

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

PRINTED: 04/15/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/11/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>QYANNA CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 GREG KRUSCHEK AVENUE (P.O. BOX 966) NOME, AK 99762</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 2/8-11/16. The sample included 7 residents and 1 closed record.  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, Alaska 99503	F 000			
F 156 SS=F	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156		3/27/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/04/2016

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

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F 156	<p>Continued From page 1</p> <p>items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to inform residents and/or their legal representative in writing prior to or at the time of admission of a financial break down of costs for items and services that they will not be charged based on a census of 18. These failures denied the residents opportunity for informed consent regarding additional costs. Findings:</p> <p>Record review on 2/10/16 of the admission packet all residents were to receive prior to or on admission contained no information related to costs of services the resident may not be</p>	F 156	<ol style="list-style-type: none"> <li>1. Cost of care breakdown was sent to all 18 residents and/or their legal representatives.</li> <li>2. All 18 residents have the potential to be harmed by this alleged deficient practice.</li> <li>3a. Social Service Director will educate Social Service Assistant to ensure the Cost of Care Breakdown form is in every new admission packet.</li> <li>4a. Quality Assurance Assessment will be performed after every admission by</li> </ol>		

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F 156	Continued From page 3 charged.  During an interview on 2/11/16 at 11:45 am the Social Services Assistant stated she had not seen a breakdown of costs.  During an interview on 2/11/16 at 12:00 pm the Director of Nurses stated she was not aware of how the cost of services was communicated to residents.	F 156	SSD/designee to ensure all information has been given to resident/legal representative.  4b. SSD/designee will report any discrepancies to the administrator.  4c. Administrator will discuss any discrepancies at QCC PIC for a period of 90 days.		
F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS  Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.  The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)  The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.  The facility must establish and maintain a system that assures a full and complete and separate	F 159		3/27/16	

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F 159	<p>Continued From page 4</p> <p>accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>. Based on account review and interview the facility failed to ensure quarterly statements of the resident accounts managed by the facility were sent to the residents and/or their representatives. In addition, the facility failed to ensure petty cash funds were accounted for. This failed practice had the potential to effect 17 residents with accounts managed by the facility and placed them at risk for financial abuse. Findings:</p> <p>Resident Accounts:</p>	F 159	<p>1a. Statements were mailed on February 11, 2016 for all residents/legal representatives who have trust accounts.</p> <p>1b. \$15.00 was added to petty cash to equal \$50.00.</p> <p>2. All residents with trust accounts have the potential to be harmed by this alleged deficient practice.</p> <p>3a. Social Service Director (SSD) will educate Social Service Assistant (SSA)</p>		

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F 159	<p>Continued From page 5</p> <p>Review of the Resident accounts on 2/11/16 with Accounting Staff (AS) #1 and #2 revealed no evidence of quarterly statements had been sent to the Residents and/or their representatives.</p> <p>During an interview on 2/11/16 at 11:30 am AS #1 stated quarterly statements of the Residents' accounts had not been sent to the Residents and/or their representatives. During the interview AS #1 stated the responsibility of the account had changed hands several times and confirmed there was no policy for the administration of the accounts.</p> <p>Petty Cash:</p> <p>During an interview on 2/11/15 at 1:10 pm, Licensed Nurse (LN) #3 stated the petty cash is kept in the nurse's medication cart.</p> <p>Review of the money in the cart revealed a book of receipt slips and \$35.00 in petty cash. There was no ledger reflecting how much money was supposed to be in petty cash nor was there a list of residents that had accounts with the facility.</p> <p>When asked how much money was supposed to be in the petty cash, LN #3 stated she didn't know.</p> <p>During an interview on 2/11/16 at 1:30 pm, the Director of Nursing (DON) stated there should be \$50.00 in the petty cash. The DON stated she had not replenished it last time there was a withdrawal.</p> <p>Review of the information "Quyanna Care Center Request to Handle Nursing Home Resident's Personal Monies", was undated and revealed "I</p>	F 159	<p>and accounting staff regarding the timely provision of trust account statements.</p> <p>3b. SSA will compile a list of residents with trust accounts and keep it with the petty cash along with a ledger for accountability, in the locked medication cart.</p> <p>3c. SSA will reconcile petty cash bi-monthly and report any discrepancies to Director Of Nursing (DON)/designee.</p> <p>3d. DON/designee will report any deficiencies noted to the Administrator.</p> <p>3e. SSD/designee will perform Quality Assurance (QA) checks on a quarterly basis and report any deficiencies found to the Administrator.</p> <p>3f. Administrator will discuss any discrepancies at QCC PIC for a period of 90 days.</p>		

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F 159	Continued From page 6 will have access to a quarterly accounting of my account activity given or mailed to me or my authorized representative."	F 159			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by:  Based on record review, observation and interview the facility failed to evaluate the suitability of a device that reduced 1 resident's (#1) mobility, out of 5 sampled residents. Specifically, the facility failed to assess and evaluate the risks and benefits of using a wheeled lounge chair (geri-chair) to ensure it was not being used for staff convenience. In addition, the facility failed to ensure the potential negative outcomes of the device were mitigated. This failed practice placed the resident at risk for pressure sores, increased bowel and bladder incontinence, and physical deconditioning. Findings:  Record review on 2/8-11/16 revealed Resident #1 had diagnoses that included dementia (short and long-term memory loss with cognitive impairment) with behaviors and kyphosis (curvature of the	F 221	1a. Risk and benefits were discussed with Physical Therapy regarding the Geri Chair usage for Resident #1.  1b. Risks and benefits of Geri Chair usage were discussed with the responsible party.  1c. Care plan was written to address negative outcomes resulting in Geri Chair usage.  1d. "High risk for falls r/t visual function" was amended to list the immobility caused by the Geri Chair as a potential problem and lists interventions to address potential outcomes.  2. All 18 residents have the potential to be harmed by this alleged deficient practice.	3/27/16	

