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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 66 and/or the medication errors, he stated, "No, I didn't notify the physician."	W 368		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1220j) 350.1230b)6)7) 350.1230d)1)2)3) 350.1230e) 350.1430d) 350.1430e) 350.3220f) 350.3240a) 350.3750 Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's	W9999		

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W9999	Continued From page 67 condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illnesss e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.1430 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation and a	W9999		

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notation made in the resident's record.

e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.

Section 350.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

Section 350.3750 Consultation Services and Nursing Services

Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month.

These Regulations were not met as evidenced

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Based on observation, interview and record review, the facility failed to ensure that individuals are receiving health care monitoring and services as based on their individual needs as evidenced by their failure to ensure that:

A) An aggressive program for diabetes control is implemented for 3 individuals (R2, R8 and R11) whose blood sugar readings are taken prior to each meal and at bedtime by failing to ensure that:
- Blood sugar readings are documented prior to each meal and at bedtime (R2, R8 and R11) as ordered by the physician;
- Direct care staff implement the individual's nursing protocol for contacting the RN (Registered Nurse) Consultant if the individual's blood sugar reading is below 60 and over 250 when taken and rechecked;
- The physician is notified if the individual's blood sugar reading is below 60 and above 400 as per the physician's order sheets (R2, R8 and R11);
- Sufficient nursing staff are available to administer insulin injections on an as needed basis for R8 who received her insulin injections on a sliding scale basis as based on her blood sugar readings prior to her discharge on 05/31/12; and
- Direct Care staff monitor individuals for dietary compliance during meals (R11).

B) A post discharge plan of care is developed and implemented for 1 individual (R11) readmitted back to the facility on 07/02/12 after having hip surgery resulting from an injury of unknown origin

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W9999	Continued From page 70 by failing to: - Inform staff of the hospital's discharge instructions for post operative care; - Ensure that staff received training prior to R11's readmission back to the facility and/or ongoing training after admission to meet her physical therapy needs at the facility; - Complete an admission and pain assessment at the time of admission back to the facility; - Develop and implement a plan of care for post operative care inclusive of a plan for pain control management; and - Ensure that nursing staff are available to administer as needed pain medication as ordered by the physician. C) An aggressive skin integrity plan is implemented for decubitus prevention for 3 individuals (R8, R10 and R12) utilizing a wheelchair for mobility assistance and/or postural support by failing to: - Complete weekly skin assessments as per the individual's nursing plan of care (R8, R10 and R12); - Ensure that individual's utilizing wheelchairs spend the majority of time out of bed (R10); and - Document and maintain a daily food log to monitor and assess R10's nutritional and fluid needs and provide nutritive supplements as identified per her skin integrity plan. D) Implement an aggressive fall prevention plan for 1 individual (R10) who has had three documented incidents of falls in the past 90 days by failing to ensure that: - Direct staff are providing stand by assistance as identified per R10's plan of care;	W9999		

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W9999	Continued From page 71 - Direct staff and nursing are completing neurological checks for forty eight hours after falls; and - Fall risk assessments are updated and revised to reflect current falls. E) Implement the individual's medical plan for weight monitoring and maintaining continuous 02 (oxygen) for 1 individual (R1) of the facility with a diagnosis of COPD (Chronic Obstructive Pulmonary Disease) by failing to: 1) Document daily weights and ensure that these weights are monitored and that significant weight gains and/or losses within 1 -3 days are reported to the physician; and 2) Provide necessary monitoring and supervision to ensure that continuous oxygen per nasal cannula is worn continuously as ordered by the physician. F) Medications are administered as ordered by the physician when they failed to ensure that: 1) Medication error reports are completed and that these errors are immediately reported as per the facility's policy and procedures for 11 individuals (R1, R2, R3, R5, R5, R8, R9, R10 - R13) living at the facility within the past three months (04/01 - 06/30/12); 2) Nursing staff is available to administer insulin injections for 1 individual. (R8 who was discharged on 05/31/12) receiving insulin on a sliding scale basis; and 3) Medications are given on time and within the two hour medication window for 9 individuals of the facility (R1, R2, R3, R5, R9, R10, R11, R12 and R13) who did not receive their 7:00 A.M.	W9999		

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medications between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician on 06/17/12.

G) Individuals receive their annual TB (Tuberculosis) vaccine as ordered by the physician for Tuberculosis prevention and control of for 4 individuals. (R1, R8, R11 and R12).

