STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025028	A. BUILDING _____ B. WING _____	11/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORDOVA COMMUNITY MED LTC	P.O. BOX 160 CORDOVA, AK 99574

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F 000	INITIAL COMMENTS . The following deficiencies were noted during an unannounced standard recertification Medicare/Medicaid survey conducted 11/7-11/16. The sample included 6 sampled residents (5 active and 1 closed record). In addition,2 nonsampled residents were included in the report. State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd. Ste 24, Bldg L Anchorage, AK 99503	F 000		
F 164 SS=D	. 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164		12/24/16

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

Electronically Signed | 12/20/2016

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F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: . Based on observation and interview the facility failed to ensure: 1) a previous survey's resident identifier sheet was maintained in a manner to ensure full privacy of health related information of 10 residents (#s 1,4, 5, 6, 9, 10, 11, 12, 13, 14); and 2) full privacy was given to one resident (#5) during morning cares. These failed practices placed 11 residents at risk for violation of privacy and decreased self-worth. Findings: Survey Resident Identifiers: During an observation in the activities room on 11/7/16 at 7:45 pm revealed a binder titled "Survey" on the top of a book shelf with a document entitled "2/16-19/15 Confidential Resident List Cordova Medical Center [Long Term Care] Do not Post with 2567[Federal / State Deficiency Report]. "The list contained 10 resident names from the survey conducted on 2/16-19/15.	F 164	1. The survey identifier sheet was removed from the survey book when found. 2. No other residents were listed on the survey identifier sheet. 3. Going forward, no previous surveys will be placed in the survey book until the CEO/Administrator reviews the document to make certain no resident information is included. 4. The CEO/Administrator will approve all documents placed in the survey book before those documents are posted.	

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F 164	Continued From page 2	F 164		

During an interview on 11/7/16 at 7:45 pm the Administrator confirmed the confidential resident list should not have been posted with the survey findings.

Resident #5

Record review on 11/7-12/16 revealed the Resident had diagnoses that included Alzheimer's disease and chronic pain.

Review of the most recent Minimum Data Set, a federally required annual assessment, dated 9/18/16, revealed the Resident needed maximum assistance with all activities of daily living.

Observation on 11/8/16 at 11:15 am revealed Certified Nurse Assistant (CNA) #'s 1 and 2 provided morning cares to Resident #5. While undressing the Resident from the waist down, Resident #5 made several attempts to cover himself/herself with a sheet on the bed. Once the peri-care had been completed, the CNAs left the Resident uncovered from the waist-down. Next, a sling was placed onto the upper back of the Resident while the arms of the sling were wrapped around each leg. The CNA's began to raise the Resident off the bed exposing the Resident's genital area and buttocks. The Resident's body was position to which his/her knees were pushed against his/her chest. The buttock was lower than the heels of both feet. No attempts were made by the staff to cover the openly exposed genital area and/or buttocks during the transfers.

During an interview on 11/10/16 at 5:10 pm the Director of Nursing stated all residents should be covered during cares and transfers to ensure

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F 164	Continued From page 3 dignity and privacy. Review on 11/11/16 of the facilities admission packet that included "Resident Rights" revised 6/15 revealed "Right to Privacy and Confidentiality...During treatment and care of one's personal needs. Regarding medical, personal, or financial affairs."	F 164		
F 167 SS=C	. 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: . Based on observation and interview the facility failed to ensure the most recent survey results were accessible to all residents (based on a census of 10). This failed practice denied them the right to information about the performance of the facility. Findings: Observation on 11/7/16 at 7:30 pm revealed	F 167	1. The most recent survey was placed in the survey book when it was discovered to be missing. 2. No other residents were affected by this deficiency. 3. The CEO/Administrator will make	12/24/16

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F 167	Continued From page 4 Federal and State survey results were located in a binder on the Long Term Care activities/dining area. The most recent survey, a complaint survey, completed on 5/18/16, was not in the binder. During an interview on 11/7/16 at 7:45 pm the Administrator confirmed the most recent complaint survey was not posted in the binder.	F 167	certain that all future survey results are accessible to all residents. 4. The CEO/Administrator will make certain that all future survey results are placed in the survey book as soon as the POC is approved.	
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: . Based on policy review and interview the facility failed to implement policies and procedures for abuse and neglect that included the use of photographs or recordings in any manner that would demean or humiliate a resident(s). The failure to implement policies and procedures placed all the residents (based on a census of 10) at risk for abuse and neglect. Findings: Review on 11/10/16 of the facility's policy "Abuse Prevention, Recognition and Reporting," review date of 10/13/16 and "Reporting Suspected Crimes under the Elder Justice Act" dated	F 226	1. The staff was made aware of the process for not allowing the photographing or videotaping of residents. 2. All residents had the potential to be affected. 3. All staff were educated on this new requirement earlier in the fall. They were also provided with copies of CMS communication on the new requirements.	12/8/16

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F 226	Continued From page 5 10/13/16 revealed the policy did not address videotaping or photographing of residents. During an interview on 11/11/16 at 10:15 am, the Quality Coordinator confirmed the policy provided did not included videotaping and photographing of residents.	F 226	4. The facility had two policies covering abuse reporting. These policies have been combined and specific language on the prohibition of photographing and videotaping residents has been added. The Health Services Board will approve the policy on 12/08/2016. Staff will be educated on these requirements each year. The policy will be reviewed annually for any needed updates.	
F 241 SS=E	. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: . Based on record review, observation and interview the facility failed to ensure assistance with daily cares was provided in a dignified manner to 3 residents (#s 2, 3, and 5) out of a census of 10. These failures had the potential to promote an atmosphere in which residents are treated in a manner that can potentially affect their quality of life and/or negatively affect the resident's self-esteem. Findings: Resident #2 Record review on 11/8-10/16 revealed, Resident #2 was admitted to the facility with diagnoses that	F 241	1. A. Discussion with direct care providers regarding dignity when providing care, presented direct care employees on duty 11/08/2016, 11/09/2016 and 11/10/2016. B. Nursing Department employee meeting 12/06/2016 detailed survey findings regarding dignity and respect of individuality, with specific bullet points addressing respectfully informing each resident of all tasks performed before, during and after the task. Respectful conversation maintained throughout the interaction with the resident and privacy standards. Specific instances of dignity compromise shared with employees	12/24/16

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F 241	Continued From page 6 included pain, restlessness, agitation, adjustment disorders, and cognitive deficits. Review of most recent MDS (Minimum Data Set) assessment, dated 9/26/16 revealed, the Resident was severely impaired with decision making, had short/long term memory loss, and required extensive assistance with dressing, toileting, bathing, hygiene, and transferring. Continuous observation on 11/9/16 from 10:30 am - 11:15 am revealed Resident #2 receiving am care by Licensed Nurse (LN) #1 and Certified Nurse Assistant (CNA) #2. Morning cares included undressing, peri-care and dressing, oral care, and transferring to wheel chair. LN #1 and CNA #2 spoke to the resident very little while delivering cares. In addition, LN #1 and CNA #2 did not inform Resident #2 prior to task and assistance with morning cares. Resident #3 Record review from 11/7-10/16 revealed Resident #3 was admitted to the facility with diagnoses that included: dementia, Osteopenia (bone density that is lower than normal peak density but not low enough to be classified as osteoporosis), and pain. Review of the most recent MDS, a Federally required annual assessment dated 10/18/16, revealed the Resident was coded as having vision impairment and severly impaired cognitive ability. Observation on 11/8/16 at 11:30 am revealed CNA #2 providing morning cares to Resident #3. These cares included undressing and peri-care.	F 241	regarding resident # 2, 3, and 5. Identify other Potential Residents: 2. All residents have the potential to have dignity if there is a compromise in care reflecting the essential philosophy of dignified care. Systemic Changes: 3. A. Review and revision of facility Resident Rights policy by 12/24/2016. B. Develop and implement Watson's Caring Theory into all aspects of nursing care delivery to promote a dignified environment for all residents, visitors and employees. Education: C. All direct care employees will participate in a resident focused training module defining dignified care during initial orientation and on an annual basis. Implement Watson's Caring Theory into all aspects of care delivery to promote a dignified environment for all residents, visitors and employees. Initial education completed in an online training module the week of December 19, 2016. Any employee absent due to scheduled vacation will be required to complete the module within 2 weeks of returning to work. D. Current employee training will occur the week of December 19, 2016. E. Review and acknowledgement of Resident Rights policy completed upon initial orientation and on an annual basis. F Current employee review and acknowledgement of Resident Rights policy completed the week of December 19, 2016.	