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F 221	<p>Continued From page 7 spine).</p> <p>Review of the most recent Minimum Data Set, a comprehensive significant change-in-status assessment, dated 11/26/15, revealed the Resident was moderately impaired in making decisions; had a history of wandering 4-6 days in 7 days; was unsteady when walking and standing; and had fallen since the most recent assessment.</p> <p>Observation on 2/8/16 at 3:50 pm, Resident #1 was observed seated in a geri-chair in the sitting area, the chair was reclined and the foot rest was up. During the observation the Resident moved her right leg over the side on the foot rest and leaned forward several times. The Resident was unable to lower the foot rest or rise from the chair.</p> <p>Review of the Resident's comprehensive care plan, undated, revealed "ADL [activities of daily living] functional deficit [related to] cognitive impairment...Intervention Allow [Resident's Name] to ambulate self with her rolling walker and assist as needed. The problem "High risk for falls [related to] cognitive, visual function" had the intervention "Ambulates self as tolerated, may sit in geri chair." The care plan did not list the immobility caused by the geri-chair as a potential problem, and did not list interventions to address potential negative outcomes.</p> <p>Review of the "C.N.A. Care Plan Sheet," revised 12/28/15, revealed "May sit in geri-chair" and "In geri-chair, stand every 2 [hours]."</p> <p>During an observation on 2/9/16 at 7:30 am, Resident #1 was observed sitting on the side of the bed (which had a concave mattress that</p>	F 221	<p>3a. Director of Nursing (DON)/designee will education Audit Nurse, MDS Nurse and Physical Therapist on the importance of discussing the risk/benefits prior to initiating any changes in the residents' ADL's.</p> <p>3b. DON/designee will educate staff regarding Resident #1's care plan changes.</p> <p>4a. Random staff will monitor residents for restraints and report any issues to DON/designee.</p> <p>4b. DON/designee will report any discrepancies found to the Administrator.</p> <p>4c. Administrator will discuss any discrepancies found at QCC PIC for a period of 90 days.</p>		

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F 221	<p>Continued From page 8</p> <p>prevented easy rising), assisted with standing, and ambulated to the bathroom.</p> <p>Further random observations throughout the survey on 2/9-11/16 revealed the Resident was seated in the geri-chair during meals, while attending activities, and was pushed to and from the bedroom while seated in the chair. The Resident was occasionally observed ambulating with a walker while accompanied by staff.</p> <p>During an interview on 2/9/16 at 10:02 am, Certified Nursing Assistant (CNA) #1 stated Resident #1 was in the geri chair because she had been falling. The CNA stated the Resident could walk using a walker without staff assistance when out of the geri-chair.</p> <p>During an interview on 2/10/16 at 11:30 am, Licensed Nurse #1 stated Resident #1 could rise from a regular chair but could not get up from the geri-chair.</p> <p>Review of a physical therapy clinic note, dated 12/1/15, revealed "Pt. [patient] was seen sitting up in geri-chair in the dining room. Pt. was unresponsive to physical therapist attempts to arouse pt...It is recommended that pt sit in a geri-chair as the pt. has an increased thorasic kyphosis in sitting and trunk lean which she is unable to control due to poor posturing." Further review of the medical record revealed the negative effects of using seating that prevented rising had not been assessed.</p> <p>During an interview on 2/11/16, the Physical Therapist (PT) stated the geri-chair could be considered a restraint if it prevented the Resident</p>	F 221			

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F 221	Continued From page 9 from standing up. The PT confirmed the risk and benefits of using the geri-chair had not been evaluated.  Review of the facility policy "Physical Restraints," revised 2/10/11, revealed "Physical restraints include, but are not limited to...Placing the resident in a chair that prevents rising."	F 221			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview the facility failed to ensure dishware used to provide food and fluids to 1 non-sampled (Resident #6), out of 18 residents in the facility, were in good condition. This failed practice had the potential to negatively affect the resident's self-esteem and quality of life.  Observations in the Long-Term Care Kitchen on 2/8/16 at 2:00 pm revealed red ceramic dishware located in the cabinets. Several of the dishes, bowls, and cups had chips on the sides and included: 3 medium sized chipped plates; 5 chipped bowls; 1 large chipped plate; and 2	F 241	1a. Three medium sized chipped plates, five chipped bowls, one large chipped plate, and two chipped cups were discarded.  1b. Medium red bowl that resident was eating out of was discarded.  2. All 18 residents have the potential to be harmed by this alleged deficient practice.  3a. All staff will be educated by Director Of Nursing (DON)/designee regarding dignity related to serving meals on chipped tableware.	3/27/16	

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F 241	Continued From page 10 chipped cups. Some of the dishware had multiple chips.  During an interview on 2/10/16 at 2:30 pm, when asked about the chipped dishes, the Dietary Manager confirmed having knowledge of chipped dishes and stated she had instructed the staff not to use them some time ago.  On 2/11/16 at 10:20 am Resident # 6 was observed eating cereal out of a red bowl that had a large chip on the side.	F 241	3b. Dietary Manager/designee will educate the kitchen staff about discarding any dishes that get chipped during the cleaning process.  3c. Dietary Manager and DON are researching chip resistant tableware.  4a. Random staff will monitor cupboards and report to DON/designee any discrepancies found.  4b. DON/designee will report any discrepancies to the Administrator.  4c. Administrator will discuss any discrepancies at QCC PIC for a period of 90 days.		
F 249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL  The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.	F 249		3/27/16	