Findings include:

A) Based on record review and interview the facility failed to ensure that an aggressive program for diabetes control is implemented for R2, R8 and R11.

1) The Physician's Orders dated 06/01/2012 states that R11 has a diagnosis of Diabetes and receives Metformin two 500 milligrams tablets in the morning and at bedtime and Lantus Inj (injection) Solostar 15 Units every evening. R11 has diet orders for an 1800 calorie Low Cholesterol, Low fat diet.

The menu for 05/31/12 identifies that for an 1800 calorie diet, R11 is to receive 3 ounces of steak with 1 ounce gravy, a half a cup of mashed potatoes, a half a cup of brussels sprouts, 1 square (2x2) brownie, 1 slice of bread, 1 cup of skim milk and a beverage with artificial sweetener as desired. R11 is not to receive margarine with the meal.
On 05/31/12 at 5:05 P.M., R11 left the dining room and went into the kitchen at the facility. She returned to the dining room table with a large tub of margarine. R11 removed the lid off of the margarine tub and scooped a mounded, heaping

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teaspoonful of butter onto her mashed potatoes. She then spread the remainder of the margarine left on the teaspoon onto her bread. Staff (E11/Direct Care Staff and E4/LPN) were present in the dining room at this time and did not intervene and/or redirect R11 until brought to their attention by the surveyor. Neither of these two staff removed R11's mashed potatoes and/or the buttered bread from R11's plate. When E11 was asked if R11 is to receive margarine with her meal, she stated, "No."

In the section of the Physician's Orders (dated 06/01/12) entitled Patient Notes, it states that R11 is to have her glucose monitored as needed with Ascensia contour strips QID (four times daily) and (at) HS (bedtime) and that Lantus is to be held if her HS Glucose is below 100. Under the section entitled Routine Orders, it is noted that the physician is to be notified if R11's blood sugar is 60 or below or 400 or above.

Review of April's Blood Sugar (BS) Monitoring sheet identifies that R11 had BS readings below 60 on the following dates, 04/01 BS of 60, 04/06 BS of 53 at 4:00 P.M., 04/07 BS of 13 before breakfast, 04/08 BS of 55 before breakfast, 04/14 BS of 45 before breakfast, 04/18 BS of 44 before breakfast, 04/21 BS of 55 before breakfast, 04/22 BS of 51 before breakfast, 04/23 BS of 55 before breakfast and on 04/24 BS of 48 before breakfast. There is no documentation that the physician was notified of R11' s BS readings of 60 or below.

R11's Quarterly Nursing assessment dated 04/21/12 does not identify any type of fluctuations in her blood sugar readings. It is also noted that this assessment was completed by E4 (LPN) and has not been countersigned by the RN Consultant/E5.

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The Blood Sugar Monitoring sheet for May 2012 identifies that R11's blood sugar readings were at or above 400 on the following dates: 05/02 BS of 467 at HS, 05/11 BS of 427 at 4:00 P.M. and BS of 488 at HS, 05/20 BS of 406 at HS, 05/23 BS of 483 at HS, 05/24 BS of 482 at HS, 5/29 BS of 406 at HS (rechecked at 9:30 P.M. 166) and on 05/30 BS of 410 at HS (rechecked 277). There is no documentation that the physician was notified regarding R11's Blood sugar being at 400 or above for the above mentioned dates.

On 06/04/12, an attempt was made to interview E15 (facility's Medical Director) by telephone at 10:56 A.M. Z1 (E15's Nurse) returned the call at 1:00 P.M. and stated, "In reviewing our records, the last time the facility called about R11's blood sugar reading was on 04/24/12. E13 (Direct Care staff) called and said that R11 was disoriented and that her blood sugar was 40. The doctor (E15) decreased the Lantus from 10 Units to 5 Units at bed time." The surveyor then reviewed R11's blood sugar readings for the dates in April and May 2012 that her blood sugar was at 60 or below and/or at 400 or above. Z1 stated that the facility had not called and informed the doctor of R11's blood sugar readings for any dates in April and/or May with the exception of 04/24/12.

R11's Blood Sugar monitoring sheet for June 2012 identifies that her blood sugar readings were elevated 06/07 (BS of 426) and on 06/08/12 (BS of 400). There is no documentation within the Hab Notes and/or Nurses Notes that the physician has been notified of R11's elevated blood sugar.

