental Status.

Additionally, continued review of Resident #4's BMVR revealed the resident had a BM on 05/11/15, with no documented evidence of another BM until 05/17/15, six (6) days later. However, there was no documented evidence of the prn laxatives or Fleets Enema being administered during the time frame and no documented evidence in the Departmental Notes of reference to the resident having no BM or, of nurses performing an abdominal assessment done during the timeframe.

Further review of the BMVR revealed Resident #4 had a BM on 05/20/15, with no documented evidence of another BM until 05/25/15, five (5) days later. Review of the MAR, revealed a Fleets Enema was administered on 05/25/15, five (5)days later. Review of the Departmental Notes revealed no documented evidence of reference to the resident having no BM or of nurses performing an abdominal assessment during the

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referenced timeframe.

F 309

Review of the June 2015 BMVR revealed Resident #4 had a BM on 06/03/15 with no further BM until 06/08/15, five (5) days later. Review of the MAR, revealed no documented evidence of laxatives or Fleets Enema having been administered during that timeframe. Review of the Departmental Notes revealed there was no reference to the resident not having a BM during the timeframe, and no reference of nurses having performed an abdominal assessment.

Continued review of the BMVR revealed Resident #4 had a BM on 06/10/15 with no further BM documented until 06/15/15, five (5) days later. Review of the MAR revealed there was no documented evidence of laxatives or Fleets Enema being administered during the timeframe. Review of the Departmental Notes on 06/14/15 at 3:54 AM revealed documentation noting the resident's abdomen was soft and non tender with no distension; however, there was no reference to the resident not having had a BM during the timeframe.

Further review of the BMVR revealed Resident #4 had a BM on 06/16/15, with no further BM documented until 06/21/15, five (5) days later. According to review of the MAR, there was no documented evidence of a laxative or Fleets Enema administered during the timeframe. Review of the Departmental Note on 6/16 at 4:35 AM, revealed the resident's abdomen was soft and nontender; however, there was further documentation of an abdominal assessment and no reference to the resident not having a BM during the timeframe.

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F 309

Interview, on 06/26/15 at 9:30 AM, with Licensed Practical Nurse (LPN) #2, revealed when she worked she was usually assigned to Resident #4 and had been assigned to the resident on the days she worked in May and June 2015. Per interview, if a resident had not had a BM in three (3) days, MOM 30 ml was to be administered on the morning of the 4th day with no BM. She stated in the MOM was ineffective, the next shift was to administer a Bisacodyl Suppository 10 mg, and if that was ineffective in twelve (12) hours, a Fleets Enema was to be administered. According to LPN #2, on the facility's midnight shift a computerized sheet was ran off noting which residents needed bowel care, and this was passed along to day shift. LPN #2 reviewed Resident #4's May and June 2015 MAR's and stated the resident had only received a Fleets Enema on 05/25/15. She revealed however, no other laxatives were given for those months. Per LPN #2, Resident #4 should have had laxatives administered on the 4th day of no BM, such as, on 05/03/15, 05/15/15, 05/24/15, 06/07/15, 06/14/15, and 06/20/15.

2. Review of Resident #9's medical record revealed the facility admitted the resident on 05/11/15, with diagnoses which included Urinary Retention, Congestive Heart Failure and Acute Kidney Failure. Review of the Admission MDS dated 05/18/15, revealed the facility was unable to assess Resident #9's BIMS score. Continued review of the MDS revealed the facility assessed Resident #9 to require extensive assist of two (2) persons for toileting, as always continent of bowel and as not rated for urinary incontinence.

Review of Resident #9's Physician's Orders dated May 2015, revealed orders for Bisacodyl

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<p>F 309 Continued From page 21</p> <p>suppository 10 mgs prn for constipation; Fleets Enema use as directed for constipation per bowel policy; Docusate Sodium 100 mgs every twelve (12) hours as needed; and MOM 30 mls prn for constipation. Additionally, new orders were received on 05/17/15 for Miralax (a laxative medication) 17 grams (gms) in water every day.</p> <p>Review of Resident #9's BMVR for May 2015, revealed the resident had a BM on 05/23/15; however, there was no further documented evidence of a BM until 05/29/15, six (6) days later.</p> <p>Review of the MAR dated May 2015, revealed Resident #9 received a Bisacodyl suppository on 05/27/15 at 3:56 AM and MOM 30 ml on 05/27/15 at 2:14 PM. However, there was no documented evidence on the MAR or noted in the Departmental Notes to indicate if the medications were effective during the timeframe until 05/30/15.</p> <p>Review of the Departmental Notes revealed the following was documented: on 05/24/15 at 2:48 AM Resident #9's abdomen was soft and nontender with active bowel sounds in all four (4) quadrants (quads) with no diarrhea or constipation noted; on 05/25/15 at 2:13 AM, Resident #9's abdomen was soft and nontender with active bowel sounds in all four (4) quads with no diarrhea and no constipation; on 05/26/15 at 2:33 AM, the resident had positive bowel sounds in all four (4) quads; on 05/27/15 at 3:29 AM, the resident had positive bowel sounds in all four (4) quads and the abdomen was soft, round, and nontender; on 05/28/15 at 6:29 PM, bowel sounds were heard all four (4) quads; on 05/29/15 at 2:57 AM, the resident's abdomen was soft and non</p>	<p>F 309</p>
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tender with active bowel sounds in all four (4) quad and there was no diarrhea or constipation; on 05/29/15 at 7:32 AM, Resident #9 had refused all bowel treatments; and on 05/30/15 at 6:16 AM, revealed the resident had a BM "last night".

Further interview with LPN #2 on 06/26/15 at 9:30 AM, revealed Resident #9 had improved since admission and now was ambulating independently. She stated therefore, there might be times Resident #9 was going to the bathroom and using the toilet without staff's knowledge. She reviewed Resident #9's May 2015 MAR, and stated she could not tell if the laxatives administered on 05/27/15 were effective or not as there was nothing noted to indicate this.

Interview with the Director of Nursing (DON) on 06/26/15 at 3:00 PM, revealed she started working at the facility two (2) weeks ago. Per interview, the Certified Nursing Assistants (CNA's) documented residents' BM's in the facility's computerized documentation system. According to the DON, a list was printed from the computerized documentation for residents who had not had a BM entered for three (3) days. The DON revealed anyone could print the computerized list at any time; however, normally Monday through Friday, medical records staff printed the list. She stated Monday through Friday the computerized list of residents with no BM entered for three (3) days was taken to the facility's morning meeting. Continued interview revealed the staff present in the morning meeting included herself, the Administrator, the MDS Nurses, and a nurse from each resident hall. The DON stated the list was taken to the resident units where nurses communicated with each other and the Certified Medication Technicians

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(CMT's) which residents needed laxatives related to not having had a BM in three (3) days. She stated the staff were to ensure residents received the laxatives as ordered for constipation. Further interview revealed the Electronic MAR (e-MAR) system did not note the effectiveness of the bowel medications administered, and therefore, the nurses were to document the effectiveness of the medications in the residents' Departmental Notes. Further interview revealed if a resident, such as, Resident #9 was able to go to the bathroom on his/her own, then staff should be asking the resident if he/she had experienced a BM each shift and documenting the information in the resident's medical record.

F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's "Care System Guideline", it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one (1) of fifteen (15) sampled residents (Resident #7).