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F 249	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a qualified professional was available to conduct activity assessments and evaluate the activities program. This failure had the potential to affect all residents based on a total census of 18. As a result, an activity director was not available to ensure assessments reflected resident skills, abilities, and interests. Findings: Observations from 2/8-11/16 revealed ongoing activities provided by the staff with the residents. During an interview on 2/8/16 at 1:30 pm the Director of Nurses stated the facility did not have a qualified activity coordinator and that she was assuming that role for now. In addition, she stated extra staff had been scheduled to assist residents with activities. During an interview on 2/10/16 at 5:00 pm the Administrator stated the facility had been recruiting for an Activity Director but had not received qualified applicants. Additionally, no current staff would agree to begin training for the activity coordinator position.</p>	F 249	<p>1a. Facility is actively recruiting for a qualified Activity Coordinator.</p> <p>1b. Facility is actively recruiting for an Occupational Therapist to conduct activity assessments and evaluate the Activities Program.</p> <p>2. All 18 residents have the potential to be harmed by this alleged deficient practice.</p> <p>3a. Activity Coordinator will immediately, upon hire, begin working toward his/her Certification.</p> <p>3b. Occupational Therapist will evaluate all 18 residents. He/she will work with the Activity Coordinator to ensure the Activity Program meets the resident's needs.</p> <p>4a. Director of Nursing (DON)/designee will monitor Activity Coordinator's progress in the program and report to Administrator.</p> <p>4b. Occupational Therapist will evaluate the Activity Program and report any deficiencies noted to the DON/designee.</p> <p>4c. DON/designee will report to Administrator any discrepancies found.</p> <p>4d. Administrator will report progress of the Activity Program and any discrepancies found at the QCC PIC for a period of 90 days.</p>		

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F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: .</p> <p>Based on observation, interview and record review the facility failed to ensure 2 out of 5 Residents care plan were reviewed: 1) Resident #1's care plan was updated to include the preference for no male care givers, and 2) Resident #3's comprehensive care plan had not been updated or revised. This failed practice denied the residents the right to receive care in the manner they wished and planned for.</p> <p>Findings:  Resident #1</p>	F 280	<p>1a. Resident #1's care plan was updated to state "no male caregivers".</p> <p>1b. Care plan for resident #3's Foley catheter was resolved.</p> <p>2. All 18 residents have the potential to be harmed by these alleged deficient practices.</p> <p>3a. Education was provided to MDS coordinator by the Director of Nursing (DON)/designee regarding the updating of</p>	3/27/16	

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F 280	<p>Continued From page 13</p> <p>Record review on 2/8-11/16 revealed Resident #1 had a diagnosis that included dementia (a short and long term memory loss that can affect cognitive ability).</p> <p>During an interview on 2/11/16 at 7:15 am, Licensed Nurse (LN) #2 stated Resident #1 was not supposed to have male caregivers. The LN stated "They can assist but won't take primary on that."</p> <p>During an interview on 2/11/16 at 9:45 am, when asked about male caregivers providing care to Resident #1, Certified Nursing Assistant (CNA) #1 stated it was per family request that males not provide personal care, but could help transfer and assist the Resident with eating. When asked how staff was given this information, the CNA stated it was on the nurses "report sheet."</p> <p>Review of the Resident's CNA care plan and comprehensive care plan did not reveal information about the family members preference.</p> <p>Resident #3</p> <p>Record review on 2/8-11/16 revealed Resident #3 was admitted to the facility on 10/2/15, with a diagnosis of deconditioning.</p> <p>Random observations from 2/8-11/16 revealed Resident #3 did not have a Foley catheter.</p> <p>Review of the Resident's current comprehensive care plan, updated on 10/2/15, revealed "catheter care q [every] shift..."</p>	F 280	<p>care plans PRN.</p> <p>3b. Education was provided to all caregivers specifying that no males will give care to Resident #1.</p> <p>4a. Any resident changes will be discussed in the facility's morning meeting with the DON/designee, MDS nurse and Administrator.</p> <p>4b. Any adjustments that need to be made will be made in the morning meeting following the shift change.</p> <p>4c. Care plans will be audited quarterly in the residents' care plan conferences and PRN by the audit nurse/designee.</p> <p>4d. DON/designee will spot check care plans for accuracy.</p> <p>4e. Any discrepancies noted will be reported to the Administrator.</p> <p>4f. Administrator will discuss any discrepancies at ACC PIC for a period of 90 days.</p>		

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F 280	Continued From page 14 Review of the Resident's current "CNA care plan sheet", updated on 1/5/16, revealed "continent of bowel and bladder, use BSC [bed side commode]."  During an interview on 2/10/16 at 9:55 am the Minimum Data Set (MDS) coordinator stated the comprehensive care plan should have been updated when the Foley catheter was removed.	F 280			
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on record review and observation the facility failed to ensure 1 resident (#4) in the facility was offered appropriate hand hygiene before eating and failed to ensure 7 resident #s (3; 4; 6; 7; 8; 9; & 10) were offered hand hygiene after dining. This failed practice denied the residents care needed for good grooming. Findings:  Record review on 2/11/16 revealed Resident #4 was admitted to the facility on 8/3/15 with diagnosis of Alzheimer Dementia (can cause short and/or long-term memory loss and cognitive	F 312	1a. Resident #4's hands were washed prior to eating  1b. Resident #3, 4, 6, 7, 8, 9, and 10 were offered hand hygiene after eating.  2. All 18 residents have the potential to be harmed by this alleged deficient practice.  3a. Staff will be educated by Director of Nursing (DON)/designee regarding ADL care on residents with dementia.	3/27/16	