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F 241	Continued From page 7 During the observation CNA #2 began to undress the Resident without communicating task or intentions prior to providing cares. Next, the CNA began to clean the Resident's peri-area with a moist wipe without verbalizing intentions to the Resident. The Resident was startled and yelled out when the CNA applied the moist wipe. Observation on 11/9/16 revealed CNA #s 2 and 3 providing care to Resident #3. After providing per-care CNA #3 applied cream to the Resident's buttocks without first telling the Resident what s/he was going to do. Both CNA's put on the Resident's compression stockings and shoes without first informing the Resident. After positioning the Resident on the lift sling, CNA #s 2 and 3 brought the straps of the sling between the Resident's legs without first telling the Resident what they were doing. Resident #5 Record review on 11/8-11/16 revealed the Resident was admitted to the facility with diagnoses that included dementia with behaviors and pain. Review of the most recent MDS assessment, dated 9/18/16, revealed the Resident was severely impaired with decision making and had short and long term memory loss. In addition, the Resident required extensive assistance with toileting, dressing, hygiene, and transfers. Observation on 11/8/16 at 10:50 am revealed CNA #2 providing morning cares to Resident #5. Morning cares included undressing, dressing and	F 241	Monitoring: 4. A. Education records maintained with record of completed requirements for education by the Director of Nursing. B. Copy of policy review and acknowledgement maintained in the education record. C. The Director of Nursing (DON) or designee will monitor direct care activity of residents weekly on both shifts for 3 months. Immediate corrective action for any deficient practices identified with patient care activity that reflects of compromised dignity is an expectation at the time of occurrence. Responsibility:	

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F 241	Continued From page 8 peri-care. During the observation CNA #2 did not inform the Resident of cares provided prior to physically helping the Resident. Specifically, the CNA would begin to undress the Resident without talking to him/her. The Resident began to yell out and attempt to cover himself/herself. Next the CNA's performed bed mobility without informing the Resident prior to physical adjustments. CNA #2 then began to dress the Resident without communicating task or intentions prior to providing the care. Review of the CNA plan of care, updated 9/21/16, revealed "Encourage [Resident #5] to help with dressing, give step by step cues and simple direction." Review on 11/11/16 of the facilities admissin packet including "Resident Rights" revised 6/15 revealed "Right to Dignity, Respect, and Freedom...To be treated with consideration, respect and dignity..."	F 241		
F 278 SS=D	. 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		12/24/16

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F 278	Continued From page 9 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure the MDS (Minimum Data Set-a federally required nursing assessment) was correct for 1 resident (#1) out of 5 residents reviewed. Specifically, the resident, on a check and change program, was coded as being on a toileting program. The failed practice created a risk for an inaccurate assessment and ineffective care planning for the resident's needs. Findings: Record review on 11/7-12/16 revealed Resident #1 was admitted to the facility with diagnoses that included dementia and mixed incontinence. Review of Resident #1's most recent MDS, an annual assessment dated 10/17/16, revealed Resident required "extensive assistance" from	F 278	1. Resident # 1 Minimum Data Set (MDS) corrected to reflect current assessment and accuracy in regards to bowel and bladder habits. Correction completed 12/13/2016. 2. All residents have the potential to be affected by inaccurate assessment and coding of the MDS 3. A. The Long Term Care Coordinator/MDS Nurse will perform monthly audits to verify MDS coding is accurate. B. Audit results will be trended over three months to achieve 100% compliance.	

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F 278	Continued From page 10 1-2 staff for transfers and toileting. The MDS identified the Resident was "Frequently incontinent" of urine and "Always continent of bowel." The MDS identified the Resident was on a urinary and bowel toileting program. Review of the comprehensive care plan, revised 10/18/16, revealed the problem "Self-Care Deficit related to weakness, and poor memory." Interventions included: Offer to assist Resident to use toilet every 3 hours when awake. Check and change when in bed at least 2 times during the night. Review of the CNA care plan, updated 10/18/16, revealed "Toileting 1. Encourage toileting every 2 hours PRN [as needed] while awake, [s/he] can be incontinent of B/B [bowel and bladder]." Further review of the medical record revealed no evidence of elimination data collection that specified the Resident's voiding habits and his/her needs or a specific plan unique to the Resident's needs. During an interview on 11/8/16 at 9:30 am, Resident #1 stated "I have problems with that (incontinence), it's not real bad. Let's face it sometimes they can't get here fast enough." When asked how s/he toileted at night, the Resident stated "I wear a 'diaper' and they check me one time at night." Resident #1 stated s/he did not get up to use the commode and/or toilet during the night. During an interview on 11/8/16 at 1:00 pm, when asked about Resident #1's toileting program, Certified Nurse Assistant #1 stated it depends on what the Resident wants, usually s/he goes every	F 278	Education: C. The LTC coordinator/MDS nurse will maintain LTCnet updates and training needed to maintain full functionality of the MDS intake system. Completed by 12/24/2016. D. The LTC coordinator/MDS nurse will be responsible for completing all tutorials for LTCnet upon initial orientation and within 2 weeks of update releases. Monitoring: 4. A. Review and re-assessment of all residents by 12/24/2016 and as needed to maintain accuracy of MDS coding. Review will include discussion with direct care employees within the interdisciplinary team, and the resident by the Director of Nursing and/or designee and/or the Long Term Care Coordinator/MDS Nurse. B. Corrections to the MDS and care plan will be completed upon verification of accuracy. C. During the care-planning phase of the Resident Assessment Instrument (RAI) process, the MDS nurse will validate the residents□ status with the direct care employees.	

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F 278	Continued From page 11 2 hours. During an interview with the MDS Nurse, on 11/10/16 at 12:00 pm, the MDS Nurse stated Resident #1 was toileted every 2 hours and when s/he asks for it. S/he confirmed the Resident had not had an assessment of his/her elimination patterns, nor was the Resident specifically care planned for a toileting program individualized to his/her needs. .	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		12/24/16

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F 279	Continued From page 12 . Based on record review and interview the facility failed to ensure 2 resident's care plan (#s 5 and 7) out of 7 residents was revised to reflect current status. This failed practice placed the resident at risk for not receiving proper interventions. Findings: Record review on 11/8-10/16 revealed Resident #5 had diagnoses that included dementia with behaviors and chronic pain. Review of the most recent MDS (Minimum Data Set) assessment, dated 9/18/16, revealed the Resident had short and long term memory loss, and decision making was impaired. Additional review revealed the Resident rejected care and wandered. The resident required extensive assistance with activities of daily living. Observation during morning care on 11/9/16 at 11:30 am revealed Resident #5 resisting care and striking out at Certified Nurse Assistant (CNA) #3 with a fist. After the Resident was transferred to a wheelchair, the Resident reached over and began to stroke the CNA's chest and breasts. During an observation on 11/8/16 at 12:20 pm Resident #5 approached Resident #1 and began rubbing his/her back. No staff intervened or attempted to prevent Resident #5 from touching Resident #1. During an observation on 11/9/16 at 4:30 pm Resident # 5 was moving his/her wheelchair to the nurses station where Licensed Nurse (LN) #3 was standing, then reached forward with his/her right hand to pinch the LN on the buttocks.	F 279	1. A. The care plan for resident # 5 and resident # 7 care plan review with inaccurate information removed on 12/05/2016. B. The care plan for resident # 5 revised to reflect behavioral interventions for safe care of all employees and residents. Completed 12/05/2016 C. The care plan for resident # 7 revised to reflect interventions to prevent aspiration with ordered dietary limits. Behavioral interventions added to maintain safety for residents and employees. Completed 12/05/2016. 2. All residents have the potential of compromise by inaccurate care plans and interventions. 3. A. The facility implemented policy and procedure revision to reflect use of the Resident Assessment to develop, review and revise the resident's comprehensive care plans and promote the highest level of physical, mental, and psychosocial well-being. B. An audit of all residents (10) to validate the accuracy of the most recent MDS coding meets expectations of the comprehensive care plan. C. The resident care plans review will occur quarterly by the interdisciplinary team to discuss any needed changes to the care plan based on the current assessment. D. An education module for all direct	

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F 279	Continued From page 13 Review of the Resident's care plan, updated 9/21/16, revealed the problems "4. Potential for psychosocial, mood related issues [due to] diagnosis of depression" and "5. Chronic confusion [related to] dementia with history of agitation/aggression and refusal of care." Interventions for problem #4 included "1. Monitor for negative behavior such as hitting, yelling, being intrusive and document this." Intervention for problem #5 included "1. Explain tasks at hand step by step 2. Use open body language and calm engaging tone of voice 3. Reproach, redirect, ask another staff member as needed." Further review of the care plan revealed there were no interventions that addressed the Resident approaching other residents in the facility, nor the inappropriate behavior towards staff. Resident #7 Record review on 11/8-10/16 revealed Resident #7 had diagnoses that included Alzheimer's disease and hemiplegia (weakness on one side following a stroke). Review of the most recent MDS assessment, dated 9/20/16 revealed the Resident had short and long-term memory problems and decision making was severely impaired. The Resident was on a mechanically altered diet. Review of a "Medical Nutrition Therapy Review" entry, dated 9/23/16, revealed "Resident's food texture changed to pureed on 7/1/16 b/c	F 279	care employees to read and review. The review will include the facility standards on developing comprehensive care plans with measureable objectives and timetables. The standards reflect the use of the current resident assessment to maintain the highest level of physical, mental, and psychosocial well-being. Acknowledgement of course completion maintained in the education record. 4. A. Review and re-assessment of all residents by 12/24/2016 and as needed to maintain accuracy of and coordination of the comprehensive care plan with the MDS assessment. Review will include discussion with direct care employees within the interdisciplinary team, and the resident by the Director of Nursing and/or designee and/or the Long Term Care Coordinator/MDS Nurse. B. Corrections to the care plan will be completed upon verification of accuracy C. During the care-planning phase of the Resident Assessment Instrument (RAI) process, the MDS nurse will validate the residents' status with the direct care employees. Revision to the care plan will take place following validation.	