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Elliott Nursing & Rehabilitation Center (ENRC) 08/04/2015
endeavors to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.
On 6/26/15 the IDCPT, with input from primary care givers, the plan of care for resident #7 was reviewed and revised to ensure that all current interventions were recorded including "keep at nurses station in sight after supper, offer toileting or to lie down after supper".
On 7/9/2015, the IDCPT reviewed the nursing notes on all residents for the last 30 days to determine that any entry regarding a fall had been addressed in accordance with the Care System Guidelines related to falls. This includes assessment, notification of MD and family, and appropriate documentation. All residents were physically assessed by an RN Supervisor or LPN Charge Nurse no later than 7/9/2015 to ensure that there are no indicators, such as unexplained pain or physical injuries that may indicate an unreported fall. Only one resident was identified with potential lack of documentation related to family notification. However when family was called by the DNS on 7/9/15 they indicated that they had been notified of

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Resident #7 experienced a fall on 10/29/14, which resulted in a Hip Fracture and Wrist Fracture. However, the facility failed thoroughly investigate to find the root cause of Resident #7's fall in order to implement interventions to prevent further falls.

The findings include:

Review of the facility's "Care System Guideline", undated, revealed post fall the resident was to be physically assessed for injuries and medical attention rendered as needed, the Physician and responsible party were to be notified, a fall "huddle" was to be called to help in investigating circumstances around the fall. Per the Guideline, the fall investigation was to include information to assist in choosing interventions to prevent further falls, the fall event and intervention was to be recorded on the resident's care plan, interventions identified were to be implemented, and the Interdisciplinary Team (IDT) was to review the post fall investigations and summarize the IDT recommendations for interventions. Further review of the Guideline under the section labeled, "Key Elements", revealed when a fall occurred a post fall evaluation was completed to find causal factors and identify interventions to assist in preventing future falls.

Record review revealed the facility re-admitted Resident #7 on 09/23/14, with diagnoses which included Dementia and Diabetes Mellitus. Review of Resident #7's Significant Change Minimum Data Set (MDS) Assessment dated 11/13/14, revealed the facility assessed Resident #7 with a Brief Interview for Mental Status (BIMS) score of seven (7) which indicated the resident

F 323

this fall.

All licensed staff will receive additional education by the Administrator, DNS or RN Supervisor regarding the Care System Guidelines for Falls no later than 7/15/2015. Emphasis was placed on assessment, documentation, notification and prevention of additional falls by implementing interventions based on investigation and root cause analysis.

Education will include, but will not limited to, the following points:

- All falls must be reported to the MD and Responsible Party (this includes residents found on a matt or lowered to the floor)
- Conduct hands on head to toe assessment and render aide as necessary
- Obtain Vital Signs
- Investigate for Root Cause during the Huddle (The Huddle must be complete and accurate. All staff involved must participate)
- Implement an appropriate intervention to prevent further falls
- Ensure intervention is physically in place
- Notify MD (immediately)
- Notify Family/RP (immediately)
- Chart Incident in medical record
- Complete a Post Fall Assessment UDA
- Complete Incident Report
- Record intervention on care plan and SRNA Care Card
- Place on nursing "pass on" report and do not remove until Administrator or DON removes it from the nursing report
- Report fall and fall intervention to oncoming nurse
- Report fall and fall intervention to oncoming SRNA

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was severely cognitively impaired. Continued review of the MDS revealed the facility assessed the resident as requiring two (2) staff extensive assist with toileting, bed mobility and transfers, not to have ambulated and to have had no falls since the last MDS Assessment. Review of 04/22/15 Quarterly MDS Assessment revealed the facility assessed Resident #7 now to be cognitively intact with a BIMS score of thirteen (13). Continued review of the Quarterly MDS Assessment revealed the facility continued to assess Resident #7 to require two (2) staff extensive assist for bed mobility, toileting and transfers, not to have ambulated, and to have had not falls since the last assessment.

Review of Resident #7's Comprehensive Care Plan, dated 09/13/14, revealed the facility had care planned him/her for being at risk for falls with a goal of no unidentified complications related to being at risk for falls. Per the care plan, Resident #7 was at risk for falls due to pain, weakness, decreased mobility and a history of falls. Further review of the care plan revealed the interventions included: providing assistance with toileting; one (1) staff person for all ambulation; reminding the resident to ask for assist with ambulation; using a wheelchair for long distances; monitoring for changes in condition which might warrant increased supervision; and use of a sensor pad alarm to the resident's bed and wheelchair at all times.

Additional review of the Comprehensive Care Plan, dated 09/13/14, revealed the facility had care planned Resident #7 to require assist with his/her Activities of Daily Living (ADL's) with a goal which noted the resident's needs would be met. Further review of the ADL care plan

F 323

- EVERY fall requires a new intervention

On 7/9/2015, the IDCPT reviewed each resident in the facility in regards to potential or actual falls. The plan of care for each resident regarding falls was reviewed in addition to the SRNA care card to ensure that interventions were recorded on the plan of care and SRNA Care Card. Additionally, each resident/resident room was visually assessed to ensure that all interventions were physically in place.

During Daily Connect Meeting (Monday-Friday), the IDCPT will review each fall that occurred during the previous business day to ensure that the resident was assessed and treated for any injury, vital signs recorded, Huddle (investigation) completed, an intervention was implemented, family and MD were notified, EHR charting was completed, post fall trauma UDA was completed, incident report completed, intervention recorded on the care plan and SRNA flow sheet, that the fall was placed on nursing report "pass on" section, and that the fall and new intervention were reported to the oncoming shift for further monitoring. Any portion of the process that has not occurred will be addressed and the staff members involved will receive additional education as identified.

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revealed the interventions included: staff to check Resident #7's incontinence brief every two (2) hours and as needed, assist as needed with toileting; and provide catheter care.

Review of the Departmental Note dated 10/29/14 at 5:53 PM, written by Licensed Practical Nurse (LPN) #1, revealed the nurse was on the phone with the Physician when Resident #7 was heard yelling from the bathroom. The Note revealed another nurse and a Certified Nursing Assistant (CNA) went to check on the resident, and after completion of the phone call LPN #1 also went to check on Resident #7. Per the Note, Resident #7 was observed lying on the bathroom floor on his/her back beside the toilet. Continued review revealed Resident #7's left foot was turned outward and the resident was moaning in pain when his/her left leg and hip were palpated. According to the Note, Resident #7 was also complaining of his/her left wrist hurting. Further review revealed the other nurse called for an ambulance, notified the resident's sister. In addition, the Note revealed the Physician was notified. Review of the Departmental Note dated 10/30/14 at 2:24 AM, revealed the nurse talked with a hospital nurse who informed the facility nurse Resident #7 was being admitted to the hospital related to having a Left Hip Fracture and Left Wrist Fracture.

Review of the Hospital Discharge Summary, dated 11/04/14, revealed Resident #7's discharge diagnoses included Closed Fracture of the Distal End of the Radius (Wrist Fracture), Closed Intertrochanteric Fracture (Hip Fracture), Urinary Tract Infection (UTI) "after immobility" and Acute Blood Loss Anemia. Further review revealed Resident #7 was discharged back to the facility

F 323 Additionally, nursing staff will be quizzed daily by the Administrator (Monday-Friday) regarding resident fall protocols. Any incorrect responses will result in re-education for that staff member. The quizzes will continue until the QAPI Team meets again to determine the effectiveness of the plan listed above. Results will be forwarded to the monthly QAPI committee for further review and continued compliance.