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F 312	<p>Continued From page 15 impairment). The Resident was wheel chair bound and wandered in the facility (self-propels) via wheelchair.</p> <p>Review of the most recent Minimum Data Set, a quarterly assessment, dated 11/3/15, revealed the Resident required total assistance with personal hygiene.</p> <p>Review of Certified Nursing Assistant (CNA) care plan sheet, revised 12/28/15, revealed the Resident needed total care with hand and face washing, oral care and upper and lower body dressing. The Resident required assistance with setting up meals but was able to self-feed with cueing.</p> <p>During an observation on 2/11/16 at 8:20 am CNA #s 1 &amp; 2 were observed assisting the Resident getting out of bed. After changing the Resident's disposable brief that was soiled with feces and dressing the Resident, both CNA's transferred the Resident to a wheelchair. CNA #1 handed the Resident a damp washcloth and encouraged Resident #4 to wash her face. The Resident held the washcloth in the right hand and after wiping her face handed the washcloth back to the CNA. The Resident was not encouraged to wash both hands prior to going to breakfast.</p> <p>Continuous observation on 2/11/16 from 8:30-9:35 am, revealed Resident #4 was pushed to the dining room in her wheelchair and assisted to the breakfast bar. The Resident was not offered any hand hygiene prior to receiving her breakfast. The Resident was observed using both her hands to eat her eggs. During the meal Resident #4 was observed wiping her nose and</p>	F 312	<p>3b. Staff will be educated by DON/designee regarding hand hygiene for residents before and after eating.</p> <p>4a. Random staff will report any discrepancies noted to the DON/designee.</p> <p>4b. DON/designee will report any discrepancies to the Administrator.</p> <p>4c. Administrator will discuss any discrepancies at QCC PIC for a period of 90 days.</p>		

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F 312	Continued From page 16 her eyes using her bare hand.  In addition, Resident #s, 3; 4; 6; 7; 8; 9; & 10 were observed eating with their hands. None of the Residents were offered hand hygiene after completing their meal prior to leaving the dining room.	F 312			
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 ensure 1 resident (#1) out of 5 sampled residents (who wore hip protectors as an intervention to reduce injury from a fall), was sized in a manner to be effective. This failed practice created a risk for injury from an accidental fall. Findings:  Record review on 2/8-11/16 revealed Resident #1 had diagnoses that included dementia (short and long-term memory loss with cognitive impairment) with behaviors, degenerative joint disease and a history of falls. Further review of the medical	F 323	1a. The correct size hip protectors were put on Resident #1.  1b. Torn pair of hip protectors from Resident #1's drawer was discarded.  2. All five residents who wear hip protectors have the potential to be harmed by this alleged deficient practice.  3a. Staff was educated on proper hip protector sizing and application of hip protectors by Director of Nursing (DON)/designee.	3/27/16	

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F 323	<p>Continued From page 17</p> <p>record revealed the Resident had fallen several times over the past few months.</p> <p>Review of the comprehensive care plan, undated, revealed the problem "High risk for falls [related to] cognitive, visual function." The interventions listed included "hip protectors." Hip protectors are padded polypropylene shells sewn into the garment to absorb and disperse the shock of impact that would otherwise effect the head of the thighbone [hip].</p> <p>Review of the "C.N.A. Care Plan Sheet", revised 12/28/15, revealed "Hip protectors at all times."</p> <p>During an observation on 2/9/16 at 7:30 am Certified Nursing Assistant (CNA) #s 3 &amp; 4 assisted Resident #1 out of bed. The Resident was wearing hip protectors that sagged to the knees and the padding that was normally positioned over the hips was askew. The right pad was hanging in front of the Resident's right thigh and the left pad was hanging below the left buttock.</p> <p>During an interview on 2/11/16 at 9:45 am, when asked how staff knew what size hip protectors to use, CNA #1 stated the Restorative Nurse sized the hip protectors.</p> <p>During an observation on 2/11/16 at 1:30 pm, the Restorative Nurse opened Resident #1's drawer and removed a pair of hip protectors. When examining the hip protectors the Restorative Nurse stuck his fingers though the fly of the garment (mens pair).</p> <p>During an interview on 2/11/16 at 1:30 pm, when questioned about the sizing of Resident #1's hip</p>	F 323	<p>3b. Restorative nurse will measure the five residents wearing hip protectors now and quarterly with size adjustments made as necessary.</p> <p>3c. Restorative nurse will post the size each resident wears inside the closet door and give a copy to the DON/designee.</p> <p>4a. Random staff will spot check the residents that wear hip protectors for proper placement and sizing.</p> <p>4b. Any discrepancies will be reported to the DON/designee.</p> <p>4c. DON/designee will report any discrepancies found to the Administrator.</p> <p>4d. Administrator will discuss any discrepancies at QCC PIC for a period of 90 days to monitor issue.</p>		

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F 323	Continued From page 18 protectors, the Restorative Nurse replied Resident #1 was supposed to wear a size large. The Restorative Nurse stated the Resident must have had the wrong size on.  According to Hip protector, accessed 2/18/16, at www.hipprotector.com, hip protectors come in 5 sizes for women and are sized according to hip measurement. The measurements for men are sized differently.	F 323			
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza	F 334		3/27/16	

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F 334	<p>Continued From page 19</p> <p>immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p>	F 334			

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F 334	Continued From page 20  This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure information provided to residents and/or representative about the risk and benefits of the influenza vaccine were documented in the medical record for 2 (#s 1 and 2) out of 5 sampled residents. This failed practice denied residents and/or their representatives the right to be fully informed about the 2016 influenza vaccine. Findings:  Review of medical records on 2/8-11/16 revealed Resident #1 and Resident #2 had received the influenza vaccine on 11/6/15. The Residents' medical record did not contain evidence indicating that the Residents' representatives had received the vaccine information sheet (VIS).  During an interview on 2/11/16 at 1:50 pm, Social Worker (SW) #s 1 & 2 were asked about the documentation the Residents and/or their representatives had been provided with the VIS. SW #2 stated she thought the former social worker had mailed out the VIS sheets but confirmed that it had not been documented.	F 334	1. All residents have the potential to be harmed by this alleged deficient practice.  2a. Social Services Director (SSD) will educate Social Services Assistant (SSA) on procedures for mailing out the VIS information sheets to residents/legal representatives.  2b. SSD will educate SSA on proper documentation for VIS information responses from residents/legal representatives.  3a. SSD will do a quality check to ensure the VIS sheets have been mailed and responses documented prior to resident receiving immunizations.  3b. SSD/SSA will notify Director of Nursing (DON)/designee of any residents who have declined to receive any vaccinations.  3c. SSD will notify Administrator of any deficiencies found in this system.  3d. Administrator will report any discrepancies at QCC PIC for 90 days.		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		3/27/16	