The Hab. (Habilitation) Notes for R11 dated

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06/17/12 at 7:30 P.M. states, "E5 (Physician) called ... to report B.S. of 407. Pt. (patient) given Metformin 100 mg + 5U (units) Lantus insulin given SQ (subcutaneous) L (left) arm. To observe pt. and check B.S. q 30 min (minutes). Noted (This entry was signed by E4/LPN)."

In reviewing the Blood Sugar monitoring sheet for June 2012 the following entries are noted for 06/17/12: before breakfast 100, before lunch 184, before the 5:00 P.M. meal 191, at bedtime 407. No further entries are noted after bedtime as ordered by the physician for monitoring R11's blood sugar every thirty minutes.

A Day Training Consumer Concern report dated 06/21/12 states, "Her (R11) blood sugar at 11:40 was 501. I (E5/RN) checked it again right away and it was 432. At 12:40 P.M. it was 501. She is asymptomatic but staff informed to monitor her for any drowsiness or problems walking and don't give her anything except ice water. At 1:25 P.M. her blood sugar was down to 244. I informed staff that she still can't have any lunch b/c (because) her blood sugar was too high." There is no documentation within the Hab Notes and/or Nurses Notes that the physician has been notified of R11's elevated blood sugar reading of 501.

In addition to R11's Physician Orders for notification of blood sugar levels, she also has a nursing protocol with a signature date of 11/09/2010 which states:

"1) If her blood sugar is below 60 check it again. If it is still below 60 contact the RN Consultant. *Give her orange juice for reading less than 60. 2) If her blood sugar is over 250 check it again If

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it is still over 250 contact the RN Consultant. Hold Lantus if blood sugar is less than 100. If you have any ?'s (questions) please contact RN Consultant."

In review of R11's May, 2012 Blood Sugar monitoring sheet it is noted that she had blood sugar readings below 100 on 05/04, 05/07, 05/09, 05/18, 05/19, 05/20 and 05/21/12. There is no documentation located on this sheet or in the Hab. Notes or RN Consultant Notes that her blood sugar was rechecked, that R11 was given orange juice and/or that the RN Consultant was contacted as per her nursing protocol. Further review of the Blood Sugar monitoring sheet identifies that R11's blood sugar levels were above 250 on 05/02, 05/03, 05/04, 05/05, 05/07, 05/08, 05/09, 05/10, 05/11, 05/12, 05/14, 05/15, 05/16, 05/17, 05/18, 05/19, 05/20, 05/21, 05/22, 05/23 and 05/24/12. There is no documentation on this sheet to indicate that staff rechecked R11's blood sugar per her nursing protocol. It is documented that staff called the RN Consultant on 05/13 prior to bedtime (BS 300) and on 05/24/12 prior to to dinner meal (BS 389). Further review of this monitoring sheet, the Hab. Notes and R11's RN Consultant Notes does not identify that the RN Consultant was notified twenty eight of the thirty times during the month that R11's blood sugar level was over 250.

E1 (Assistant Administrator) was interviewed on 06/07/12 at 11:15 A.M. and stated, "We are (indicating herself and E10/QMRP who was present at the table during this interview) responsible to make sure that staff and nursing staff are doing what they are supposed to do." When E1 was asked who is responsible to notify

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the physician when R11's blood sugar is 60 below or 400 or above, she stated, "The LPN or the RN are to call the doctor. If the nurse is not present, staff are to call the nurse and the nurse will call the doctor. If the nurse does not take their call they are to call the doctor themselves." When E1 and E10 were asked who is responsible for monitoring the Blood Sugar Monitoring sheets to ensure physician notification, she stated, "E4 (LPN), E5 (RN Consultant) and E10 (QMRP) are to monitor these sheets and make sure the doctor is called." During this interview, R11 blood sugar protocol with a signature date of 11/09/10 was reviewed with E1 and E10. E1 and E10 both confirmed that this was the protocol current used by staff of the facility. When E1 and E10 were asked who is responsible for contacting the RN Consultant regarding R11's nursing protocol, she (E1) stated, "E4 (LPN) does the blood sugar levels and is to call the RN Consultant if they are too low or too high." When asked where E4 would document this information, E1 stated, "That should be in the Nurse's Notes."