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on 11/04/15.

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Review of the facility's, "Resident Incident Report" revealed Resident #7 had experienced a fall on 10/29/14 at 5:45 PM while going to the bathroom on his/her own without staff assist. Per the Report, Resident #7's left lower extremity had external rotation and the resident's left wrist looked edematous. Continued review revealed Resident #7 was transported to the hospital, and the Physician and family were notified. Review of the Report's "Resident Condition at Time of Incident" section revealed no documented evidence it had been completed to include the following information: physical restraints; bed rails; medications taken during the last eight (8) hours; mobility; medical risk factors possibly related to incident; or fall history. In addition, review of the section revealed no documented evidence of information of equipment in use at the time of the fall or whether the equipment, such as, alarms were functioning at the time of the fall. Review of the facility's, "Post Incident Actions", dated 10/30/15, not signed by staff, revealed Resident #7 already had a sensor pad in use. In addition, the "Post Incident Actions" included an intervention stating staff would be encouraged not to let Resident #7 go back to his/her room alone after meals.

Additionally, review of the facility's "Resident Incident Report" documentation revealed no documented evidence of a thorough investigation in order to identify the root cause of Resident #7's fall. Also, further review revealed no documented evidence of additional investigation to include: obtaining witness statements; whether a fall huddle had been held to help in investigating the circumstances of the fall; an IDT review of the fall

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circumstances to summarize the IDT's recommendations for interventions; or revision of the care plan to prevent further falls.

Interview, on 06/24/15 at 4:50 PM, with LPN #3 revealed when Resident #7 experienced the fall she had been at the nurse's station when she heard the resident hollering and heard the sensor alarm going off. Per interview, Resident #7 had been having more courage after working with Physical Therapy (PT) and the resident thought he/she could transfer on his/her own without assistance. She stated she found Resident #7 in the bathroom lying on the floor on his/her side, and when she saw the resident she knew he/she was hurt. According to LPN #3, she left Resident #7 lying on the floor with other staff present, and called 911 for an ambulance. Per interview, Resident #7 was transported to the hospital emergency room (ER), and was later admitted to the hospital. Continued interview revealed at the time of the fall Resident #7 had an indwelling urinary catheter and the resident told staff when he/she needed to be toileted. Further interview revealed since Resident #7's fall, staff now knew to offer to take the resident to the bathroom or assist him/her to bed when they saw the resident returning to the unit after supper.

Interview, on 06/24/15 at 4:30 PM, with CNA #7 revealed when Resident #7 experienced the fall, she had been returning from the dining room when someone told her the resident had fallen. Per interview, when she went to Resident #7's room, a nurse was assessing the resident and checking his/her hips and legs. Further interview revealed she had observed feces on the toilet and therefore, concluded Resident #7 had experienced a bowel movement.

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Interview, on 06/24/15 at 4:20 PM, with CNA #8 revealed on the day of Resident #7's fall she had been assigned to the resident. Per interview, she had toileted Resident #7 prior to supper that day, and the last she observed the resident before the fall was when he/she was in the dining room.

She stated Resident #7 must have wheeled his/her wheelchair back to the unit on his/her own after supper that day. According to CNA #8, she was later informed Resident #7 had fallen in the bathroom. Continued interview revealed normally Resident #7 told staff when he/she needed to go to the toilet; however, she stated the resident was not on a routine toileting schedule. Further interview revealed since the fall, staff now knew to ensure Resident #7 stayed near the nurse's station until they could assist the resident to his/her room to use the bathroom or lie down to prevent further falls.

Interview, on 06/25/15 at 11:00 AM, with LPN #1 revealed at the time of Resident #7's fall she was assigned to the resident's care, and she had written the Note related to his/her fall. Per interview, Resident #7 had attempted to toilet on his/her own without staff's assistance and had fallen in the bathroom where LPN #3 had found the resident lying on the floor. LPN #1 stated at the time Resident #7 fell she had been on the phone and LPN #3 had responded and assessed the resident before she got to his/her room. Continued interview revealed usually there were two (2) nurses and three (3) CNA's who stayed on the hall during the supper meal to assist residents as needed. She stated Resident #7 normally told staff if he/she needed to go to the bathroom. Further interview revealed since Resident #7's fall, staff knew not to let the

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resident go to his/her room alone after supper until staff assisted him/her at bed time.

Further review of Resident #7's Comprehensive Care Plan revealed no documented evidence it was revised with the interventions staff revealed in interview, such as, offering to toilet the resident after supper, or assist the resident to bed after supper or keep him/her in sight near the nurse's station. Additionally, review of the Comprehensive Care Plan revealed no documented evidence of the "Post Incident Action" intervention that staff would be encouraged not to let Resident #7 go back to his/her room alone after meals.

Interview, on 06/25/15 at 1:30 PM, with the Director of Nursing (DON), revealed she had only been at the facility for two (2) weeks and was not the DON at the time of Resident #7's fall. Per interview, the facility had recognized falls were not being investigated thoroughly and now through the facility's Quality Assurance Performance Improvement (QAPI) process, the "fall huddle" was being implemented again. She stated to her understanding the "fall huddle" had not been done for a while. Continued interview revealed the facility was in the process of implementing a Falls Committee to ensure better investigation of residents' falls. The DON stated each morning she received a shift report from the units which noted if a resident had experienced a fall, and she also printed off Incident Reports from the computer each morning related to falls and this information was taken to the morning meetings. She stated the morning meeting started off with all department heads present which included the Administrator, MDS Nurses, and herself. Per the DON, after that meeting

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another meeting was held which included staff involved in resident care and falls were discussed in the meeting. Further interview revealed during that meeting the staff present looked at the circumstances surrounding a resident's fall to see what could be done differently to prevent further falls and in order to add new interventions to the resident's care plan. The DON stated Resident #7's fall should have been thoroughly investigated and the policy should have been followed in order to evaluate the resident for additional interventions to prevent further falls and the care plan should have been updated/revised with the interventions.

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F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (1) of fifteen (15) sampled residents (Resident #7).

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endeavors to maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and that a resident receives a therapeutic diet when there is a nutritional problem.
On 7/6/15 current weights for resident #7 were reviewed by the MD and RD. Weight is stable and no recommendations were received for this resident. Dietary recommendations for the last 90 days were reviewed by the DNS and the Dietary Manager to ensure that all recommendations had been reviewed by the MD and implemented if indicated by MD approval on 7/21/15.
All licensed nursing staff will receive additional education by the DNS and Dietary Manager regarding the process for reviewing and implementing the RD recommendation that are received for each resident. All nursing staff will receive additional education related to the importance of obtaining and reporting weights as ordered. Education to be completed by 7/31/15.
The Dietary Manager will audit the Dietary recommendations monthly to ensure that any

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Resident #7 sustained a 13 % weight loss from 12/18/14 until 01/30/15 according to the facility's weight log. Although the Registered Dietician (RD) made recommendations for a re-weight and weekly weights for four (4) weeks, there was no documented evidence the recommendation was followed.