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F 371	<p>Continued From page 21</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <ul style="list-style-type: none"> <li>· Based on observation, interview and policy review the facility failed to ensure: 1) All kitchen equipment was cleaned appropriately in the main kitchen and Long Term Care (LTC kitchen); 2) donated food was dated and labeled; 3) spoiled produce was pulled from service; 4) frozen items were stored appropriately; and 5) dietary staff washed their hands in a manner to prevent contamination of food and equipment. This failed practice placed all residents (based on a census of 18), receiving food from the facility at risk for food borne illnesses. Findings: <p>During the initial tour of the facility's main kitchen on 2/8/16 at 1:10 pm, the following concerns were noted:</p> <ul style="list-style-type: none"> <li>· Bins containing dry goods had dried debris sprinkled among the top and sides of containers,</li> <li>· The kitchen hood located over the stove and deep fryer was tacky and had a coating of debris and dusty looking strings hanging down from the sprinklers over the stove.</li> </ul> </li> </ul>	F 371	<p>1. *Bins containing dry goods were wiped down and debris removed.</p> <ul style="list-style-type: none"> <li>*The kitchen hood located over the stove and deep fryer was cleaned and debris removed.</li> <li>*The vitamix blender stand was wiped clean.</li> <li>*Cabinets and drawers containing crumbs/debris and drawer with a dried, spilled substance was wiped clean and debris removed.</li> <li>*Baggies containing unlabeled/undated green leaves were discarded.</li> <li>*Large plastic jar containing green leafy mix, unlabeled and undated was discarded.</li> <li>*Bag of unlabeled orange colored spherical balls dated 7/28/15 was discarded.</li> <li>*Jar of green mixture dated 3/10/15, unlabeled was discarded.</li> <li>*Jar of herring eggs dated 6/25/15 was discarded.</li> <li>*One frozen bag of unlabeled</li> </ul>		

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F 371	<p>Continued From page 22</p> <p>Observation of the LTC kitchen area, on 2/8/16 at 2:00 pm, revealed:</p> <ul style="list-style-type: none"> <li>· 1 Vitamix blender with debris on the motor stand,</li> <li>· Cabinet and drawers containing crumbs and debris and 1 drawer with a dried spilled substance.</li> </ul> <p>Observations of the LTC pantry room on 2/8/16 at 2:30 pm revealed:</p> <p>Freezer A</p> <ul style="list-style-type: none"> <li>· Multiple green baggies containing green leaves, unlabeled and undated;</li> <li>· Large glass jar containing green leaves dated 6/28/14, unlabeled;</li> <li>· A large plastic jar containing a green leafy mix, unlabeled; and undated.</li> <li>· One bag of orange colored spherical balls that had resemblance of fish eggs, dated 7/28/15, unlabeled.</li> </ul> <p>Freezer B</p> <ul style="list-style-type: none"> <li>· One jar of green mixture dated 3/10, unlabeled;</li> <li>· A jar of herring eggs dated 6/25/15 (more than 6 months old);</li> <li>· 1 frozen bag of unlabeled blueberries;</li> <li>· white lard-like hardened substance in a jar, unlabeled; and</li> <li>· A coffee container filled with fish heads, unlabeled and undated.</li> </ul> <p>Other community foods, such as frozen waffles and cheese, were comingled in the same freezer.</p> <p>During the same pantry room observation, the</p>	F 371	<p>blueberries was discarded.</p> <ul style="list-style-type: none"> <li>*White, lard-like hardened substance in a jar that was unlabeled, was discarded.</li> <li>*Coffee container filled with fish heads, unlabeled and undated, was discarded.</li> <li>*Large package of opened sandwich cookies, undated, was discarded.</li> <li>*Case of spoiled butternut squash was discarded.</li> <li>*Case of spoiled melons was discarded.</li> <li>*Four individual sherbet ice cream cups with liquefied contents were discarded.</li> <li>*Staff were instructed not to use the sink by the dishwasher and salad prep area.</li> <li>*They were directed to use another Sink Located in the kitchen area.</li> </ul> <p>2. All 18 residents have the potential to be harmed by these alleged deficient practices.</p> <p>3a. Work order was put in for the splash guards to be installed on dietary sink by the dishwasher/salad prep area. Staff will continue to use an alternate sink until the splash guards have been installed.</p> <p>3b. Dietary manager/designee will in-service kitchen staff on:</p> <ul style="list-style-type: none"> <li>*Keeping bins containing dry goods clean and free of debris</li> <li>*Proper procedures for cleaning the kitchen hood</li> <li>*Proper monitoring of produce and when to discard</li> <li>*Proper procedures for monitoring frozen items stored in the freezer</li> </ul> <p>3c. QCC Director of Nursing</p>		

