F 248 483.15(e)(1) REASONABLE ACCOMMODATION
OF NEEDS/PREFERENCES

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to accommodate the needs and choices of 2 of 13 (Residents #93 and 96) sampled residents of the 28 residents included in the stage 2 review.

The findings included:

1. Observations in Resident #93's room on 10/1/13 at 8:03 AM, revealed Resident #93's door was open.

During an interview in Resident #93's room on 10/1/13 at 8:03 AM, Resident #93 stated, "They [staff] leave the door open and it lets cold in from the hall. They just forget to close the door."

2. Observations in Resident #96's room on 10/1/13 at 8:03 AM, revealed Resident #96's door was open.

During an interview in Resident #96's room on 10/1/13, Resident #96 stated, "I ask them [staff] every time they come in to shut the door and leave it cracked so it doesn't get stuffy. We can tell them 500 times and they still forget to close it.

Patient #93 and #96 door to room was corrected by staff. 10/1/13

Overseen by DON. All other patients were assessed to determine needs and choices on 10/2/13

Overseen by DON. All partners were inserviced on pt #93 and #96 preference of keeping door closed by 10/4/13

Social Work will monitor patient #93 and #96 preferences weekly x4 or until substantial compliance is met. Results will be reported to QA committee by 11/18/13
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
</table>
| 246 | **F 246** Continued From page 1 [the door]."  
3. During an interview at the nurses station on 10/1/13 at 8:50 AM, the Director of Nursing (DON) was asked what she expected the nurses to do when a resident asked that their door be kept closed. The DON stated, "...Communicate to all the staff... Keep the door closed..." " |
| 253 | **F 253**  
483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  
The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  
The origin of the odor on west hall was found and removed on 10/1/13.  
North hall was checked for odor on 10/1/13.  
Center partners were in-serviced by the housekeeping supervisor on what to do when odors present themselves and how to remove them in an appropriate manner by 10/4/13.  
QA team led by the housekeeping supervisor and audited by the administrator will check the center for odors 3x per week x4 weeks or until substantial compliance is met. Results will be reported to QA committee by 11/20/13.  
|
| 280 | **F 280**  
483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
The resident has the right, unless adjudged
Continued from page 2

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 medical record review, observation and interview, it was determined the facility failed to revise the care plan to reflect the current status of residents related to dental and a nutritional supplement for 2 of 13 (Residents #54 and 56) sampled residents of the 28 residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #54 documented an admission date of 12/12/11 with diagnoses of Right Ureteral Obstruction, Chronic Kidney Disease, Scrotal Cellulitis, Diabetes Mellitus, Hyperkalemia, Hypermotremia, Aphasia, Methicillin Resistant Staphylococcus Aureus, patient #54, and #56 care plans were updated to reflect current status related to dental and a nutritional supplement 10/4/13:

All other patient's care plans were reviewed to ensure current status related to dental and nutritional supplements 10/4/13:

Overseen by DON, Dietician and MDS coordinator were inserviced on updating care plans to reflect current status related to nutritional supplements (RD) and dental (MDS) 10/2/13:

Overseen by DON, 6 care plans will be reviewed weekly x4 or until substantial compliance is met for reflecting patient's current status related to nutritional supplements and dental. Results will be reported to QA.
F 280  Continued From page 3

Hypertension, Esophageal Reflux and Insomnia. The quarterly Minimum Data Set (MDS) dated 9/13/13 documented it requires one person physical assistance to brush the resident's teeth to maintain oral care. Review of the care plan dated 9/13/13 documented, "...Oral care daily and as needed... has his own teeth..."

During an interview at the nurses station on 10/11/13 at 8:50 AM, the Certified Nursing Assistant (CNA) #1 was asked about oral care to brush the resident's teeth. CNA #1 stated, "There are two ways to brush his teeth... if he puts his cheeks means that his teeth are hurting... use a toothbrush with mouthwash... if the resident smiles... use the toothbrush with toothpaste..."

The care plan did not include the interventions as noted above for oral care for Resident #54.

2. Medical record review for Resident #56 documented an admission date of 10/13/12 with diagnoses of Pneumonia, Altered Mental Status, Acute Renal Failure, Hypotension, Insufficiency, Pulmonary Hypopertrophy, Hypertension, Hypothyroidism, Atrial Fibrillation, Syncope, Gastro Esophageal Reflux Disease, Stress Incontinence and Depression. Review of the dietary progress notes documented, "...5/16/13... 2 oz [ounces] Medpass TID (three times a day) added for additional nutrition option... 6/4/13... 2 oz Medpass TID discontinued at this time..." Review of the care plan dated 8/22/13 documented, "...PROBLEM... PATIENT AT NUTRITIONAL RISK... APPROACHES... 2 OZ MEDPASS TID FOR ADDITIONAL NUTRITION..."

During an interview in the conference room on...
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X) ID</td>
<td>(X) PREFIX</td>
<td>(X) TAG</td>
<td>(X) ID</td>
<td>(X) PREFIX</td>
<td>(X) TAG</td>
</tr>
<tr>
<td>F 260</td>
<td>Continued from page 4</td>
<td>10/1/13 at 9:15 AM, the Registered Dietitian (RD) was asked about weight loss for this resident. The RD stated that the resident was started on Medpass, but she did not like the Medpass so it was discontinued. The RD was asked about the intervention of Medpass on the care plan. The RD stated, &quot;...must have been a mistake on the care plan since it [Medpass] was discontinued...&quot;</td>
<td>F 333</td>
<td>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</td>
<td>Nurse #1 was counseled regarding insulin administration 10/1/13</td>
</tr>
</tbody>
</table>

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on review of the "MED-PASS COMMON INSULINS" provided by the American Consultant Pharmacists, policy review, medical record review, observation and interview, it was determined the facility failed to ensure 1 of 2 (Nurse #1) nurses administered medications free of a significant medication error. Nurse #1 failed to administer insulin within the proper time frame related to food intake for Resident #1.