The findings include:

Review of the facility's policy titled, "Weight Monitoring", dated 08/01/12, revealed the purpose was to maintain residents' acceptable parameters of nutritional status, such as, body weight and protein levels, unless the resident's clinical condition demonstrated this was not possible. Per the Policy, residents' weights were to be obtained "at least" monthly, with more or less frequent monitoring done as necessary according to the resident's condition, nursing assessment or Physician's Orders. The Policy revealed the facility would establish a schedule for obtaining a resident's weight based on the resident's needs. Further review revealed residents' weights would be reviewed by the Interdisciplinary Team (IDT) during the "Focus meeting/Care Plan meeting", and as indicated by the resident's condition, Physician's Orders, etc. In addition, the Policy noted at the time of a monthly weight being obtained for a resident, the nurse would indicate a "gain/loss in pounds".

Review of Resident #7's medical record revealed the facility re-admitted the resident on 09/23/14, with diagnoses including Diabetes Mellitus, Dementia and Hypertension. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 04/22/15, revealed the facility assessed the resident as having a Brief Interview for Mental

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recommendations have been presented to the MD and implemented if directed by the physician any discrepancies noted will be reported to the Administrator and DNS for immediate action. The results of these audits will be forwarded to the monthly QAPI committee for further review and continued compliance.

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F 325	<p>Continued From page 33</p> <p>Status (BIMS) of a thirteen (13) which indicated the resident was cognitively intact.</p> <p>Review of the facility's weight record for Resident #7 revealed on 12/18/14, the resident was noted to weigh 162.8 pounds and on 01/30/15, he/she was noted to have a weight of 141.8 pounds, a 13% weight loss in one (1) month indicating a significant weight loss.</p> <p>Review of the Dietary Note written by the previous RD on 02/06/15 at 12:52 PM, revealed Resident #7's current weight was 141.8 pounds and a significant weight loss was noted over thirty (30) days. Continued review revealed the RD noted no significant changes in the resident's appetite, and his/her diet was recently upgraded to regular. Further review revealed Resident #7 had edema which might have contributed to the weight change, but the RD questioned a twenty (20) pound weight loss. In addition, the RD noted the resident's intake of the regular diet provided adequate energy and protein to maintain nutritional status; however, the RD recommended a re-weight be obtained and staff should monitor Resident #7's weights weekly for four (4) weeks.</p> <p>However, further record review and review of the facility's weight records for Resident #7 revealed no documented evidence the RD's recommendations were implemented regarding the weekly weights be obtained for four (4) weeks. The weight record revealed a re-weight was obtained on 02/10/15, four (4) days after the recommendation, with a re-weight for Resident #7 of 143.6 pounds. Further review revealed Resident #7's next weight obtained was on 03/11/15 with a weight of 144 pounds and further monthly weights were noted subsequently. In</p>	F 325		
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addition, there was no documented evidence of a Physician's Order for the weights to be obtained as per the RD's recommendation.

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Interview with the Dietary Supervisor (DS) on 06/26/15 at 12:39 PM, revealed the RD was to give the dietary recommendations to the nurses at the nurse's station and the nurses then contacted the Physician for approval. Per interview, if the Physician approved the recommendation, an order was to be written related to the recommendation. She stated the dietary recommendations were a four (4) part copy and she kept a copy and the original copy went to the Director of Nursing (DON). Continued interview revealed when there was a request for weekly weights the resident's name went on a list at the nurse's station and the weights were obtained on Sundays. She stated anytime there was a significant weight loss weekly weights were to be done for four (4) weeks, as per the facility's protocol even without a Physician's Order. The DS revealed the weights then went into the DON's box and then were to go to her (the DS); however, this had not always occurred in the past. She stated she had seen the original RD recommendation for the weekly weights for Resident #7 and wrote the resident's name on the list at the nurse's station herself; however, there had been a breakdown in the system and she could find no evidence the weekly weights were ever obtained. Continued interview revealed she generated a list of weights needed and took it to the nurse's station on Fridays. Per interview, she then tried to follow up to ensure the weights were obtained, but it had been a concern with weights not being obtained for a while, or a question of accuracy of the weights and the facility had talked about this in the last Quality Assurance (QA)

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F 325	<p>Continued From page 35</p> <p>Meeting held "last week". Further interview revealed the facility had a focus meeting weekly which consisted of herself, the DON, the Administrator, the Staff Development Nurse and the Registered Nurse Supervisor where they discussed residents' weights and nutrition for residents who had weight changes or were not eating well. Per the DS, the information obtained during the meeting was not documented in the resident's medical record however. She stated although the meetings were to be weekly, and were currently conducted weekly, previously for several months they were done only monthly. Review of a Weight Notification Audit completed on 02/02/15, revealed the Nurse Practitioner had signed she was notified of Resident #7's weight loss from 162.2 to 141.8 which was a 13% weight loss.</p> <p>Interview with the DON on 06/26/15 at 3:00 PM, revealed she had been at the facility for only two (2) weeks and was not yet knowledgeable of the system for communication of RD recommendations. She stated there had discussion in the facility's QA Meeting about weights being a concern and they needed to come up with a system to ensure the weights were obtained timely. The DON revealed currently a Hoyer Lift (mechanical lift) scale was utilized for obtaining all residents' weights, but the facility was now looking into possibly obtaining a wheelchair scale. She stated although the staff was trained on obtaining weights with the Hoyer lift, arrangements had been made for a representative to come in July to in-service staff on obtaining weights per the Hoyer lift, to ensure residents' weights were being obtained accurately.</p>	F 325	
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F 431 483.60(b), (d), (e) DRUG RECORDS, SS=D LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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endeavors to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

On 6/25/15 the Administrator notified the Office of the Inspector General, Adult Protective Services and local Law Enforcement of the missing controlled medication for Resident #3. On 6/25/15 the charge nurse notified the MD and the family of Resident #3 of the missing controlled medication. The order for the missing controlled medication for Resident #3 was discontinued on 6/10/15. All remaining vials of the discontinued controlled medication were reconciled and removed from the refrigerated lock box and placed in a double locked narcotic box to be destroyed.

On 6/25/15 the physician orders for Resident #3 were reviewed to ensure there were no other discontinued controlled medication that had not been removed. All of the controlled medications for Resident #3 were reconciled per facility policy with two nurses counting and signing that the count was correct.

On 6/25/15 the house stock of controlled medications and the controlled medications for all residents were reconciled with two nurses counting and signing that the count was correct. There were no other discrepancies.

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This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain an accurate account of all controlled drugs and periodically reconciled the narcotic count.

Observation of the medication refrigerator in one (1) of one (1) of the facility's medication rooms revealed eight (8) vials of injectable Lorazepam (a narcotic medication used to treat anxiety) were present. However, review of the narcotic controlled drug record revealed there were nine (9) injectable vials of Lorazepam documented for Resident #3. Additionally, there was no documented evidence the facility noted the discrepancy in the medication until Surveyor intervention during the current survey, although the last dose of Lorazepam was documented as administered on 05/01/15, fifty-three (53) days previously.

The findings include:

Review of the facility's, Medication Storage In The Facility Policy, undated, revealed medications included in the Drug Enforcement Administration (DEA) classification as controlled substances were subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations. The Policy revealed at each shift change a physical inventory of all controlled medications was conducted by two (2) licensed nurses (or individuals licensed to pass medications in the facility) and was documented on the controlled substances accountability/shift

F 431 The DNS/RN Supervisor will provide education to all licensed nurses and CMTs regarding the following:
Pharmacy Policy and Procedure manuals and locations; policies and procedures regarding the storage and handling of controlled medications; medication administration; verification of narcotic count; signing out narcotics; accuracy of documentation; proper procedure in wasting narcotics; discrepancies in controlled drug counts; reporting of discrepancies in controlled medication counts.
The DNS and /or the RN Supervisor will count all Controlled Medications at least once per week on a random basis to ensure proper storage and handling. This will continue for 6 months and then monthly thereafter. The results of these audits will be forwarded to the monthly QAPI committee for further review and continued compliance.