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F 371	<p>Continued From page 23</p> <p>pantry shelf contained:</p> <ul style="list-style-type: none"> <li>· A large package of opened sandwich cookies, undated.</li> </ul> <p>A second observation in the main kitchen on 2/10/16 at 7:15 am, revealed the walk-in cooler contained:</p> <ul style="list-style-type: none"> <li>· One case of multiple butternut squash with multiple pock marks filled with a black fuzzy substance;</li> <li>· A case of mellons covered with a fuzzy grey substance; and</li> <li>· 4 individual sherbet ice cream cups with liquified contents.</li> </ul> <p>Hand Hygiene in Main Kitchen:</p> <ul style="list-style-type: none"> <li>· During the observation Dietary Staff (DS) #1 washed both hands in the sink which resulted in dirty water splashing onto an adjacent counter top containing clean utensils and dishes, and</li> <li>· Cook #1 was observed at a different sink washing both hands. Water splashed up onto a container of biscuits that was placed nearby.</li> </ul> <p>During an interview on 2/10/16 at 3:00 pm the Dietary Manager (DM) stated dietary staff were not responsible for monitoring the freezer in the LTC pantry. The DM stated the food should be labeled and dated.</p> <p>When asked about the discolored vegetables, fruits and melted sherbert found in the main kitchen refrigerator, the DM stated the squash and melons appeared spoiled and should have been removed from the walk-in cooler. The DM stated she had noticed the melted sherbert the day before and had asked someone to remove it. The DM stated she noticed the handwashing sink</p>	F 371	<p>(DON)/designee will in-service all staff on:</p> <ul style="list-style-type: none"> <li>*Cleaning kitchen appliances immediately after use</li> <li>*Wiping up spills immediately</li> <li>*Keeping drawers closed to keep them free of debris</li> <li>*Proper way to label stored food in the freezers and cabinets</li> <li>*Freezer "A" will be designated for meats, fish and related items</li> <li>*Freezer "B" will be designated for ice cream, desserts, bread and related items</li> </ul> <p>4a. Dietary manager/designee will spot check kitchen for cleanliness and food safety</p> <p>4b. Dietary manager/designee will spot check produce in walk in cooler to monitor for food spoilage</p> <p>4c. DON/designee will spot check LTC pantry for any open dry goods not dated or labeled</p> <p>4d. DON/designee will spot check freezers to make sure food is not comingled and does not contain food items that are on the "Foods We Cannot Accept" list.</p> <p>4e. Dietary manager/designee will report any discrepancies found to the Administrator</p> <p>4f. DON/designee will report any discrepancies found to the Administrator</p> <p>4g. Administrator will discuss</p>		

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F 371	<p>Continued From page 24</p> <p>was close to the counter and had created a risk for splashing water onto clean items and food nearby.</p> <p>During a second interview 2/11/16 at 10:00 am when asked about the dirty kitchen hood and the hanging dust over the stove-top, the DM stated it needed to be cleaned.</p> <p>Review of the facility's policy on 2/11/16, "Native Food Usage," revised 9/19/14, revealed "Procedure...B. donated foods must be inspected by the QCC Activities Director...C. A log is kept to record information on all food...which is not USDA or FDA approved...D. Due to significant health hazards and potential for human illness, the following foods will NOT be accepted...Seafood...all foods must be labeled with date received, name of food, source, pull date, and log book entry number... Maximum length of storage for donated foods...6 months processed or cut up red meat; fish; birds."</p> <p>Review of the document "Donated Foods We Can Accept" revealed "Foods We Cannot Accept...seal or whale oil with or without meat..."</p> <p>Review of the facility's dietary policy revised 2/27/15, revealed "...hoods are cleaned at the end of the day...for blenders, mixers, scales and knives; 1. Equipment is rinsed and or washed with detergents after each use and allowed to air dry..."</p>	F 371	discrepancies at QCC PIC for 90 days		
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		3/27/16	

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F 428 SS=D	Continued From page 25 IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to act on a physician's order in response to the pharmacist's drug regimen review (DRR). This failure affected 1 resident (#2) out of 5 sampled residents. This failed practice placed the resident at risk for adverse side effects from antipsychotic medication use. Findings:  Record review on 2/7-11/16 revealed Resident #2 had diagnoses that included status post stroke and dementia (short and long term memory loss that affects cognitive ability) with behavior disturbances.  Review of the physician's orders revealed the Resident's medication regime included aripiprazole (Abilify) 5mg daily. Aripiprazole is an antipsychotic medication with adverse side effects that can cause extrapyramidal symptoms (EPS), such as uncontrolled body movements and Parkinson's disease type symptoms.	F 428	1. Benztropine 1mg PO BID was transcribed on the MAR, ordered from pharmacy and initiated.  2. All 18 residents have the potential to be harmed by this alleged deficient practice.  3a. Pharmacy consultants will be educated by the Director of Nursing (DON)/designee to put the original form in the physicians book for signature, the yellow copy will be placed in the DON's mailbox.  3b. Pharmacy recommendations will be discussed daily in morning start up meeting with the Administrator.  3c. MD will be notified by charge nurse of any medications/treatments that need to be started, changed, or discontinued.  4a. Audit nurse/designee will monitor all		

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F 428	<p>Continued From page 26</p> <p>Review of a "Pharmacy Consultation" dated 1/30/16, revealed "Nursing notes: an improvement in outbursts since [increase] an aripiprazole dose, but does note pt. [patient] (Resident #2) will frequently kick [with right] leg, does not seem to be directed towards any person. Concern that kicking could be an EPS due to antipsychotic use. Recommend trial of benzotropine to see if there is an improvement in symptoms: Benzotropine [medication used to treat involuntary movement from antipsychotic medications]."</p> <p>Below the pharmacy note the physician had written "Agree Benzotropine 1mg po [by mouth] BID [two times a day]." The entry was dated 2/3/16.</p> <p>Review of the medication administration record and the physician's orders revealed the order had not been initiated.</p> <p>During an interview on 2/10/16 at 10:45 am, the Pharmacist stated the completed DRRs were put in the binder for physician review. When asked about the order written on Resident #2's DRR, the Pharmacist confirmed the order hadn't been transcribed or initiated.</p>	F 428	<p>pharmacy recommendations for accuracy and timeliness of order initiations.</p> <p>4b. Audit nurse/designee will report to DON any discrepancies found.</p> <p>4c. DON/designee will report any discrepancies to the Administrator.</p> <p>4d. Administrator will discuss any discrepancies at QCC PIC for a period of 90 days.</p>		
F 431 SS=F	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all</p>	F 431		3/27/16	

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F 431	<p>Continued From page 27</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to ensure: 1) repackaged medications had an expiration date; 2) unused repackaged medications were disposed of appropriately; and, 3) development of policies and procedures for the</p>	F 431	<p>1a. When the issue of no expiration dates on the bubble packs and bottles was discovered, pharmacy was notified and the dates were written on the medications.</p> <p>1b. Unused medications were taken off</p>		