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F 279	Continued From page 14 [because] unable to tolerate mech [mechanical] soft texture [related to] dementia. Has been receiving pureed texture." Review of the Resident's most recent care plan, dated 9/23/16, revealed the problem "Risk for aspiration." Interventions revealed the Resident was to receive a "Regular pureed diet, thin liquids." Further review revealed the problem "Potential for Psychosocial mood issues [related to] Alzheimer's disease." Interventions included "Resident likes candy Tootsie Pops'-works well for redirection when unacceptable behaviors are displayed." During an interview on 11/10/16 at 12:00 pm, LN #2 stated the Resident hadn't had any recent behaviors and had not been using the Tootsie Pops. The LN confirmed Resident #7 was on a pureed diet now. .	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, record review, and interview the facility failed to ensure care plan	F 309	1. Those residents found to be at risk for this deficient practice fall into two situations referred to as A & B.	12/24/16

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F 309	Continued From page 15 interventions were implemented for 2 of 5 sampled residents. Specifically, the facility failed to consistently monitor 1 (#1) resident's response to pain interventions using a comparative pain scale; failed to ensure fluids were encouraged for 1 resident (#1), and failed to ensure 1 resident's (#3) teeth fit and glasses were clean and fit. This failed practice placed residents at risk for not receiving the care needed to promote their highest practicable level of wellbeing. Findings: Resident #1 Record review on 11/8-11/16 revealed the Resident had diagnoses that included dementia and joint pain. Pain Review of the most recent annual MDS (minimum data set-a federally required nursing assessment), dated 10/17/16 revealed the Resident had identified his/her pain at a "6", on a scale of 0-10, indicating a moderately strong pain. Review of the quarterly "Pain Assessment Tool", dated 10/20/16, revealed the Resident had "Left hand 'arthritis' per pt." and used "warm towels, scheduled cream, PRN [as needed] meds" for the pain. The Resident had stated there was occasional mild pain for more than 5 days. Review of the physician's orders, dated 11/1/16 revealed the Resident's medication regime included Tylenol 975mg (3- 325 mg tablets) by mouth every 6 hours as needed for pain, Ibuprofen 600 mg every 6 hours as needed for pain, Vicodin (narcotic analgesic) 1 by mouth as needed for pain not relieved by over the counter	F 309	A. Monitor Pain B. Follow care plan by encouraging fluids, dentures and glasses. The primary physician of those residents found to have been affected has been advised of the deficient practices and had determined there has been no negative consequence for the resident. 2. All residents have the potential to be affected by the same deficient practice. 3. A. Facility policy for pain management has been reviewed, revised and explained to the licensed nursing staff. Licensed nursing staff have been re-educated on assessing, managing, and documenting pain. During initial nursing orientation all licensed nurses will complete a training module on pain management. Staff will acknowledge receipt of the facility policy. B. The facility policy for use of nursing care plans have been reviewed. All nursing staff have been re-educated on the importance of following the care plan. During initial nursing orientation all new nursing staff will complete a training module on pain management. Staff will acknowledge receipt of the facility policy. 4. Direct cares of the resident will be observed and monitored. Using a	

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F 309	Continued From page 16 medications, Voltaren 1% topical cream two times a day as needed for joint pain. Resident #1's care plan, last updated 10/18/16, revealed "Potential for discomfort [due to] occasional area pain, headache, and or [right] great toe, left hand. Interventions included "1. Offer PRN analgesic when resident has complaints of discomfort or note grimacing, guarding-document results. 2. Determine intensity, character, location, and duration of pain and monitor effects of analgesic within 1 hour... 5. Evaluate effectiveness of current pain management regime and consult provider as needed." Review of the "Medication Administration Comments [MAC]" were nurses documented the reason for giving an as needed medication revealed in October 2016, the administering nurse had not documented the intensity of the discomfort using a pain scale for a comparative measurement: 10 times when administering Tylenol for pain; 3 times when administering ibuprofen; and 7 times when administering the Voltaren gel; and 1 time when administering the Vicodin. In addition, no results were documented for the effectiveness of the medications 4 times. Review of the November 2016 MAC revealed no pain scale was used 5 times when administering the Voltaren gel, and 3 times when administering the Ibuprofen. During an interview on 11/8/16 at 9:30 am, Resident #1 stated s/he had arthritis in his/her left hand, they "put stuff on it" and s/he takes "ibuprofen."	F 309	standardized check list, the Director of Nursing, (DON) or designee, will observe the delivery of cares weekly, on both shifts for a period of 3 months. Deficient practices will be monitored, trended, and be used as opportunities for further training and process improvement.	

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During an interview on 11/9/16 at 10:12 am, when asked about Resident #1's pain, Licensed Nurse (LN) #3 replied Resident #1 always wants an aspirin, sometimes Tylenol or ibuprofen. When asked what tool was used to monitor the intensity of the pain and if the intervention was effective, the LN replied Resident #1 typically doesn't do one (pain scale).

Hydration

Review of the Resident CNA (certified nursing assistant) care plan, updated 10/18/16, revealed "Eating/Hydration...4. Encourage healthy fluids to drink water."

Review of the comprehensive plan of care, dated 10/18/16, revealed the problem "Potential risk of impaired skin integrity..." Interventions included "3. Encourage fluids throughout the day."

Observation on 11/8/16 at 9:00 am revealed Resident #1 sitting in a lounge chair. A plastic 1 Liter water jug with a straw was placed on the bedside table out of the Resident's reach. The straw still had the paper end on it and the jug was full of water.

During an interview on 11/8/16 at 9:30 am, when asked if s/he was able to reach the water jug, Resident #1 stated "I can't reach the water; I guess it's not in the right place."

Observation during the noon meal revealed the Resident received 1 cup of coffee and a water glass containing approximately 200 cc of water. During the meal the Resident drank half the water and took a few sips of the coffee.

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Review of the "Meal Intake Flow" sheet, dated 11/8/16 revealed staff documented the Resident had 200 cc of fluids at lunch.

Random observations throughout the day on 11/8/16 from 9:00 am-2:00 pm revealed the 1 liter water jug, located on the Resident's bedside table, remained full with the bit of paper still covering the straw.

During the noon meal on 11/10/16 at 12:00 pm, Resident #1 exclaimed out loud s/he needed to drink more fluids and added it was hard to remember to do so.

Resident #3

Record review from 11/7-10/16 revealed Resident #3 was admitted to the facility with diagnoses that included: dementia, Osteopenia (bone density that is lower than normal peak density but not low enough to be classified as osteoporosis), and pain.

Review of the most recent MDS (Minimum Data Set) assessment, an annual assessment dated 10/18/16, revealed the Resident was coded as having vision impairment and swallowing difficulties.

Review of the Resident's CNA care plan, dated 10/18/16, revealed "clean [Resident's] upper denture and use a small amount of Fixodent ...wears glasses, see they are clean."

Observation on 11/8/16 at 11:48 revealed CNA #1 placed Resident #3's dentures into his/her mouth without any adhesive glue. The Resident attempted to talk to the Surveyor but had difficulty

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as the dentures were falling off the top gum line. Further observation revealed no visible tube of denture adhesive in the patient care area.

During a dining observation on 11/8/16 at 12:20 pm Resident #3 was observed eating lunch in the activity room. CNA #2 sat next to the Resident and assisted the Resident with dining. During the observation CNA #2 exclaimed "[Resident #3] is having trouble with [his/her] teeth." Later during the meal, CNA #4 assisted the Resident with the remainder of his/her meal. During the observation, the CNA stated "we need to do something with [his/her] teeth."

On 11/9/16 at 10:57 am, CNA #s 2 and 3 were observed assisting Resident #3 with activities of daily living. After assisting the Resident into a wheel chair, CNA #2 told the Resident "I have your teeth." and inserted the dentures into the Resident's mouth. The CNA did not apply denture adhesive to the dentures prior to insertion.

Random observations from 11/7-9/16 revealed the Resident's dirty glasses were falling down the tip of his/her nose. The nose piece designed to hold glasses on the bridge of nose were placed on the lower tip of the nose.

During an interview on 11/10/16 at 9:15 am the Social Worker stated the Activities Coordinator (AC) was in charge of setting up eye and dental appointments for the Residents.

During an interview on 11/10/16 at 9:20 am the Ward Clerk stated Resident #3's last annual eye exam was on 7/25/16 and the last annual dental exam was completed on 2/3/16.