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change record. Per the Policy, any discrepancy in controlled substance medication counts was reported to the Director of Nursing (DON) immediately. Further review revealed a determination was made by the Administrator, the consultant Pharmacist, and the DON concerning possible notification of the police or other enforcement agencies and any other actions to be taken.

Observation, on 06/23/15 at 1:15 PM, of the Medication Room refrigerator revealed eight (8) vials of injectable Lorazepam, controlled substance, in the refrigerator for Resident #3. Observation of the label on the bag which contained Resident #3's injectable Lorazepam, revealed ten (10) vials of the medication had been delivered on 04/08/15 for the resident.

Record review for Resident #3 revealed on 04/08/14, the Physician had given a telephone order for Ativan (Lorazepam) 0.5 milligrams (mgs) intramuscular (IM) to be given daily as needed for agitation.

Review of the facility's Controlled Drug Record for Resident #3 revealed one (1) vial of injectable Lorazepam was removed from the resident's stock on 05/01/15. Continued review revealed nine (9) vials were left in Resident #3's stock.

Review of the Medication Administration Record (MAR) for Resident #3 revealed one (1) dose of the Lorazepam injectable was documented to have been administered to the resident on 04/08/15, which had been obtained from the house stock as Resident #3's had not arrived at the facility yet. Continued review of the MAR revealed another dose was documented as

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administered on 05/01/15. Which should have left a total of nine (9) vials according to the Lorazepam medication bag label, which noted ten (10) vials had been delivered 04/08/15.

Interview with Licensed Practical Nurse (LPN) #4 on 06/24/14 at 1:15 PM, revealed it had not registered with her, when performing the narcotic count for the Surveyor, that there should have been nine (9) vials of Lorazepam in the bag for Resident #3. She stated until the Surveyor brought it to her attention she just had noticed the count was incorrect. Per interview, during the narcotic counts, the staff counting apparently had not been looking at the narcotic record correctly. Further interview revealed there should have been nine (9) vials of Lorazepam present, not eight (8). She stated a nurse had documented removing the Lorazepam number nine (9) vial; however, had went back and crossed out her initials therefore, there should have been nine (9) vials of the medication present.

Interview with LPN #1 on 06/25/15 at 1:45 PM, revealed several weeks after 04/08/15, she realized she had taken the vial of Lorazepam she administered to Resident #3 on 04/08/15 out of the House Stock, as the Pharmacy had not yet delivered the resident's stock and the resident needed a dose of the medication. LPN #1 revealed after recalling this several weeks later she had went to Resident #3's Controlled Drug Record and had drawn a line through her initials to indicate the vial she had used had not been removed from the resident's stock, but had been taken from the house stock. According to LPN #1, this left nine (9) vials in Resident #3's stock. LPN #1 revealed she knew the narcotic count was off currently; however, had not done anything

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as she understood the Nurse Supervisor knew about it.

Interview with Registered Nurse (RN) #1, the RN Supervisor, on 06/26/15 at 3:40 PM, revealed she did recall one (1) of the nurses reporting to her several weeks ago that the count was off on an injectable vial of Lorazepam. RN #1 stated she could not solve the problem of the discrepancy in the narcotic count and had turned the issue over to the DON. Per interview, she had not heard anything since, and stated she was uncertain whether the Administrator had been made aware of the narcotic count discrepancy.

Review of the Daily Narcotic Count Sheet for the Nurse's Cart for April, May and June 2015 revealed the nurses were to document the accuracy of the count at the end of the 7:00 AM to 7:00 PM shift (Day Shift) and the 7:00 PM to 7:00 AM shift (Night Shift). However, no documented evidence was provided for the Nurses Cart for the May 2015, 7:00 PM to 7:00 AM shifts by the end of the survey.

Review of the April 2015 Daily Narcotic Count Sheet for the Nurses' Cart revealed eighteen (18) shifts with documentation of only one (1) nurse witnessing the narcotic count out of sixty-two (62) shifts.

Review of the May 2015 Daily Narcotic Count Sheet for the Nurses' Cart revealed three (3) shifts with no documented evidence of nurses performing the narcotic count, and nineteen (19) shifts with documentation of only one (1) nurse witnessing the count out of a possible sixty-two (62) shifts.

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Review of the Daily Narcotic Count Sheet for the Nurses' Cart for 06/01/15 thru 06/23/15 revealed two (2) shifts with no documented evidence of nurses performing the narcotic counts, and sixteen (16) shifts with documentation of only one (1) nurse witnessing the count out of a possible forty-six (46) shifts.

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Continued interview with LPN #1 on 06/25/15 at 1:45 PM, revealed the nursing staff had not been counting the narcotics in the refrigerator in the Medication Room for quite some time now and that was likely the reason the discrepancy in the count was present. She revealed the nurses were "so busy" and trusted each other, so therefore, they sometimes did not get two (2) nurses to witness the count or to waste a narcotic. Further interview revealed the nurses were supposed to count the narcotics with a witness when coming on and going off a shift; however, that had not always been being done.

Interview with the DON on 06/26/15 at 2:45 PM, revealed she had recently taken the position as DON with the facility. She stated she was aware there were problems with the controlled substance medications related to documentation and witnessing the wasting of narcotic medications. The DON stated this was "just not right" and she had "a lot of re-educating to do". The DON revealed she knew there were problems when she accepted her position, but had not realized there were so many. Further interview revealed she was unaware the nurses were not documenting the narcotic count at the beginning and end of each shift; however, she revealed they should have been doing so.

Interview with the Administrator on 06/26/15 at

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3:45 PM, revealed no one had reported to him any discrepancies with narcotic medications or with narcotic medications missing. The Administrator revealed the first time he had heard of the issue was when the Surveyor had discovered the missing narcotic medication. Further interview revealed he was unaware the narcotic count had not been being done consistently at the beginning and end of each shift as required.

F 431

F 441 483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

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endeavors to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

On 6/23/15 Resident#7's urinary drainage bag and tubing were immediately removed from the floor and secured to her wheelchair.

On 6/24/15 the Aquaphor Ointment used on Resident # 4 was discarded due to contamination.

On 6/24/15 the RN Supervisor re-educated CNA #6 and LPN #4 regarding proper hand washing techniques per the Infection Control policies.

On 6/26/15 CNAs #1, #2, #3, #4, #5, & #6, along with RNs #1, #2, #3, #4 and LPN #5 were educated by the Maintenance Director on the proper disinfection for the whirlpool tub per manufacturer's instructions.

On 6/29/15 the Infection Control Log was reviewed by the DNS. A look back period of 60 days indicated that no resident had been adversely affected.