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F 431	<p>Continued From page 28</p> <p>disposal of unused and/or expired medications. These failed practices placed all residents at risk (census of 18) of receiving expired medications where the medications desired effects were compromised. Findings:</p> <p>Re-packaged medications:</p> <p>Observation on 2/9/16 at 1:30 pm of multiple residents' medications that had been repackaged into bubble packs revealed the packages did not have a medication expiration date. In addition, there were 8 repackaged bottles of medications in the medication cart without expiration dates.</p> <p>During an interview on 2/11/16 at 10:00 am, the Pharmacist was asked to identify where the expiration dates were on the repackaged medication bubble packs and bottles. The Pharmacist stated there were no expiration dates on the identified re-packaged medications.</p> <p>During an interview on 2/9/16 at 1:45 pm Licensed Nurse (LN) #1 stated unused medications are to be removed and disposed of when found. However, LN #1 stated the medication processes had changed recently and the LN was not sure how to dispose of unused bottles of medication.</p> <p>Policy:</p> <p>During an interview on 2/10/16 at 10:00 am the Pharmacist stated the facility had not developed a policy on how to dispose of the unused medications that had been repackaged.</p> <p>During an interview on 2/10/16 at 5:00 pm the</p>	F 431	<p>the cart and placed in a locked cabinet in the medication room.</p> <p>2. All 18 residents have the potential to be harmed by this alleged deficient practice.</p> <p>3a. Pharmacy will ensure that all medication bottles and bubble packs have expiration dates on them.</p> <p>3b. Director of Nursing (DON)/designee will take non-narcotic medications and deposit them in the blue Med Safe outside pharmacy.</p> <p>3c. DON/designee will reconcile narcotics with a pharmacist on a monthly basis.</p> <p>3e. Pharmacist and DON/designee will co-sign the form, which will be kept in a binder in the DON's office.</p> <p>3f. Pharmacist and DON/designee will put the drugs in the blue Med Safe outside pharmacy together.</p> <p>3g. Policy will be written by Pharmacist/DON stating the procedure of drug destruction.</p> <p>3h. DON/designee will educate all licensed nurses on the proper procedure for drug disposal of unused meds.</p> <p>4a. DON/designee will spot check bubble packs and medication bottles for expiration dates.</p> <p>4b. DON/designee will monitor medication</p>		

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F 431	Continued From page 29 Director of Nurses stated the process of repackaging medications in the bubble packs was new, and the facility had not developed a policy for the disposal of unused repackaged medications.	F 431	cart for unused medications on a weekly basis.  4c. Any discrepancies will be reported to Administrator.  4d. Administrator will discuss any discrepancies to QCC PIC for a period of 90 days.		
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 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	F 441		3/27/16	

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F 441	<p>Continued From page 30</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <ul style="list-style-type: none"> <li>· Based on observation, interview and record review the facility failed to ensure: 1) appropriate personal protective equipment was donned when handling soiled lined; 2) resident clothing was not comingled with other community linen; 3) the soiled linen sorting room had a hand hygiene sink; and 4) hand hygiene was performed when moving from a dirty to a clean task during resident cares for 1 resident #1. Failure to ensure good infection prevention practices placed all residents at risk for transmission of infectious bacteria. Findings: <p>Observations in the soiled laundry room (located on the 3rd floor) on 2/10/16 at 11:00 am, revealed:</p> <ul style="list-style-type: none"> <li>· Laundry Staff (LS)#1 scrubbing a white garment with a brush and laundry spot remover at a large sink with no personal protective facial shield for her face;</li> <li>· LS #2 was rinsing clumps of fecal matter from an absorbent pad into the toilet hopper with no personal protective shield for her face.</li> </ul> </li> </ul>	F 441	<p>1a. Personal Protective Equipment (PPE) was issued to laundry staff #1.</p> <p>1b. PPE was issued to laundry staff #2.</p> <p>1c. Clothing and linens were being washed together due to a misunderstanding by laundry staff of the load capacity of the washer. Staff education and training have been performed by the Environmental Services supervisor (EVS) immediately upon discovery. Linen and clothing now being washed separately.</p> <p>1d. Feces was immediately removed from laundry item when found.</p> <p>1e. Hand sanitizer will be used by laundry staff until sink has been installed in laundry room.</p> <p>1f. Staff education and training were performed by Director of Nursing (DON) on February 11, 2016 regarding hand hygiene during ADL and peri-care.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>QUYANNA CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 GREG KRUSCHEK AVENUE (P.O. BOX 966) NOME, AK 99762</b>		
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F 441	<p>Continued From page 31</p> <p>Further observation revealed a large grey portable laundry cart full of laundry ready to be washed. The LS Supervisor stated, the grey laundry cart was from Quayanna Care Center (QCC) and was sorted and ready for the washing machine. The clothing in the laundry cart consisted of resident clothing, table cloths, napkins, clothing protectors, and towels.</p> <p>During an interview on 2/10/16 at 11:00 am the LS Supervisor stated unless the laundry was very soiled, resident clothing was comingled with towels, napkins, tablecloths, and clothing protectors and washed as one load.</p> <p>In addition, the LS Supervisor stated often times laundry from QCC was transported to the 3rd floor laundry full of feces and the feces would fall out of the linen during sorting.</p> <p>Further observation in the soiled linen room revealed there was no hand hygiene sink present for staff use after removal of the personal protective gloves and gown and before handling clean linen.</p> <p>During an interview on 2/10/16 at 11:30 am the Environmental Services Manager stated gloves, gowns, and face shields should be worn when staffs are cleaning and or sorting dirty laundry.</p> <p>Record review from 2/8-11/16 of the Linen and Laundry policy, "Gowning/Un-gowning Procedures" dated 4/14/15, revealed "Gowning up: .... Place mask on so it completed covers the nose and mouth and fits securely."</p> <p>Record review on 2/8-11/16 revealed Resident #4</p>	F 441	<p>2. All 18 residents have the potential to be harmed by this alleged deficient practice.</p> <p>3a. EVS manager/designee will in-service staff on policy regarding wearing PPE.</p> <p>3b. Infection Control nurse will in-service QCC and laundry staff regarding hand hygiene and glove use.</p> <p>3c. EVS manager/designee will in-service laundry staff to notify DON/designee of any feces found in laundry.</p> <p>3d. QCC staff will be issued barrels with plastic liner insert with staff name on each bag used to identify origin of any fecal matter found in laundry.</p> <p>3e. In-service will be performed with QCC staff by DON/designee regarding new procedure regarding handling of soiled linens and clothing.</p> <p>4a. EVS manager/designee will spot check laundry staff regarding wearing of PPEs</p> <p>4b. Any discrepancies noted will be reported to DON/designee.</p> <p>4c. Charge nurse will spot check staff on proper hand hygiene and glove use.</p> <p>4d. Charge nurse will report any discrepancies to DON/designee.</p>		