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F 309	Continued From page 20 During an interview on 11/10/16 at 9:30 am the AC stated each Resident gets an annual eye and dental exam. Any issues outside of the annual assessment would be dealt with accordingly. When asked about Resident #3's poor fitting glasses and dentures, the AC confirmed the facility has not addressed Resident #3's glasses or dentures. In addition, the AC stated weight loss would be an effect of the fitting of the Resident's dentures. Furthermore, the AC stated he/she was not sure what was causing the Resident's glasses to fit poorly and slide down. Review of the CNA's weight charting, dated March to November of 2016, revealed the Resident had an overall weight loss of 29.4 pounds.	F 309		
F 323 SS=D	. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: . Based on record review, observation, and interview the facility failed to: 1) ensure staff were adequately trained in the use of a sling used for mechanical transfers for 1 resident (#5); 2) the	F 323	1. A. Lift Sling manufacturer's instructions retrieved and reviewed with direct care employees at nursing department meeting 12/06/2016.	12/24/16

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F 323	Continued From page 21 Wanderguard system (alarm system that sounds when identified residents pass the sensor) used for 2 residents (#s 5 and 8) was maintained according to manufactures specifications; 3) failed to ensure the environment was free of potential hazards, in the areas of exposure to chemicals and hot liquids, for 3 residents (#s 1, 5, and 8) out of 10 residents residing in the facility. This failed practice placed residents in the facility, at risk for injury and/or harm. Findings: 1) Sling Transfer: Record review on 11/7-10/16 revealed Resident #5 had diagnoses that included dementia with behaviors and chronic pain. The Resident required maximal assistance with activities of daily living and transfers in and out of bed. Observation on 11/8/16 at 11:15 am revealed Certified Nursing Assistants (CNA) #s (1 and 2) provided morning cares to Resident #5. After undressing the Resident from the waist down the CNAs wrapped Resident #5 in a U-Sling (a green sling attached to a mechanical lift used to transfer a resident from one location to another). The sling was placed onto the upper back of the Resident while the arms of the sling were wrapped around each leg. The CNAs began to raise the Resident off the bed. The Resident's body was position to which his/her knees were pushed against his/her chest. The buttock was lower than the heels of both feet. The bottom of the sling was positioned on the upper back. The Resident was transferred in this manner to and from bed side toilet. During an interview on 11/9/16 at 7:15 pm CNA #5 stated the green U-Sling was designed to have	F 323	B. Provided information to direct care employees during a nursing department meeting 12/06/2016 to review the requirement for wander guard daily check. C. Sanitation wipes not designated for use on the skin removed from direct access in both public and resident care areas. Completed 11/15/2016. D. Red band rope placed across entrance to mini kitchen where coffee pot is located. Completed 11/10/2016. E. Cleaning chemicals kept on housekeeping carts moved to area out of reach of residents. Housekeeping carts kept out of resident areas when unattended. Completed 12/05/2016. F. Nursing Department employee meeting 12/06/2016 detailed survey findings with specific discussion regarding use of U sling, sanitation wipes, wanderguard, hot liquids in accessible areas, and cleaning chemicals to be kept out of accessible reach of residents. Housekeeping carts out of resident care areas when not attended. 2. All residents have the potential of compromise by inaccurate procedure of hazard checks, supervision, or device misuse. 3. A. Resident personal care and safety policy review and revision to ensure safe care when using the U sling for the Hoyer lift. Dignity and privacy maintained during all transfers with the Hoyer lift using the U sling.	

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F 323	Continued From page 22 the Resident sit in a seated position for transfer. In addition, the CNA stated the Resident should not have his/her knees above the waistline. The CNA stated the nurses informed the CNAs on how to use the green U-Sling. Review on 11/10/16 of the facility provided document "Patient Lift Sling Guide," no date, revealed "Apply the sling ...The self-leveling cradle will bring consumer into a sitting position." The sling was designed to allow the Resident to be placed in a sitting position and support the lower back and thighs of the Resident. During an interview on 11/10/16 at 5:55 pm the Director of Nursing (DON) stated the above described observation was not the proper way to use the green U-Sling. The DON confirmed the staff had not received formal training on how to use the U-Sling. 2) Wanderguard System: Random observations from 11/7-11/16 revealed the facility has a Wanderguard system in place at all major exits of the healthcare area. Random observations from 11/7-10/16 revealed the Residents #s 5 and 8 had Wanderguard bracelets attached to their wheelchairs. Record review of Resident #5's Medication Administration Record (MAR), dated 11/2016, revealed the Resident had the order "daily Check that the wander guard sensor is working...if doors are not alarming and inform oncoming staff: Wander/elopement risk" at night. Record review of Resident #8's MAR dated	F 323	B. Wander guard policy revised to reflect weekly door monitor checks on each shift with all surrounding power devices turned on to maximize possible electromagnetic interference as reflected in the operating instructions (2006). C. Sanitation Wipes policy and procedure for safe use review and revision. D. Thick barrier rope placed to divert incidence around hot liquids (coffee pot). E. Locking housekeeping carts ordered to ensure cleaning chemicals are kept out of the reach of all residents. F. DON or designees will round to inspect for proper use of U sling. Rounding will also include 1. Testing of wanderguard system 2. Verification that sanitation wipes are stored in correct place with correct use identified 3. thick barrier rope in place to divert attention away from hot liquids 4. Housekeeping carts attended in all patient/resident care areas. G. An education and competency module implemented to assess direct care employees understanding of procedure and use of the U sling used for the Hoyer lift. Lippincott procedure and competency review upon initial orientation and annually. H. Wanderguard procedure for daily safety check and function. Review policy and procedure for use and documentation. Each direct care employee will acknowledgement receipt of policy and procedure. I. In-service huddle for proper use of	

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F 323	Continued From page 23 11/2016 revealed the order "wander guard: Check placement [each] night daily." During an interview on 11/9/16 at 7:25 pm Licensed Nurse (LN) #4 stated he/she was not sure what the order was asking in the medication administration records. The LN further stated he/she was not clear on what a "wander guard sensor" meant per Resident #5's MAR. In addition the LN confirmed the order for Resident #8 stated to check for placement. During an interview on 11/9/16 at 8:30 pm LN #5 stated he/she sometimes would walk the mobile assistive devices with Wanderguard bracelets down by the doors to check if they activated the door sensor. During an interview on 11/10/16 at 5:10 pm the DON stated she was unsure of the testing requirements for the Wanderguard system. Review of the "Wanderguard Universal Tester Operating Instructions," dated 2006, revealed "Test bracelets daily ...Record the results in the resident's records. It is important to test the bracelet before putting it into use and daily thereafter. Failure to do so could result in injury to or death to a person in your care." Further review revealed "Test doors monitors at least weekly on each shift with all surrounding power devices turned on to maximize possible electromagnetic interference." 3) Environment Sanitation Wipes: Observation on 11/9/16 at 12:00 pm revealed	F 323	sanitation wipes difference in available wipes, and acknowledgement of procedure. J. Thick theater barrier rope to remain in place for safety. Information delivered during huddle in-service before 12/24/2016. K. Attention to unattended housekeeping carts and notification of relocating the carts out of resident areas. 4. A. Monitor proper use of the U sling for the Hoyer lift with 100% compliance for proper use. B. Monitor testing and documentation of wanderguard with 100% compliance over 3-month timeframe. C. Monitor proper use of sanitation wipes over 3-month timeframe for 100% compliance. D. Monitor compliance with use of theater rope to divert access to hot liquids over 3-month timeframe with 100% compliance. E. Monitor for housekeeping carts attended or unattended; cart relocated to a non-resident area if unattended. Monitoring for 3-month timeframe with 100% compliance. Above items A-E will be monitored by the Director of Nursing and/or designee and/or the Long Term Care Coordinator/MDS Nurse.	

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Staff # 1 pulled out a moist wipe from a purple and white container that was located next to a dining table. Next, the Staff handed a moist wipe to Resident #1 and Resident #5 indicating it was used to wipe their hands before the lunch meal.

During an interview on 11/9/16 at 8:30 pm LN #5 stated the purple and white container contained sanitation wipes used for disinfection of surfaces. The LN further stated you were required to wear gloves when using the wipes from the purple and white container. In addition, the LN stated the blue and white container was safe to use on your hands. The LN confirmed the purple and white container of moist wipes was called Super Sani-Cloth Germicidal Disposable wipes.

During an interview on 11/10/16 at 11:45 am Staff #1 stated the purple and white container contained wipes you use for hand cleaning and the blue and white container contained wipes for cleaning. In addition Staff #1 stated you are always to give a moist wipe to the Residents prior to meal time.

Review of the material data sheet for Super Sani-Cloth Germicidal Disposable Wipes, dated 11/30/2009 revealed, "Harmful if absorbed through skin...do not get...on skin."

During an interview on 11/10/15 at 5:10 pm the DON stated the staff should not use the purple and white container of moist wipes on the Residents' skin. The DON stated the staff needed further education on the matter.