The Hab. Notes and R11's RN Consultant Notes for April and May were reviewed for documentation of nursing notification. There is no documentation with the exception of 05/13 and 05/23/12 identifying that the RN Consultant was notified regarding R11's elevated blood sugar levels, 250 or higher.

2) In review of the Blood Sugar monitoring sheets for April and May, 2012, it is noted that R8 has a goal to maintain her blood sugar within normal limits. Approaches within this plan states:

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W9999	Continued From page 78 1) Assist client with following her diet (LCS - Low Concentrated Sweet diet - 1500 calorie ADA (American Diabetic Associated diet, skim milk, diet dessert - may do Mayo Clinic diet) 2) Obtain blood sugar before meals and @ (at) HS, (notifications to the nurse will be made according to the sliding scale insulin) 3) Follow sliding scale insulin order for administration of insulin (RN Consultant) The Physician's Orders dated 05/01/12 states that R8 has orders for, "Novalin R Inj (injection) - U (units) -100 per sliding scale: 201 - 250 3U, 251 - 300 6U, 301-350 9U, 351 - 400 12U, 400 - Notify physician." In review of Blood Sugar monitoring sheet for April 2012 and the MARS for April it is noted that R8 did not receive her Novalin Injection per sliding scale as physician ordered on 04/01, 04/16, 04/25, 04/28 and on 04/29. The following documentation was noted: 04/01 Prior to bedtime, R8's BS was 214 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 3 Units of Novalin as ordered by the physician; 04/16 Prior to the evening meal (dinner), R8's blood sugar was 287 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 6 Units of Novalin as ordered by the physician; 04/25 Prior to bedtime, R8's BS was 224 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she	W9999		

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received 3 Units of Novalin as ordered by the physician;
04/28 (Saturday) Prior to lunch, R8's BS was 201 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 3 Units of Novalin as ordered by the physician; and
04/29 (Sunday) Prior to lunch, R8's BS was 201 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 3 Units of Novalin as ordered by the physician.

No medication error reports were provided by the facility for the above mentioned dates for R8 for April 2012. There is no documentation noted within the Hab Notes and/or RN Notes identifying that the physician was notified that R8 did not receive her Novalin on 04/01, 04/16, 04/25, 04/28, nor 04/29/12.

R8's Quarterly Nursing Assessment dated 04/25/12 does not identify any issues regarding her not receiving her Novalin medication and the lack of medication error reports for April 2012. Additionally, this assessment does not identify that nursing staff implemented a system for monitoring for adverse effects of her not receiving her Novalin on 04/01, 04/16, 04/25, 04/28 and on 04/29.

In reviewing the Blood Sugar monitor sheet for May 2012 and as based on review of the MARS for May, 2012, R8 did not receive her Novalin Injection per sliding scale, as ordered by the physician during the weekend of 05/05 and 05/06/12. It is also noted that R8 was administered 6 Units of Novalin for a blood sugar

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reading of 242 on 05/19/12. R8's Physician Orders dated 05/01/2012 states that she is to receive 3 Units of Novalin for a blood sugar reading of 242, rather than 6 Units.

No medication error reports were provided by the facility for the above mentioned dates for R8 for May 2012. There is no documentation within R8's Hab Notes and/or RN Notes stating that the physician was notified that she did not receive her Novalin on 05/05 nor 05/06. These notes do not reflect that nursing staff implemented a system for monitoring R8 for adverse effects of her not receiving her Novalin on 05/05 and/or 05/06/12.

3) The Physician's Orders dated 05/01/12 states that R1 is a 58 year old male who functions at a moderate level of mental retardation and has diagnoses inclusive of Diabetes.

R1's (undated) plan to address his Diabetes for maintaining his blood sugar within normal limits identifies that staff are to obtain a blood sugar reading before meals and at bedtime. No parameters for RN and/or physician notification are stated on this plan. Review of R1's Physician's Orders dated 06/01/12 states, "Contact MD (medical director) if sugar is less than 60 or greater than 400."