Staff education began on 6/23/15 and will be completed by 7/31/15. All licensed nursing staff will be re-educated to follow manufacturer recommendations for disinfection of the whirlpool tub after each use. Staff competencies for cleaning and disinfection of the whirl pool tub will be updated and completed based on the manufacturer recommendations for disinfection no later than 7/31/15. All nursing staff will be reeducated by the DNS/RN Supervisor by 7/31/15 regarding the

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F 441 Continued From page 43
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the manufacturer's instructions for the whirlpool (w/p) tub, it was determined the facility failed to have an effective Infection Control Program which ensured the facility's w/p tubs were disinfected between uses for two (2) unsampled residents (Unsampled Residents A and B).

In addition, the facility failed to ensure staff adhered to proper infection control procedures for one (1) of fifteen (15) sampled residents (Resident #7). Observation revealed Resident #7's urinary drainage bag tubing was dragging the floor while the resident was in the wheelchair.

Also, during observation of indwelling urinary catheter care for Resident #7, the Certified Nursing Assistant (CNA) completed the catheter care, then with the same soiled gloves, dipped her hand in a jar of Aquaphor to apply to the resident's perineal area.

F 441 importance of maintaining an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development of and transmission of disease and infection. This reeducation will include a review of proper infection control techniques and review of information obtained on the CDC website. This education will emphasize proper use of ointments and proper placement of catheter tubing and bags. The DNS/RN Supervisor will visually monitor via daily compliance rounds (on all shifts) various aspects of the infection control program at least 3 times per week for 4 weeks and once per month ongoing. Any infraction will be addressed immediately with one-on-one education.
The DNS/RN Supervisor will audit 1 Foley (indwelling) catheter care per shift for the next 4 weeks. After the 4 week period, 1 procedure will be monitored per month thereafter. This shall continue monthly until a 100% compliance rate is achieved for three consecutive months. Any violation will be addressed with one-on-one education.
In addition the DNS/RN Supervisor will randomly audit whirlpool cleaning and disinfection for the next 4 weeks. After the 4 week period, 1 cleaning and disinfection will be monitored per month thereafter. Any violation will be addressed with one-on-one education.
The results of the daily compliance rounds and the observations will be forwarded to the monthly QAPI committee for further review and continued compliance.

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The findings include:

1. A Policy related to disinfecting the whirlpool tub was requested; however, not received.

Review of the manufacturer's instructions titled, "Disinfecting the Tub Using the Closed Loop System", undated, revealed it contained detailed instructions on the proper procedure for disinfection of the w/p tub system. Continued review revealed all w/p jets were to be closed, the w/p inlet closed, the aerator opened and ensure the disinfectant siphon tube was placed in the disinfectant container. Per the instructions, the disinfectant was then to be turned on, with the adjustment knob on the flowmeter for the disinfectant at thirty-five (35) cubic centimeters (cc) per minute. Review revealed all interior surfaces of the tub including the jets were to be scrubbed, and also the overflow fitting and w/p inlet. The instructions revealed the disinfectant was to be turned off, leaving the disinfectant in the loop and on the tub surfaces for ten (10) minutes, rinse the interior surface of the tub and open the w/p jets and inlet. Further review revealed the w/p tub should be disinfected after each use to avoid resident infection and contamination of the w/p tub and only Invacare disinfectant was to be used.

Observation during the initial tour of the facility on 06/23/15 from 12:30 PM until 2:30 PM, revealed there was a w/p tub on the Main Unit in the Central Bath on the 100 Hall and a w/p tub on the Lighthouse Unit.

Interview, on 06/23/15 at 4:00 PM, with CNA #1 revealed she had never used a w/p in the facility, and had never been trained on how to disinfect

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F 441	<p>Continued From page 45</p> <p>the tub. She stated the w/p tub where she worked on the Main Unit was broken.</p> <p>Interview, on 06/23/15 at 4:05 PM, with CNA #2 revealed it had been six (6) years since she had used the w/p tubs, and she did not know how to clean and disinfect it. She stated nobody on the Main Unit where she worked received a w/p.</p> <p>Interview, on 06/23/15 at 4:10 PM, with CNA #3, who was also working on the Main Unit revealed she had never used a w/p at the facility; however, she was aware there was a w/p on the Lighthouse Unit that worked. She stated she had never been educated on how to clean and disinfect the w/p tubs and would have to find someone to show her how to disinfect the tub if she used the tub for a resident.</p> <p>Interview, on 06/23/15 at 5:00 PM, with CNA #4, who was working on the Lighthouse Unit, revealed she had never used the w/p tub on the unit, but if she did she would disinfect the tub using the bottle of "Spitfire Spray" disinfectant. Further interview revealed she would spray the w/p tub down with the product and leave it on for ten (10) minutes before rinsing, and she would spray the w/p jets with the same spray.</p> <p>Interview, on 06/23/15 at 5:30 PM, with CNA #5, who worked on the Lighthouse Unit, revealed she did not give w/p baths; however, Unsampled Resident A and Unsampled Resident B who resided on the Lighthouse Unit received w/p baths. She attempted to demonstrate how to disinfect the w/p tub, but was unable to do so as the tub would not turn on. Per interview, the w/p tub had not been working properly for the past four (4) days, and Maintenance was notified of</p>	F 441		
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F 441	<p>Continued From page 46</p> <p>this. Further interview revealed she was unaware of how to properly disinfect the w/p tub.</p> <p>Interview, on 06/23/15 at 5:40 PM, with Registered Nurse (RN) #2, who was working on the Lighthouse Unit, revealed she had never been inserviced on how to disinfect the w/p tub and would be unable to demonstrate how to clean the tub if staff were to ask her how to do it. She stated Unsampled A was the only resident on the Unit who used the w/p tub.</p> <p>Interview with the Maintenance Director on 06/24/15 at 2:18 PM, and observation of the Maintenance Director disinfecting the w/p tub, revealed he demonstrated how to properly disinfect the w/p as per the manufacturer's instructions. He stated he kept an extra jug of the Invacare disinfectant inside the compartment panel of the w/p tub. Per interview, he checked the disinfectant once a month as part of his maintenance rounds to ensure the reservoir was full and it usually lasted about six (6) months. Continued interview revealed the w/p tub on the Main Unit had not worked for years, and it was old and he was unable to obtain parts to repair it.</p> <p>Interview with RN #3 on 06/24/15 at 2:40 PM, who was working the Main Unit, revealed she had never been educated related to disinfecting the w/p tub and she had worked at the facility for a year. She stated she sometimes was pulled to the Lighthouse Unit to work.</p> <p>Interview with LPN #5 on 06/24/15 at 2:45 PM, revealed the w/p tub on the Main Unit had not worked for the two (2) years she had been at the facility. She stated she did not remember ever being educated on how to disinfect the w/p tub.</p>	F 441		
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however, she knew there was a w/p on the Lighthouse Unit that worked. She stated currently she was unaware of any residents on the Main Unit getting a w/p bath, but if there was a Physician's Order for a w/p they would take the resident to the Lighthouse Unit.

Interview, on 02/26/15 at 2:50 PM, with RN #4, who was working the Lighthouse Unit, revealed she would be unable to tell a CNA how to disinfect the w/p tub as she had never used the tub and was not aware of how to disinfect it. She looked for instructions; however, she was unable to find the instructions for disinfecting the w/p tub. Further interview revealed Unsampled Resident A and Unsampled Resident B were the only residents who used the w/p tub, and there was only two (2) CNA's who used the tub who were both off on leave that week.

Interview, on 06/24/15 at 3:15 PM, with CNA #6 revealed she worked the Lighthouse Unit and had never used the w/p tub. She stated she had never been educated on how to disinfect the w/p tub.