Hot Liquids

Observations on 11/7/16 at 6:30 pm, Resident #5

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followed this surveyor into another resident's room. No staff was in the vicinity to redirect the Resident. Further random observations during the survey on 11/7-10/16 revealed Resident #s 5 and 8 frequently propelling themselves unattended via wheelchair throughout the facility. Both Residents would independently traverse the entire circumference of hospital unit.

Random observations on 11/8-10/16 of the open dining room revealed a BUNN coffee maker located inside the open kitchenette. The burner was often on with a pot of hot water or coffee sitting on it.

Observation on 11/9/16 at 4:40 pm, Resident #8 was in the dining room with his/her family member. Observation of the BUNN coffee maker revealed a full pot of coffee. The temperature of the coffee was 160 degrees Fahrenheit. Resident #8's family member stated s/he had just made a fresh pot.

Chemicals

Observations on 11/10/16 at 2:27 pm revealed an unattended housekeeping cart sitting in the back hallway, an area accessible to residents. Spray bottles containing cleaning chemicals, which hung from the rim of the trash can, and included Spitfire power cleaner, Virex, and Windex.

According to the Safety Data Sheet, Virex can cause serious eye damage/eye irritation. Spitfire power cleaner may be severely irritating to eyes and is harmful if swallowed.

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F 325	Continued From page 26	F 325		
F 325 SS=D	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 record review, interview and observation the facility failed to identify, implement and provide dietary interventions in a timely manner as a result of significant weight change. This failed practice placed 1 resident (#3), out of a census of 10, at risk for inadequate nutritional assessment and delayed implementation of nutritional supplemental intervention. Findings: Record review from 11/7-10/16 revealed Resident #3 was admitted to the facility with diagnoses that included: dementia, Osteopenia (bone density that is lower than normal peak density but not low enough to be classified as osteoporosis), and pain. Review of the most recent MDS (Minimum Data Set), a quarterly assessment dated 7/24/16,	F 325	1. A. Resident # 3 evaluation by the primary physician provides the determination that current therapies are appropriate for this resident at this time. Completed 11/14/2016 B. Nursing Department employee meeting 12/06/2016 detailed survey findings 2. All residents have the potential of the same deficient practice affecting nutritional status. 3. A. Policy change regarding considerations for three and 6-month nutritional assessment. Standard of practice for weight monitoring by the DON	12/24/16

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F 325	Continued From page 27 revealed the Resident was coded as having severe cognitive impairment, dependent on staff for completion of activities of daily living. Review of the most recent MDS annual assessment dated 10/18/16, revealed the Resident was coded as having swallowing difficulties, dependent on staff for completion of activities of daily living, severe cognitive impairment, and non-physician prescribed weight loss. Record review of Resident #3's Nutritional Care Plan, dated 10/18/16 revealed the Resident had alteration in nutrition related to obesity, swallowing problems and decreased meal intake. The plan's goal was to avoid significant weight change. Interventions included to monitor weights weekly and provide a can of Ensure (dietary supplement) if less than 50% of a meal was consumed. Previous versions of the Nutritional Care Plan, dated 2/18/16, 5/10/16 and 8/1/16 did not indicate interventions indicative of significant weight change. Record review of the CNA's weight documentation revealed from 7/3/16 (178.4 lbs) to 8/7/16 (167.0 lbs) the Resident lost 11.5 lbs. As a result, a weight loss of 6.4% occurred over approximately a month. Record review of the CNA's weight documentation revealed from 7/3/16 (178.4 lbs) to 10/2/16 (164.0 lbs) the Resident lost 14.4 lbs. As a result, a weight loss of 8% occurred over approximately three months. Record review of the CNA's weight documentation revealed from 5/16/16 (185.4 lbs)	F 325	or designee is a continuous basis. Weight changes falling within the parameters of the RAI parameters (3 months and 6 months) will be coded and monitored as described in the policy. An observed weight variance will not wait until the three or 6-month interval for assessment and intervention. B. The DON or designee will review weights within 48 hours of measurement. Any unexpected weight change of 3 % or 5 lbs. In 30 days will be reported to the attending physician with a consideration for Registered Dietician (RD) evaluation. C. Weight loss or gain will become a standing item discussed at every care planning session. Education: D. All direct care providers (RN, LPN, CNA) will complete a training module on managing weight variations. Training will be completed during initial orientation and annually. Completion of training will be maintained in employee education records. Employees will acknowledge receipt of facility policy. 4. The DON or designee will collaborate with the Registered Dietician monthly to review all weights and identify residents at risk.	

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to 11/6/16 (157 lbs) the Resident lost 28.4 lbs. As a result, a weight loss of 15.3% occurred over approximately six months.

Record review of the physician's progress notes, dated 5/24/16; 7/25/16; and 9/30/16, revealed no documentation indicating evaluation, plan, goals or interventions related to weight loss.

Record review of the Interdisciplinary Team (IDT) Meeting Reports, dated 5/25/16; 6/22/16; 7/19/16; 8/17/16; and 9/21/16, revealed no discussion of significant weight change.

Record review of the Medical Nutrition Therapy Review, dated 8/1/16, revealed a section titled "Weight Data." Further review revealed, the "Current Weight ...174.2...[as of] 6/10/16."

As a result, the non-current data used was 53 days old. If current data was used on the 8/1/16 Medical Nutrition Therapy Review a weight loss of 13.2 lbs would have been noted from 7/3/16 to 7/31/16. As a result, a weight loss of approximately 7.4% occurred.

During an interview on 11/9/16 at 9:00 am the Dietary Manger (DM) stated she monitors the weights monthly and if significant weight loss was noted; then, the Dietitian was to be notified. The DM further confirmed a significant weight change between the months of July through October should have been noticed and a plan of care implemented at that time.

Review of the physician orders, dated 11/2016, revealed Ensure supplement was started on 10/18/16 and prescribed as having one can up to three times a day if consumed less than 50% of

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F 325	Continued From page 29 the meal. During an interview on 11/9/16 at 9:25 am the Medical Doctor (MD) confirmed fluctuation in Resident #3's weight. The MD further stated the facility did not notice a significant weight change prior to October 2016. The MD added, if discovered sooner the dietary supplement could have been started prior to 10/18/16.	F 325		
F 354 SS=C	. 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: . Based on observation, record view, and interview the facility failed to provide a Director of Nursing (DON) for at least 35 hours/week. This failed practice placed all residents,(based on a census of 10), at risk for lack of oversite of care and services provided by the facility to each of the	F 354	1. A. Under the guidance and direct supervision of the DON, the Long Term Care Coordinator provides oversight to nursing within the long-term care environment. An interim LTC coordinator in place as of 11/28/2016.	12/24/16

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F 354	Continued From page 30 residents. Findings: Throughout the 11/7-11/16 survey the DON was observed working as the Long Term Care (LTC) and Critical Access Hospital (CAH) DON. Record review on 11/10/16 of the Job Description for the DON revealed, no verbiage regarding the number of hours dedicated for the DON working in the LTC. Review of the staffing hours provided by the facility for a two week period, dated 11/9/16 revealed, the DON working 40 hours in LTC in two weeks. During an interview on 11/11/16 at 10:30 am the DON stated she worked 20 hours a week for the LTC and the rest of the hours are in the CAH . The DON confirmed the job description did not specify that the DON worked at least 35 hours for the LTC unit. .	F 354	B. Revision of LTC Coordinator job description to reflect specific oversight of the long term care areas and responsibilities of the facility C. Advertising LTC Coordinator 2. All residents have the potential of the same deficient practice affecting nursing related responsibilities. 3. A. Revision of the DON Job description to reflect facility overall nursing activity oversight, including oversight of the LTC Coordinator for long-term care management responsibilities. B. Revision of the LTC coordinator and MDS nurse job description to reflect full time oversight of the long-term care area of this facility to ensure care and services provided to the residents. All activities monitored for compliance and excellence of care. C. Review job description with LTC Coordinator to acknowledge understanding of expectations and responsibilities. D. Review chain of command and reporting procedures with nursing department employees. 4. Quarterly submission of Payroll Based Journal (PBJ) data available to review for compliance with this requirement by CEO, DON, LTC Coordinator, or designee for each position.	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS	F 365		12/24/16

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F 365	Continued From page 31 Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: . Based on observation and interview the facility failed to ensure pureed food was prepared to meet the needs of one resident (#7). This failed practice placed the only resident (based on a census of 10) on a pureed diet at risk for choking and/or aspiration. Findings: Review of the "Cordova Community Medical Center Nursing to Dietary Communication Form," dated 7/5/16, revealed Resident #7 received an order for regular pureed diet. Review on 11/9/16 of the diet cards located in the central kitchen revealed Resident #7 was to have a regular diet with pureed texture. An observation on 11/9/16 at 12:15 pm revealed a test tray, requested by the Surveyor, contained pureed vegetables. When the Surveyor sampled the pureed vegetables, it was noted the serving contained two whole peas and one whole cubed carrot (approximately 1/4" by 1/4"). During an interview on 11/10/16 at 3:30 pm the Dietary Manager (DM) confirmed the pureed vegetables were not supposed to contain whole vegetables. In addition, the DM stated the kitchen staff who prepared the pureed vegetables used too large of a blade.	F 365	1. The affected resident (resident #3) has been seen by the attending physician and assessed for harm as a consequence of this deficient practice. The resident did not experience harm from this deficient practice. 2. All residents with modified consistency diets have the potential to be affected by this practice. All residents have their Diet Order listed on their Diet Card and Preference Sheet. 3. Review and revision of policy. A. Policy 308 Techniques for Blending and Pureeing will be revised to include: Pureed foods will be processed according to blender instructions and all pureed foods will be inspected for any remaining chunks of food by the cook and discarded B. Pureed foods will be passed through a sieve to ensure new machine is working properly and no chunks of food remain. All purees will be monitored for until 3 consecutive days (9 meals) have passed inspections C. A new Vitamix, high powered blender, has been ordered that specializes in	