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F 441	Continued From page 32 had a diagnosis that included dementia (cognitive short and long-term memory loss). The Resident required maximum assistance with all personal care.  During an observation on 2/11/16 at 8:20 am, Certified Nursing Assistants (CNA) #s 1 & 2 began to assist Resident #4 with morning care. After the CNAs donned gloves, CNA #1 removed the bed covers and discovered the Resident's disposable brief was soiled. The CNA assisted the Resident with turning to the right side. Then, CNA #1 used his right gloved hand to clean the Residents buttocks with several disposable wipes.  After removing the soiled brief the CNA removed the soiled gloves and asked CNA #2 for a clean pair. CNA #2 pulled out a clean pair from her scrub pocket and handed them to CNA #1 who donned the gloves without first performing hand hygiene. After placing a new brief under the Resident's buttocks, CNA #2 washed the Resident's groin using disposable wipes. CNA #2 then removed the soiled gloves, grabbed a clean pair from her pocket and donned them without first performing hand hygiene. Both CNAs assisted the Resident with putting on pants, positioning the sling, and getting up into the wheelchair with a lift. CNA #1, while wearing the same gloved hands, assisted the Resident with washing her face, combing her hair, and changing her shirt.	F 441	4e. DON/designee will report any discrepancies to Administrator.  4f. Administrator will report any discrepancies found at QCC PIC for a period of 90 days.		
F 514	483.75(l)(1) RES	F 514		3/27/16	

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F 514 SS=D	<p>Continued From page 33</p> <p><b>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</b></p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>. Based on record review and interview the facility failed to ensure an order was transcribed correctly on the medication administration record (MAR) and failed to ensure a page of the MAR was dated for 1 resident (#1) out of 5 sampled residents. This failed practice created a risk for medication errors and resulted in an incomplete medical record. Findings:</p> <p>Record review on 2/8-11/16 revealed 86 year-old Resident #1 had a diagnosis that included dementia with behaviors.</p> <p>Review of the physician's orders, dated 12/10/15, revealed an order for "Risperidone Consta 25 mg/2 ml intramuscular syringe INTRAMUSCULAR ...Take SYRINGE</p>	F 514	<p>1a. Resident #1's Risperdone Consta injection order was changed to reflect the current order of Risperdal Consta 25mg/2ml intramuscular every two weeks.</p> <p>1b. Nurse's initials and date were added to the Risperdone Consta injection order on the "Treatment Record".</p> <p>2. All 18 residents have the potential to be harmed by this alleged deficient practice.</p> <p>3a. Director of Nursing (DON)/designee will in-service all licensed nurses on the proper procedures for transcribing an order, to include initials and the date order was transcribed.</p> <p>3b. DON/designee will in-service Audit nurse and MDS nurse on making sure all</p>		

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F 514	Continued From page 34 INTRAMUSCULAR EVERY TWO WEEKS..."  Risperdal Consta is an antipsychotic medication. Risperdal Consta carries an Food and Drug Administration (FDA) black box warning and has been known to increase the risk of death in older patients with dementia like illnesses, uncontrolled muscle movements, and very stiff muscles.  Review of the February 2016 MAR, used by the nurses to administer medications, revealed the order "Risperdal Consta 25mg/ 2ml intramuscular 2 times a week", different from the physician's order of every 2 weeks.  During an interview on 2/9/16 at 10:55 am, Licensed Nurse (LN) #1 stated Resident #1 was supposed to receive the Risperdone Consta injection every 2 weeks. The LN stated the nurse checking the MAR had to manually enter the orders.  Further review of the medical record revealed an undated page titled "Treatment Record" listing the medications "Vit [vitamin] B 12 IM [intramuscular] every 30 days; Risperdal 25 g IM every 2 weeks; Bisacodyl suppository rectally as needed [used for the treatment of constipation]; and "if eating [less] than 50 % of meal Ensure (1 can)." The treatment record/MAR did not have the dates the medications were given. The rewritten orders were not initialed or dated by the nurse that had transcribed them.	F 514	MAR's, TAR's and Treatment Sheets have the month noted on each sheet.  4a. Random licensed nurses will spot check MAR's and TAR's and Treatment Sheets to ensure all orders have been transcribed correctly as well as ensuring the date is marked on each sheet.  4b. Random licensed nurses will report any discrepancies found to the DON/designee.  4c. DON/designee will report any discrepancies to the Administrator.  4d. Administrator will discuss any discrepancies found at QCC PIC for a period of 90 days.		

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

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F 514	Continued From page 35 During an interview on 2/10/16 at 10:45 am the Pharmacist stated the MAR should have a date and confirmed the nurse rewriting the medications should also initial and date when the medication is rewritten on a new record.	F 514		