Interview with RN #1/Staff Development Nurse on 06/26/15 at 1:35 PM, revealed she had never been taught how to disinfect the w/p tubs and she had not taught the disinfection process to staff. She stated she was unsure of who kept up with ensuring there was disinfectant in the reservoir. Continued interview revealed the facility had "spa specialists", who were two (2) CNA's who gave the w/p baths. She further stated they were both off on leave that week.

Interview, on 06/26/15 at 3:00 PM, with the Director of Nursing (DON), revealed she had

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F 441 Continued From page 48

been at the facility and in the position for two (2) weeks and was currently the Infection Control Nurse (ICN) until someone else was trained. She stated staff should be inserviced on hire and ongoing at least annually on how to clean and disinfect the w/p tubs. Per interview, there should be return demonstration with staff to ensure they were using the correct procedure for disinfecting the tub to prevent the spread of infection. Further interview revealed she was unaware staff did not know how to disinfect the w/p tubs properly.

F 441:

2. Review of the facility's reference manual, "Perry/Potter Clinical Nursing Skills and Technique", 8th Edition, copywrite 2014, under "Hand Hygiene" revealed to wash hands with either plain soap and water and/or antibacterial soap and water when hands were visibly dirty, soiled with blood or other body fluids. Per the reference manual, if hands were not visibly soiled, one could use an alcohol based hand rub for routine decontaminating hands before and after direct contact with patients, after contact with body fluids or excretions, mucous membranes or nonintact skin.

Review of Resident #4's medical record revealed the facility admitted the resident on 10/07/13, with diagnoses including Multi-Infarct Dementia, Depression, Parkinson's Disease and Cerebral Vascular Accident (CVA) with Hemiplegia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 04/28/15, revealed the facility assessed the resident as having both short and long term memory loss.

Observation, on 06/24/15 at 11:40 AM, of Foley (indwelling) catheter care for Resident #4, revealed CNA #6 completed the catheter care.

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and with the same soiled gloves dipped her hand in a jar of Aquaphor Ointment which LPN #4 was holding and applied the ointment to the resident's perineal area.

Interview, on 06/24/15 at 12:00 PM, with CNA #6 and LPN #4, who was assisting at the time of the indwelling urinary catheter care, revealed CNA #6 confirmed she had dipped her hand in the Aquaphor with her soiled gloves on contaminating the ointment. LPN #4 confirmed the Aquaphor went into the treatment cart after being used and this was an infection control issue due to the CNA dipping contaminated gloves into the ointment.

Interview, on 06/24/15 at 1:40 PM, with the DON revealed the CNA should have washed her hands and changed gloves before applying the Aquaphor Ointment to prevent contamination of the jar of Ointment which was returned to the treatment cart.

3. Continued review of the facility's reference manual, "Perry/Potter Clinical Nursing Skills and Technique", 8th Edition, copywrite 2014, regarding insertion of a straight or indwelling urinary catheter revealed the indwelling catheter was attached to a urinary drainage bag to collect the continuous flow of urine. Further review revealed the bag or tubing should never touch the floor.

Review of Resident #7's medical record revealed the facility re-admitted the resident on 09/23/14, with diagnoses which included Dementia and Diabetes Mellitus. Review of the Quarterly MDS Assessment dated 04/22/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a thirteen (13)

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indicating the resident was cognitively intact.

F 441

Observation of Resident #7 on 06/23/15 at 3:35 PM, revealed the resident's urinary drainage bag and tubing was dragging the floor while the resident was sitting in the wheelchair.

Interview with the DON on 06/24/15 at 1:40 PM, revealed residents' urinary catheter drainage bags should not touch the floor due to this being an infection control issue. She stated she looked at infection control issues as she was out on the units, but was unaware of any infection control audits being performed at that time.

F 465 483.70(h)
SS=D SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

F 465 Elliott Nursing & Rehabilitation Center (ENRC) 08/04/2015

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

endeavors to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

On 6/24/15 the dumpster lid was closed by the Maintenance Director.

The Administrator and the Maintenance Director will provided education to all staff by 7/31/15 that the dumpster lid is to be closed at all times.

The Maintenance Director will conduct daily environmental audits (Monday-Friday) of the dumpster area for four weeks and weekly thereafter to ensure that the facility environment is safe, functional, sanitary and comfortable.

The results of these audits will be forwarded to the monthly QAPI committee for further review and continued compliance.

This REQUIREMENT is not met as evidenced by:

Based on observation, and interview, it was determined the facility failed to provide a safe, functional, and sanitary environment for residents, staff, and the public. Observation revealed the dumpster lid was open during the environmental tour of the facility.

The findings include:

Observation during the environmental tour of the facility on 06/24/15 at 2:00 PM, revealed the dumpster outside the facility had an open lid and

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trash bags could be seen inside the dumpster.

F 465

Interview with the Maintenance Director at the time of the observation, revealed he checked the dumpster every morning to ensure the lid was closed; however, someone must have left it open today. Further interview revealed the lid was to be closed at all times to aid in the prevention of pests.

Interview, on 06/26/15 at 3:50 PM, with the Administrator, confirmed the dumpster lid should be closed at all times.

F 514 483.75(l)(1) RES
SS=D RECORDS-COMplete/ACCURATE/ACCESSIBLE

F 514

Elliott Nursing & Rehabilitation Center (ENRC) endeavors to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.
On 6/25/15 the Administrator notified the Office of the Inspector General, Adult Protective Services and local Law Enforcement of the missing controlled medication for Resident #3. On 6/25/15 the charge nurse notified the MD and the family of Resident #3 of the missing controlled medication. The order for the missing controlled medication for Resident #3 was discontinued on 6/10/15. All remaining vials of the discontinued controlled medication were reconciled and removed from the refrigerated lock box and placed in a double locked narcotic box to be destroyed. On 6/25/15 the physician orders for Resident #3 were reviewed to ensure there were no other discontinued controlled medication that had not been removed. All of the controlled medications for Resident #3 were reconciled per facility policy with two nurses counting and signing that the count was correct.

08/04/2015

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

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

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure clinical

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NAME OF PROVIDER OR SUPPLIER ELLIOTT NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171
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F 514 Continued From page 52
records were accurately documented for one (1) of fifteen (15) sampled residents (Resident #3).

Review of a Physician's Order for Resident #3 revealed the resident was to receive 0.5 milligrams (mgs) or 0.25 milliliters (mls) of Ativan (a narcotic medication used for anxiety) intramuscularly (IM) as needed for agitation. Observation of the Lorazepam (Ativan's generic name) vials for Resident #3 revealed the vials were 2 mgs per milliliter (ml) vials. Review of the Narcotic Controlled Drug Record revealed on 04/08/15, a nurse documented administering 0.5 ml of Lorazepam from the vial, and noted she wasted (discarded) 0.5 ml of the medication. However, according to the Physician's Order, Resident #3 was to receive 0.25 ml, and therefore, 0.75 ml of the narcotic medication should have been wasted. Interview with the nurse revealed she had given the correct amount of medication and she was able to correctly calculate the correct dosage, but she had not documented accurately.

Also, review of the Narcotic Controlled Drug Record revealed a nurse documented administering a dose of the Lorazepam to Resident #3 on 05/01/15, was to be administered as 0.25 ml or 0.5 mgs from a 2 mg per ml vial; however, there was no documented evidence the rest of the medication in the vial was wasted.