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F 365	Continued From page 32 Review of the facility's policy "Techniques for Blending/Pureeing," original date 6/7/01, revealed no guidance on how to determine blade size for particular vegetables. In addition, no guidance was provided to ensure vegetables were completely pureed. .	F 365	pureeing food efficiently, and has one blade, so there will be no confusion. D. Dietary staff will be re-trained in the use of the new blender, according to blender instructions, with an in-service regarding pureeing processes and the importance of inspecting food for any remaining chunks of food that have not reached puree consistency. 4. Consulting dietician will test the consistency of all modified textures during each quarterly visit. The dieticians findings will be reviewed by the Dietary Manager and the Director of Nursing (DON) or designee.	
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant	F 373		12/24/16

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feeds only residents who have no complicated feeding problems.

Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:
o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:
Feeding techniques.
Assistance with feeding and hydration.
Communication and interpersonal skills.
Appropriate responses to resident behavior.
Safety and emergency procedures, including the Heimlich maneuver.
Infection control.
Resident rights.
Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

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F 373	Continued From page 34 This REQUIREMENT is not met as evidenced by: . Based on record review, interview, and observations the facility failed to ensure staff used as a paid feeding assistant had completed the State-approved training course, nor had the facility assessed and care planned for the use of a paid feeding assistant for 1 resident (#5) out of 3 residents observed receiving assistance with meals. This failed practice placed the resident at risk for choking from incorrect feeding techniques. Findings: Record review on 11/9-11/16 revealed Resident #5 had diagnoses that included dementia with behaviors and chronic pain. Review of the most recent Minimum Data Set (a federally required nursing assessment), dated 9/18/16, revealed the Resident required the limited assistance of 1 staff while eating. During an interview on 11/8/16 at 11:30 am, Activity Coordinator (AC) stated although s/he was no longer a certified nursing assistant, s/he had completed the paid feeding assistance program so she could assist residents with eating in the dining room. The AC stated s/he usually helped Resident #5 with meals. Observation on 11/8/16 at 12:10 pm revealed AC serving lunch to the residents seated in the dining room. The AC then brought Resident #5 to the table and served his/her meal. THe AC sat to the right of Resident #5 and assisted the Resident with lunch. The AC occasionally put food on the fork and handed it to the Resident and cued	F 373	1. The feeding assistant involved has been instructed to refrain from feeding residents until they have successfully completed a training program recognized by the State of Alaska. 2. All residents needing assistance with eating have the potential to be affected by the same deficient practice. 3. The facility has requested the reference(s) for a training program acceptable in the State of Alaska. All paid feeding assistants will complete the program prior to assisting. The Director of Nursing (DON) or designees along with the Director of Human Resources will maintain documentation of the training for all staff serving as paid feeding assistants. Any resident being assisted by a paid feeding assistant will have an appropriate entry in their care plan. 4. The DON or designee will review the training of all staff serving as paid feeding assistants.	

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F 373	Continued From page 35 him/her to eat the meal. Review of the Resident's care plan dated 10/18/16, revealed "Potential Alteration in Nutrition related to: 1. Resident gets distracted at meal times." Interventions included "Staff redirects resident to stay focused on the meal as needed." There was no information about utilizing a paid feeding assistant to feed the Resident. Further review of the medical record revealed no assessment of the Resident's eating/ swallowing skills to determine the use of a paid feeding assistant. During an interview on 11/10/16 at 1:11 pm, the Human Recourses Director stated AC had completed a paid feeding assistance program developed by a prior Director of Nursing. Review of the employee's educational file on 11/10/16 revealed the employee had completed the "Texas Department of Aging and Disability Services" paid feeding assistance program "Module 6" in August of 2016 and not the curriculum the State agency had provided to the facility last August.	F 373		
F 431 SS=F	. 483.60(b), (d), (e) DRUG RECORDS, 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	F 431		12/24/16

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F 431	Continued From page 36 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. This REQUIREMENT is not met as evidenced by: . Based on observation, interview and record review the facility failed to ensure: 1) expired over the over the counter (OTC) medications and expired narcotics with a high potential of abuse were removed and discarded;and 2) documentation of controlled substance inventory was maintained in a clear and organized manner. This failed practice placed all residents (based on	F 431	1. A. Expired OTC medications disposal policy change to reflect shift responsibilities to verify all OTC medication kept on the LTC medication cart remains current. Expired medication will be disposed of per policy at the end of the expiration month. Shift responsibility of the RN/LPN night shift will check OTC medications on the last day of each	

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F 431	Continued From page 37 a census of 10) at risk for receiving the incorrect medication and/or expired medication. Findings: Expired Medications: Observation on 11/9/16 at 8:15 am of the Long Term Care (LTC) medication cart revealed 1 box (containing 91 tablets) of 1 mg Folic Acid Tablets with an expiration date of 10/2016 remaining in active use for residents. During an interview on 11/9/16 at 8:40 am, Licensed Nurse (LN) #5 stated the Folic Acid should have been discarded and not in circulation for resident use. An observation of the Pharmacy Room with the Pharmacy Technician (PT) on 11/9/16 at 12:05 pm revealed 58 expired oxycodone (narcotic pain medication) 5 mg tablets for Resident #15. Further observation revealed the expiration date of the oxycodone was 10/4/16. During an interview on 11/9/16 at 12:20 pm the PT stated, the nurses are responsible for removing medications from the LTC medication cart, medication room and bringing them to the Pharmacy room leaving them on the counter for him/her. The PT is responsible for the inventory in the Pharmacy room. The PT further stated LTC medications are wasted in the cactus machine (device that dissolves medications) in the medication room. When asked about the expired medications being in active circulation for Resident's the PT did not respond. During an interview on 11/10/19 at 1:30 pm the Director of Nursing (DON) confirmed expired medications should be removed from active	F 431	month. B. Expired and discontinued narcotics for Long Term Care residents. Disposal policy revision to reflect use of collection receptacle for disposal immediately but no longer than three days after expiration or discontinuation of medication C. Narcotic inventory log organized to maintain order for narcotic inventory. D. Nursing Department employee meeting 12/06/2016 detailed survey findings 2. All residents have the potential to be affected by the same deficient practice. 3. A. Policy review and revision for expired OTC medication monitoring and disposal. Nursing shift responsibilities revised to reflect policy change (12/24/2016) B. Policy review and revision for expired and/or discontinued long term care resident medications to reflect use of disposal receptacle and timeframe for disposal (within 3 days after expiration or discontinuation of medication) C. RN responsibility each shift to maintain proper order and management of narcotic inventory log. Education: D. Policy review and acknowledgement by all licensed nursing employees E. Review shift responsibilities for monitoring OTC medication expiration dates and disposal of expired medications. 4.	

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F 431	Continued From page 38 Resident use areas and disposed of properly. Review of facilities policy titled "Outdated and Discontinued Pharmacy Items," dated 4/4/16, stated "...All non-returnable medication(s) will be disposed of...Long Term Care controlled substances will be disposed of within three business days..." Review of the "Disposal Act: Long-Term Care Facility Fact Sheet" on 11/16/16 located at www.deadiversion.usdoj.gov/drug_disposal/fact_sheets/disposal_ltcf.pdf>> revealed "On September 8, 2014, the Drug Enforcement Administration (DEA) made available for public view a final rule regarding the disposal of pharmaceutical controlled substances in accordance with the Controlled Substance Act, as amended by the Secure and Responsible Drug Disposal Act of 2010 ("Disposal Act")...When disposing of pharmaceutical controlled substances by transferring those substances into a collection receptacle, such disposal shall occur immediately, but no longer than three business days after discontinuation of use by the [Long Term Care Facility] resident..." Controlled Medication Documentation: An observation of the medication room on 11/9/16 from 3:30-3:45 pm with LN # 3 revealed narcotic medication inventory logs in a 3 ring binder separated by dividers marked with medication names. Documentation check of inventory found: Oxycontin (narcotic pain medication) 10 mg tablets, Tramadol (controlled pain medication) 50 mg tablets, Oxycodone 5 mg tablets and Lorazepam (an anti-anxiety medication) 0.5 mg	F 431	A. Employee acknowledgement of facility policy and required education regarding expired medication and disposal of medication. B. Monitor shift responsibilities checklist for 3 months to ensure proper checking of OTC expiration dates. C. Monitor organization of narcotic logbook for proper management and organization of logbook. Above items A-C will be the responsibility of the Director of Nursing and/or designee and/or the Long Term Care Coordinator/MDS Nurse.	