In reviewing the Blood Sugar monitoring sheets for the months of April, May and June 2012 it is noted that R1's blood sugar readings were below 60 on 04/12 before dinner (BS 50), 05/17 before bedtime (BS 59), 05/28 before lunch (BS 50) and on 06/02/12 before bedtime (BS 57). There is no documentation that the physician was notified regarding R1's blood sugar reading of less than

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W9999	Continued From page 81 60. Review of the RN Consultant notes from April 2012 - June 2012 identifies that the RN and/or LPN have not documented that the physician has been notified of R1's blood sugar readings of less than 60. Also while reviewing the Blood Sugar monitoring sheet for May 2012 the surveyor noted that on 05/22/12 prior to breakfast, staff documented, "No strips for testing." During the interview with E1 (Assistant Administrator) on 06/07/12 at 11:15 A.M., she stated, "E4 (LPN), E5 (RN Consultant) and E10 (QMRP) are to monitor these sheets and make sure the doctor is called," when asked who is responsible for monitoring the Blood Sugar Monitoring sheets to ensure physician notification. B) Based on interview and record review the facility has failed to ensure that a post discharge plan of care is developed and implemented for R11 who was readmitted back to the facility on 07/02/12 after having hip surgery. The Accident/Incident report identifies that on 06/24/12, R11 was in her room and was heard, "yelling." Staff (E4/LPN and E2 and E3 - Direct Care staff members) then went to check on her and found her on the floor holding her left hip. This report then states that E4 (LPN) told us (E2 and E3) to send her out. This report does not identify that E4 checked R11's range of motion and/or that her hips were checked for outward rotation and shortening.	W9999		

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E4 was interviewed on 07/05/12 at 2:50 P.M. and stated, "I checked R11's blood sugar after it happened and completed an assessment." When E4 was asked where his assessment of R11 for 06/24/12 was located, he stated, "In her chart." E4 left the area and returned with R11's chart and handed the surveyor R11's Hab Notes dated 06/24/12. These notes state, "Resident (R11) yelling in room. Sitting on floor in front of dresser. Holding L (left) hip and guarding L hip when she tried to position herself for comfort. 149/76 64 - 18 L arm. Blood sugar 167 and diaphoretic (sweating heavily). Further assessment by CMT (Certified Medical Technicians). Out per stretcher with 2 CMT's... Transfer to ...ER (Emergency Room) for further evaluation." When E4 was asked where he documented checking R11's range of motion and/or checked her hips for external rotation and/or shortening, E4 stated, "I didn't do an assessment. I just knew something was wrong and sent her out."

An (undated) hospital History and Physical report (showing an admission date of 06/24/12) states, "This is a mentally challenged lady who is a resident of a skilled nursing facility... fell in the nursing home and it was a mechanical fall. She tripped. It is unclear at this point how exactly she fell as the patient herself is not a good historian because of her being mentally challenged. She also has deafness. From the documentation, it was a mechanical fall and she tripped from a standing position. After that she started complaining of severe left hip pain and on physical examination as well. She was found to holding left hip in hands and her left leg was also

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shortened and externally rotated. She was admitted for left hip fracture..." This report states, "Left hip acute fracture after a fall. Orthopedic consultation has been called at this point. The patient requires surgery."

R11's Discharge Instructions dated 07/02/12 states,

*Diet: 1800 Calorie ADA
*Activity: per PT (physical therapy) Partial weight bearing left lower extremity
*Weight Monitoring: Weigh yourself daily and keep track of weight 2) If you notice a weight gain of more than 2 pounds in 1 to 3 days or 5 pounds in a week, please contact your physician and follow his/her instructions.
*Discharge Pain Management: Take your pain medicine if prescribed. Take it before the pain becomes severe enough to interfere with your activities. Call your physician if your pain is not controlled.
*Signs and symptoms to report: Increased swelling of your legs, Unusual increase in shortness of breath, Redness or drainage at incision, uncontrolled pain, fevers above 101, shortness of breath or any other concerns, notify physician or go to ER (emergency room)
*Additional Instructions: Partial weight bearing to left lower extremity - avoid hip flexion greater than 75 degrees/hip adduction/internal rotation.
*Case Management: ... V*A T*P (name of agency) -home health..."