The findings include:

Review of the facility's policy titled, "Medication Storage In The Facility, 3. Controlled Medication Storage", undated, revealed medications included in the Drug Enforcement Administration (DEA)

F 514: On 6/25/15 the house stock of controlled medications and the controlled medications for all residents were reconciled with two nurses counting and signing that the count was correct. There were no other discrepancies.
The DNS/RN Supervisor will provide education to all licensed nurses and CMTs regarding the following: Pharmacy Policy and Procedure manuals and locations; policies and procedures regarding the storage and handling of controlled medications; medication administration; verification of narcotic count; signing out narcotics; accuracy of documentation; proper procedure in wasting narcotics; discrepancies in controlled drug counts; reporting of discrepancies in controlled medication counts.
The DNS and /or the RN Supervisor will count all Controlled Medications at least once per week on a random basis to ensure proper storage and handling. This will continue for 6 months and then monthly thereafter. The results of these audits will be forwarded to the monthly QAPI committee for further review and continued compliance.

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F 514	<p>Continued From page 53</p> <p>classification as controlled substances were subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations. The Policy revealed when a dose of a controlled medication was removed from the container for administration, but refused by the resident or not given for any reason, it was not placed back in the container. Per the Policy, the medication was to be destroyed in the presence of two (2) licensed nurses, and the disposal was to be documented on the accountability record (Controlled Drug Record) on the line representing that dose. Further review revealed the same process applied to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason.</p> <p>Record review for Resident #3 revealed a Physician's Order dated 04/08/15, for the resident to receive Ativan 0.5 mg IM as needed daily as needed for agitation. Review of Resident #3's Medication Administration Record (MAR) revealed one (1) dose of the Lorazepam injectable was documented as administered on 04/08/15, and another dose documented on 05/01/15.</p> <p>Review of the Controlled Drug Record for the "House Stock" supply of Lorazepam revealed on 04/08/15, revealed a nurse had administered 0.5 ml of Lorazepam to Resident #3 and wasted 0.5 ml. However, per the Physician's Order Resident #3 was to receive 0.25 ml, and therefore, 0.75 ml of the medication should have been wasted. Per observation and review of the Controlled Drug Record order label, the medication was provided</p>	F 514		
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F 514 Continued From page 54
by Pharmacy in a 2 mg per ml vial.

F 514

Interview with LPN #1 on 06/26/15 at 2:40 PM, revealed she was able to correctly calculate the dosage of the Lorazepam to administer, but she had documented the dose given incorrectly on the Controlled Drug Record for Resident #3.

Continued review of the Controlled Drug Record for Resident #3 revealed a nurse administered Lorazepam 0.5 mg to Resident #3 from a 2 mg per ml vial. However, there was no documented evidence of the rest of the medication in the vial being wasted which was witnessed by two (2) nurses as per the policy.

Interview with the DON on 06/26/15 at 2:45 PM, revealed she had just recently taken the position as DON with the facility, but was aware there were problems with the controlled substance medications regarding documentation and nurses witnessing the wasting of medications. She stated she was not aware of the inaccurate documentation of the dose given however. Further interview revealed the DON stated she needed to do some major re-educating on the correct documentation of doses of medications given and amounts of medication wasted.

Interview with the Administrator on 06/16/15 at 3:45 PM, revealed he was unaware the nurses were not documenting the wasting of narcotic medications as per the policy. Per interview, he was also not aware the dosage given was not being documented correctly.

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1995 Facility type: SNF/NF Type of structure: One (1) story, Type V (000) Smoke Compartment: Three (3) Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, heat detectors in HVAC of Light House Unit. Upgraded panel in 2009 Sprinkler System: Complete sprinkler system (DRY). Generator: Type 2 generator powered by diesel A Life Safety Code Survey was initiated and concluded on 06/24/15. The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility is licensed for seventy-five (75) beds. The census the day of the survey was seventy-one (71).	K 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the following action:		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 			TITLE Administrator	(X6) DATE 7/24/2015	

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000 Continued From page 1
Deficiencies were cited with the highest deficiency identified at "F" level.

K 050 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on interview and review of the fire drill records, it was determined the facility failed to ensure fire drills were conducted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, seventy-five (75) residents, staff and visitors.

The findings include:

Review of the facility's fire drill records on 06/24/15 at 3:04 PM, with the Regional Maintenance Director, revealed the facility had failed to conduct any fire drills for the 7:00 PM to 7:00 AM shifts. Interview, with the Regional Maintenance Director, at the time of the review, revealed the past Administrator had changed the schedule and this had caused the fire drills not to be conducted.

K 000

K 050 Elliott Nursing & Rehabilitation Center (ENRC) 8/4/2015
endeavors to ensure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.
On 6/30/15 at 7:30pm the Maintenance Director held a fire drill.
On 6/23/15 the Regional Maintenance Director educated the facility Maintenance Director regarding the importance of ensuring that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.
The Maintenance Director scheduled monthly fire drills at unexpected times to include all shifts. The Administrator will audit all monthly fire drills to ensure that fire drills are held at unexpected times under varying conditions and at least quarterly on each shift.
The results of these audits will be forwarded to the monthly QAPI committee for further review and continued compliance.

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K 050 Continued From page 2

K 050

The Administrator acknowledged the findings during the exit conference.

Reference: NFPA 101 (2000 Edition)

19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

K 064 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire extinguishers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments,

K 064

Elliott Nursing & Rehabilitation Center (ENRC) endeavors to ensure that portable fire extinguishers are in accordance with NFPA.
On 6/23/15 Sentry Fire replaced the portable fire extinguishers next to Physical Therapy and on 100, 200 and 300 hall.
On 6/23/15 the Regional Maintenance Director educated the facility Maintenance Director regarding the importance of ensuring that all portable fire extinguishers are in accordance with NFPA.
On 6/23/15 all additional portable fire extinguishers were replaced to assure that the center is in compliance with NFPA.
The facility Maintenance Director will audit all portable fire extinguishers on a monthly basis. The results of these audits will be forwarded to the monthly QAPI committee for further review and continued compliance.

08/04/2015

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K 064	<p>Continued From page 3</p> <p>sixty-four (64) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 06/24/15 at 12:58 PM, with the Regional Maintenance Director and the Maintenance Director, revealed a fire extinguisher next to Physical Therapy which did not have a verification of service collar indicating a hydrostatic test had been performed. The fire extinguisher had a manufacture date of 2008. Further observations revealed the same for the fire extinguishers in the facility's 100, 200 and 300 Hall where residents resided.</p> <p>Review, on 06/24/15 at 1:15 PM, of the fire extinguisher yearly maintenance and inspection record dated 09/26/14, conducted by an outside contractor, revealed the fire extinguishers were due for a hydrostatic test. Interview, with the Maintenance Director, revealed he had failed to realize the fire extinguishers needed hydrostatic testing due to the contractor not indicating this on the form in the deficiency section.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.</p> <p>Exception: Nonrechargeable fire extinguishers</p>	K 064		
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K 064 : Continued From page 4

shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture.

Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3, 4-4.4.1* Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. x 3 1/2 in. (5.1 cm x 8.9 cm).

The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:

(a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch

(b) Name or initials of person performing the maintenance and name of agency performing the maintenance

4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.

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K 064 Continued From page 5
Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.
Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.

K 064