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F 431	Continued From page 39 tablets incorrectly filed under other medication name dividers. Further observation showed LN # 3 going through the binder to correct filing errors of the logs taking 10 minutes to rearrange the disorganized filing system. Interview on 11/9/16 at 3:45 pm with LN # 3 stated the controlled medication binder was disorganized and incorrectly maintained. During an interview on 11/10/19 at 1:30 pm the DON stated medication inventory logs need to be organized correctly.	F 431		
F 441 SS=F	. 483.65 INFECTION CONTROL, PREVENT 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	F 441		12/24/16

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F 441	Continued From page 40 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. This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and facility record review the facility failed to ensure there was a functioning Infection Control Committee (ICC) that monitored staff for compliance with hand hygiene, ensured medical equipment was cleaned per manufacturer's guidelines, and ensured infection control measures were practiced in the area of dining. These failed practices had the potential to effect 2 residents observed receiving care (#s 3 and 5), 1 resident that needed blood glucose monitoring (#1), and 2 residents observed during dining (#s 1 and 5), out of 5 sampled residents, and placed the residents at increased risk for the development and transmission of disease and infection in a vulnerable population. Findings: Hand Hygiene	F 441	1. A. Infection Control Committee re-established with planned quarterly and ad hoc meetings. DON will be acting Infection Control Coordinator. No residents were found to be directly affected by the lack of an active infection control committee B. Hand Hygiene identified as directly affecting resident # 3 and resident # 5 due to improper attentions to hand hygiene. These residents assessed and determined not to have had a negative effect from the deficient practice. C. Resident # 3 had the potential to be affected by improper disinfection of the glucometer. Re-education on the use and disinfection practices for the glucometer reviewed with licensed employees completed 11/11/2016	

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F 441	Continued From page 41 Observation on 11/8/16 at 11:40 am revealed Certified Nurse Assistant (CNA) #1 and 2 provided daily cares to Resident #5. During the observation the Resident began to scratch and grab at his/her buttocks area, which had a significant amount of fecal matter. Next, the CNA's began to put a sling around the Resident for a mechanical life transfer. The Resident placed soiled hands onto the holding bar of the mechanical lift and was transferred to the bed side toilet. After several minutes the Resident was lifted back to bed. The Resident's hands were never cleaned before or after the transfer. The CNA's immediately used the same mechanical lift to transfer Resident #3 from bed to wheelchair. During that observation, Resident #3 grabbed the same holding bar on the mechanical lift. Observations during personal cares on 11/9/16 at 10:57 am, CNA #s 3 and 4 entered Resident #3 and 5's room to assist the Residents with personal care. Both CNA's donned disposable gloves and without first performing had hygiene, began to assist Resident #3 with getting cleaned and dressed for the day. After providing pericare and removing the soiled adult brief for Resident #3, CNA #3 removed his/her gloves and, without performing hand hygiene, donned a new pair of gloves. The CNA then applied protective ointment to the Resident's buttocks, changed gloves without performing hand hygiene, and assisted with dressing the Resident and getting him/her out of bed using the mechanical lift. Observations during personal cares on 11/10/16 at 11:46 am revealed CNA #s 1 and 3 assisting Resident #5 with morning care. CNA #1 provided peri-care for the Resident. While providing care CNA # 1 removed a brief that was heavily soiled	F 441	D. Review facility policy for cleaning medical equipment completed 12/06/2016. E. Nursing Department employee meeting on 12/06/2016 detailed survey findings. 2. All residents have the potential to be affected by the same deficient practice. 3. A. Facility policy for hand hygiene reviewed, revised and explained to all direct care employees. Policy revision includes provision for resident hand cleansing before meals. B. Facility policy for cleaning medical equipment reviewed for compliance with the manufacturer's recommendations. Availability of instruction manual for glucometer at nurses' station. C. All direct care employees re-education on hand hygiene requirements and techniques for employees and residents D. All direct care employees will complete a hand hygiene competency check quarterly and during initial new employee orientation E. Employees will acknowledge receipt and understanding of facility policy for hand hygiene F. New employee orientation and annual review of the policy and procedure for maintaining the glucometer with proper disinfection of the glucometer. Glucometer cleaning competency completed annually. Employees will acknowledge receipt of facility policy.	

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F 441	Continued From page 42 with stool and placed it in the trash. The CNA discarded the contaminated gloves, and without performing hand hygiene, donned a new pair and continued dressing the Resident. Both CNAs changed gloves multiple times while providing care without preforming hand hygiene between changes. During an interview on 11/10/16 at 2:22 pm CNA # 3 stated the facility had removed the mounted in-room hand sanitizers when they had remodeled the room. Review of the Center for Disease Control website, "When to Perform Hand Hygiene" accessed at www.cdc.gov on 11/21/16, revealed "clean your hands ...If hands will be moving from a contaminated-body site to a clean body site during patient care" and "After glove removal." Glucometer During an observation on 11/9/16 at 7:30 am, Licensed Nurse (LN) # 3 gathered a glucometer (device used for checking blood sugars) and supplies. The face and front of the meter had a white film across the front of it. The LN carried the meter and supplies to Resident #3's room and proceeded to obtain the residents blood glucose level. LN # 3, then carried the glucometer used out of the room, set it on the medication cart. After documenting the results in the medical record, the LN placed the glucometer in the top drawer, without first wiping or cleaning the glucometer. During an interview on 11/8/16 at 8:30 am, when asked how the glucometer was cleaned LN #3 stated they used alcohol pads to wipe it down. The LN stated Resident #3 was the only one getting blood glucose checked at this time.	F 441	4. A. Verification of quarterly competency checks for hand hygiene B. Monitor and observe direct care of residents using a standardized checklist by the DON or designee. Observation of direct resident care on a weekly basis for both shifts over a 3-month timeframe. Deficient practices will be monitored, trended, and corrected in real time education. C. Monitor and observe the proper use and maintenance of the glucometer through weekly checklist by the DON or designee Above items A-C will be monitored by the Director of Nursing and/or designee and/or the Long Term Care Coordinator/MDS Nurse.	

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During the interview LN # 5, who was seated nearby, stated sometimes they use the purple top (super sani-cloth) to clean it.

During an interview on 11/9/16 at 7:10 pm LN # 4 stated he/she could not find any cleaning instructions for the facility's glucometer.

During an interview on 11/10/16 at 2:40 pm, when asked about the cleaning instructions for the glucometer, LN # 2 stated the sani-cloth was used to clean the glucometer.

The acute care LN then found the manufactures instructions for the glucometer in a cabinet.

Review of the "One Touch Ultra Smart Blood Glucose Monitoring System Owner's Booklet" revealed "A cloth dampened with water and a mild detergent can be used to wipe down the outside of the meter. Do not use alcohol or any other solvent to lean your meter."

Meals

During observation on 11/10/16 at 12:11 pm, Resident #5 refused morning hygiene. After the Resident was seated in a wheelchair, the CNA propelled the Resident to the activity room where Resident #3 was playing cards.

CNA staff then passed out lunch trays to the Resident's seated in the activity room. None of the residents seating in the activity room were offered hand hygiene before their meal was served to them.

During observation of the meal, Resident #3 and

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F 441	Continued From page 44 #5 were observed using their hands to feed themselves lunch. Review of the ICC meeting minutes, provided by the facility, revealed the committee had met 3 times over the past year. Further review revealed no meeting minutes were provided for the 6/16, and the 8/31/16 meetings. During an interview on 11/10/16 at 4:00 pm, the Director of Nursing and QAPI Coordinator stated they had recently designated a new Infection Preventionist in the past week. During the interview QAPI Coordinator stated there had been no hand hygiene monitoring done since May 2016. .	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and facility record review the facility failed to ensure there was an effective process for the repair of facility equipment used by the residents. This failed practice placed all residents in the facility (based on a census of 10) at risk for not receiving necessary services with functioning/ safe equipment.	F 456	1. A. The room for resident # 3 and resident # 5 was observed to have tap water taking extended time to reach tepid temperature. Maintenance identifying problem to provide tap water temperatures within acceptable range. B. Wheel chair for resident # 3 repaired by maintenance on 11/15/2016 C. Whirlpool Tub repair reported. Maintenance identifying the problem and	12/24/16