The findings included:

Review of the facility's "Insulin Administration" policy documented, "...PURPOSE: To ensure that designated partners administer insulin using proper technique into the subcutaneous tissue... OBJECTIVE: To administer insulin to patient and assure appropriate monitoring of diabetic patients... Procedure... Novolog or Humalog... will be given within a time range of no greater than 15 minutes before a meal thru no later than 30..." 

Overseen by DON, all other patients receiving insulin were monitored to ensure proper time frame related to food intake.

All licensed nurses will be inserviced on insulin administration within the proper time frame related to food intake 10/7/13.

Overseen by DON, 2 licensed nurses will be observed for insulin administration within the proper time frame related to food intake weekly x 4 or until substantial compliance is met. Results will be reported to the QA committee.
F 333 Continued From page 5

Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration related to meals documented,

"...Novolog... ONSET (In Hours, Unless Noted)...15 min...
TYPICAL ADMINISTRATION / COMMENTS... 5-[to] 10 minutes before meals..."

Medical record review for Resident #1 documented an admission date of 7/31/13 with diagnoses of Coronary Artery Disease, Diabetes, Hypertension, Esophageal Reflux, Peripheral Arterial Disease, Osteoarthritis, Hyperlipidemia, Parkinson's Disease, Osteoporosis, Anxiety and Congestive Heart Failure. Review of the physician's orders dated 9/20/13 documented,

"...NOVOLOG 100 UNIT / ML [milliliters] VIOL...
SEVEN UNITS SUBQ [subcutaneously] IF FINGERSTICK GREATER THAN 160...

Observations in Resident #1's room on 9/30/13 at 4:05 PM, Nurse #1 administered 7 units of Novolog insulin to Resident #1. Resident #1 was not given a snack. Resident #1 did not receive her meal tray until 4:50 PM, 45 minutes after the insulin had been administered. The administration of the insulin more than 15 minutes before Resident #1 received her meal tray, resulted in a significant medication error.

During an interview in the Director of Nursing's (DON) office on 10/1/13 at 1:40 PM, the DON was asked what is the expectation when giving a fast-acting insulin, such as Novolog in relation to eating. The DON stated, "...should eat a meal or snack within 15 to 30 minutes..."
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>483.65</td>
<td>INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
</tr>
</tbody>
</table>

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.
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.

The center will continue to maintain an Infection Control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection.

Nurse #1 and #2 counseled on handwashing 10/1/13

Overseen by the DON, all licensed nurses were observed for proper handwashing procedure by 10/18/13

Overseen by DON, all licensed nurses will be inserviced on handwashing policy by 10/18/13

Overseen by the DON, two random licensed nurses will be observed for proper handwashing procedure weekly x4 or until substantial compliance is met. Results will be reported to the QA committee.

10/18/13
This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined 2 of 2 (Nurses #1 and #2) nurses failed to ensure practices to prevent the potential spread of infection were maintained during medication administration.

The findings included:

1. Review of the facility’s "HANDWASHING" policy documented, "PROCEDURE... Wash hands before and after contact with each patient, after toileting, smoking or eating, and before and after removal of gloves."

2. Observations in front of room 4A on 9/30/13 at 3:55 PM. Nurse #1 applied gloves, cleaned the Accuchek machine and then removed her gloves. Nurse #1 did not perform hand hygiene. Nurse #1 then entered room 4A, applied gloves and administered insulin to a resident. Nurse #1 then removed her gloves and washed her hands.

3. Observations in room 21A on 9/30/13 at 8:10 AM. Nurse #2 applied gloves, cleaned the bedside table and applied barriers on the table. Nurse #2 returned to the medication cart, opened the cart and obtained a bin from the cart and cleaned with a sanitizing cloth. Nurse #2 removed gloves and continued to prepare medications at the cart, without performing hand hygiene. Nurse #2 entered room 21A, applied gloves and prepared water in cups and removed his gloves. Nurse #2 applied new gloves, without performing hand hygiene and administered medications through a percutaneous gastrostomy tube to a resident. Nurse #2 then removed his gloves and washed his hands.
Observations in front of room 31A on 10/1/13 at 10:25 AM, Nurse #2 applied gloves, prepared insulin and removed his gloves. Nurse #2 applied new gloves, without performing hand hygiene before preparing the medications. Nurse #2 removed his gloves and applied new gloves, without performing hand hygiene before administering oral medications to a resident. Nurse #2 administered an inhaler to a resident, then wheeled a resident into room 31A, and administered insulin to a resident. Nurse #2 then removed his gloves and washed his hands.

4. During an interview in the Director of Nursing's (DON) office on 10/1/13 at 1:35 PM, the DON was asked what is the expectation when using gloves. The DON stated, "Should use gloves between each patient contact, and wash hands between patients." The DON was asked what was the expectation when changing gloves. The DON stated, "Should use hand sanitizer or wash hands."