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F 456	Continued From page 45 Water During an observation in room #109 on 11/9/16 at 10:57 am, the water at the tap in Resident #3 and 5's bathroom was observed to run cold. After running for over 10 minutes the water reached a tepid temperature. During observation Certified Nursing Assistant (CNA) #3 stated "you have to let the water run a long time, room 104 is the same way. I reported it to maintenance." Wheel chair Random observations during the survey from 11/8-10/16 revealed Resident #3's wheelchair pedals had a gait belt (a strap with a buckle used for walking) wrapped around the legs of the pedals. During an interview on 11/8/16 at 11:00 am CNA #1 stated the gait belt was to hold the legs of the wheelchair together. Whirlpool Tub Observations during the initial tour on 11/7/16 at 6:30 pm, a handicap accessible whirlpool tub located in the residents' shower/tub room, the tub had some debris in the bottom, and appeared soiled. During an interview on 11/7/16 at 7:00 pm when asked about the soiled tub, CNA #6 stated they were not currently using it because there were no residents that wanted to take a tub bath. During an interview on 11/9/16 at 4:40 pm, Resident #8 s family member stated s/he wanted	F 456	parts needed for successful repair D. Nursing Department employee meeting 12/06/2016 detailed survey findings. 2. All residents have the potential to be affected by the same deficient practice. 3. A. Facility policy for reporting maintenance and equipment issues or repair requests revised to reflect closed loop communication and follow up for all repair requests. B. The Director of Nursing (DON) or designee will review the repair requests weekly and collaborate with the Facility Manager to determine completion of repair requests. 4. A. Education and policy review to close the communication gap for repair requests will be provided to all employees. B. Review of established process for repair requests and tracking will be reviewed with all employees. C. Facility policy will be reviewed and acknowledgement of policy review completed on initial orientation and annually. Above items A-C will be monitored by the Director of Nursing and/or designee and/or the Long Term Care Coordinator/MDS Nurse.	

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F 456	Continued From page 46 Resident #8 to take a bath but the staff had told him/her the whirlpool tub was broken. During an interview on 11/10/16 at 2:30 pm, when asked why the whirlpool tub wasn't used, CNA #3 stated "it has a leak". The CNA stated s/he had filled out a repair slip. During an interview on 11/10/16 at 2:40 pm, when asked how staff writes up request slips for broken equipment, the Ward Clerk provided a repair order book. Review of the repair order book for the month of October and November revealed no repair slips for the cold water, the whirlpool tub, or the wheelchair. 11/10/16 at 2:45 pm, the Facilities Director stated s/he had fixed the whirlpool tub 9 months ago but had not had heard about any further issues. The Facilities Director stated s/he had not received a repair request on the cold water or the broken wheelchair.	F 456		
F 514 SS=D	. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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.	F 514		12/24/16

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F 514	Continued From page 47 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 or record review and interview the facility failed to ensure verbal physician's orders were signed in a timely manner for 1 resident (#1) out of 7 sampled residents. This failed practice created a risk for inaccurate records and medication errors. Findings: Record review on 11/8/16 of the physician's orders for Resident #1 revealed an order dated 10/18/16 at 1:30 pm, "order clarification Voltaren gel 2 grams [every] am to affected joints and 2 grams [2 times a day as needed] joint pain. Per Dr. [physicians name] / [nurses name]." The physician had not signed off on the final verbal order. Review of an order dated 10/25/16 at 1:10 pm revealed "VO [verbal order] by Dr. [physicians name] to [nurses name] clarify vit B12 100mcg daily [by mouth]. [Read back checked] by [nurse's name]." The physician had not signed off on the final verbal order. During an interview on 11/9/16 at 9:00 am the MD stated s/he expects orders to be signed within 24 to 48 hours. During an interview on 11/9/16 at 9:25 am, when asked how long a physician had to sign verbal orders, Licensed Nurse #5 replied s/he wasn't sure. During an interview on 11/9/16 at 9:49 am, the	F 514	1. A. All verbal orders verified and signed off by physician within 48 hours. Corrective action reviewed with physicians on 11/29/2016. B. Nursing Department employee meeting 12/06/2016 detailed survey findings. 2. All residents have the potential to be affected by the same deficient practice. 3. A. Policy for the management of physician orders review with the Medical Director. Revisions to include the statement that verbal orders are not routinely acceptable. Under emergent conditions, verbal orders must be signed within 48 hours. B. Implement 24-hour nursing report and chart review. C. Educate on the completion process of the 24 hour nursing report and chart review D. Review facility policy for management of physician orders. Acknowledgement signed by the employee upon initial orientation. Acknowledgement maintained	

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	025028	A. BUILDING _____ B. WING _____	11/11/2016

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F 514	Continued From page 48 Director of Nursing stated verbal orders were to be signed off by the physician by the next business day. .	F 514	in education record. 4. During daily chart checks the licensed nurse will identify any verbal orders not yet signed by a physician and document on 24 hour nursing report.	
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews the facility failed to ensure staff received formal training related to the elopement of a resident. This failed practice placed two residents (#s 5 and 8) at risk for delayed or inappropriate response to an elopement emergency. Findings: Random observations from 11/7-11/16 revealed the facility has a wanderguard system in place at all major exits of the healthcare area. Further observations revealed the Residents #s 5 and 8 had wanderguard bracelets attached to their wheelchairs. During an interview on 11/9/16 at 7:15 pm Certified Nursing Asssistant (CNA) #5 stated the facility had two Residents (#s 5 and 8) who were deemed wanderers. In addition, the CNA stated	F 518	1. No residents were found to be affected by this deficient practice. 2. All residents have the potential to be affected by the same deficient practice. 3. Facility policy will be reviewed and staff trained on procedures to prevent and manage an incident of elopement. All facility staff will be educated on procedures for preventing and managing an elopement. During initial nursing orientation all new nursing staff will complete a training module on managing weight variations. Staff will acknowledge receipt of training	12/24/16

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F 518	Continued From page 49 he/she had not received any formal training related to elopement of a resident. During an interview on 11/9/16 at 7:25 pm Licensed Nurse #4 stated he/she had not received any formal training related to elopement of a resident. During an interview on 11/10/16 at 5:10 pm the Director of Nursing confirmed the facility's staff did not receive any formal training related to elopement of a resident.	F 518	and the facility policy. 4. The CEO or designee will conduct quarterly (every 90 days) elopement drills. Drills will be conducted at times to include both shifts.	
F 520 SS=F	. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		12/24/16

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F 520	Continued From page 50 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: . Based on interview and record review the facility failed to ensure the QAPI (Quality Assurance Performance Improvement), used to identify and implement change for improvement, failed to evaluate areas, implement improvement, and effect sustainable change as identified in prior surveys over the past several years and in areas that had been or should have been identified by the facility. In addition, the QAPI was not receiving data from the facility staff, had not implemented change plans or developed accurate ways to evaluate effectiveness of changes. These failed practices placed all residents (based on a census of 10) residing in the facility at risk for lack of effective Quality Assessment Performance Improvement committee: Findings: Findings during the survey revealed repeated deficient practices in: Pharmacy Services: 1) expired over the over the counter (OTC) medications and expired narcotics with a high potential of abuse were removed and discarded; 2) documentation of controlled substance inventory maintained in a clear and organized manner. Dignity: residents were treated in a dignified manner during personal care. Director of Nursing: failed to ensure the	F 520	1. Current Quality Assurance Performance Improvement (QAPI) policies and procedures will be reviewed and updated to ensure that the QAPI committee identifies and resolves systemic problems. A Continuous Quality Improvement Programs (CQIP), specifically identifying Long Term Care quality activities, will be developed. The CQIP will be reviewed and approved by the Governing Body at it's December 8, 2016 regular meeting. 2. All resident have the potential to be affected. 3. A QAPI committee will be maintained and will meet in accordance with 483.75(o)(1). Ongoing QAPI committee meetings will include review of pertinent clinical/operational systems necessary to provide quality care to CCMC residents. Identified deficiencies will be placed on a corrective action plan. The corrective action plan will be reviewed as needed at a QAPI committee meeting and revised until the deficiency has been satisfactorily resolved.	

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F 520	Continued From page 51 requirement for having a director of nursing in the long term care 35 hours a week was met or apply for a nursing waiver for that requirement. Accident and Supervision: equipment used to care for residents was used according to manufactures recommendations and staff were educated and reeducated on the use. Care planning: care plans were updated to reflect residents' current needs. Qualities of Care: interventions care planned to promote care and quality of life were implemented by the nursing staff. Medical records: medical records were complete and accurate. During an interview on 11/10/16 at 4:05 pm, the facilities QAPI Coordinator stated s/he started in the lead position August 2016 and before then s/he was on the committee but didn't know much about it. The QA Coordinator confirmed the facility currently had no action plans, concerns, surveillance or monitoring in infection control nor had the facility been conducting hand hygiene monitoring. The QA Coordinator was unable to speak as to how the facility used prior survey results to improve care and services to the residents. During the interview the QA Coordinator stated the facility was working on administration and employee turnover, however there was no data collection, evaluation, or action plans on how this was being reviewed by QAPI. During the interview, the QAPI Coordinator stated the long term care did not have its own quality committee separate from the hospital committee.	F 520	4. The CEO/designee will participate in or review ongoing QAPI meetings to ensure deficient practices are identified, trends are strategically evaluated, corrective action plans are established and monitored for effectiveness, and improvements are sustained. The QAPI program will report to the Health Services Board on a quarterly basis starting January 2017.	

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F 520	Continued From page 52 .	F 520		