The undated Patient Transfer Form for R11 sent with her at the time of discharge from the hospital on 07/02/12 states, "Physician Orders on Transfer: PT/OT (physical therapy/occupational

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W9999	Continued From page 84 therapy at facility)..." R11's Universal Notes dated 07/02/12 (1700) states, "R11 discharged from hospital, assessment done and The Medical Care Plan with a signature date of 11/19/10 states that R10 is at an increased risk for skin breakdown due to Anemia, poor nutrition, edema, Osteoporosis and Cerebellum degeneration. R10's goal states that she, "will not have (a) decline in skin integrity" by using the following approaches: "1) Make sure res. (resident) is toileted frequently 2) After any incontinency incident - provide peri care 3) Assess skin daily per direct care staff 4) Res. skin is assessed at least 1 time a week by the RN (Registered Nurse) Consultant 5) Report any signs of skin breakdown to nurse/management immediately 6) Reposition resident every two hours or as needed 7) Assess need for therapy intervention..." In reviewing R11's record, no admission assessment was located as indicated by her Universal Notes dated 07/02/12. No pain assessment for R11 was located, nor was a current physical therapy assessment located. Further review of R11's record does not identify that a plan of care has been developed to address R11's current partial weight bearing status, nor the physician's orders given at the time of her discharge from the hospital on 07/02/12. E1 (Assistant Administrator) was interviewed on 07/03/12 at 4:45 P.M. and stated, "I talked with E5 (Registered Nurse/RN) who came in to do R11's admission assessment. He said he did the assessment but did not write it down."	W9999		

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R11 was observed at the facility on 07/03/12 from 3:00 P.M. laying on her back in her bed. E13 (Direct Care staff) was present with the surveyor during this observation and stated that R11 had returned back to the facility on 07/02/12 from the hospital. When asked if R11 could sit up higher in the bed, E13 stated, "She can't sit up higher than 70 degrees in the bed." When E13 was asked how frequently R11 was getting up, she stated, "She's not. She's been in bed since she returned from the hospital. She is refusing to reposition on her right side (non operative) and has been laying flat on her back." When E13 was asked what type of therapy and exercise staff were doing with R11, she stated, "None. The visiting nurse has not secured consent from the guardian for services." The surveyor then specifically asked E13 what type of physical therapy exercises were direct care staff at the facility doing with R11 and she stated, "None, they didn't send any orders home with her from the hospital and physical therapy (through visiting nurses) has not been in yet to assess her." E13 went on to say that nursing had not developed a plan of care for R11."

Per continued observation, at 4:40 P.M., R11's skin integrity was assessed by the surveyor with E7 and E13 (Direct Care staff) present in the bedroom. R11 was excoriated, having a bright red, raised rash located between the inner crease of her right and left thighs, coursing down her leg approximately 5-6 inches mid thigh. R11's surgical site was bandaged. R11 wore bilateral support hose on her legs which had rolled down under her knee caps and appeared to be too tight. Prior to E13 adjusting R11's support hose

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above her knees, the support hose were noted to have made deep indentations in both of her legs directly below her knees. During this observation, E7 and E13 were asked how they were monitoring R11 for increased swelling of her legs after her surgery and E13 stated, "I don't know, but I know she gets medication to prevent clotting."

In reviewing R11's record, no plan of care was located addressing R11's current partial weight bearing status, or addressing the physician's orders given at the time of her discharge from the hospital on 07/02/12. No daily weight record is noted. No documentation was found identifying that the facility staff are monitoring R11 for skin break down, increased swelling of her legs, fevers and/or shortness of breath.

The hospital Discharge papers (dated 07/02/12) state that R11 has orders for Hydroco/APAP tab (tablet) 5-325 ng (milligrams) for pain to be taken every four hours as needed. On 07/03/12 at 4:45 P.M., E1(Assistant Administrator) was asked E4's (LPN's) hours of work and she stated, "He's been working from 6:00 AM to 8:00 AM and then 3:00 P.M. to 9:00 P.M. at nights." When E1 was asked who is administering R11's pain medication (every four hours as needed) during the night time hours when nursing staff is not on duty (since direct care staff are not certified to pass medications), she stated, "I guess they (direct care staff) would have to call one of the nurses to come in." On 07/05/12 at 1:15 P.M. E1 stated, "They (did not specify who) said that we are to give R11 her pain medication every four hours so that it will stay in her system and reduce her pain." Further review of R11's record does not

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identify that nursing has completed a Pain Assessment at the time of her readmission back to the facility on 07/02/12.

R11's Medication Administration Record (MAR) dated July 2012, identifies that R11 has only received a pain pill during the day time hours when a nurse was present in the facility. Documentation on this MAR identifies that she received Hydroco/APAP tab (tablet) 5-325 mg on 07/02 at 7:30 P.M., on 07/03 at 6:00 A.M., 4:00 P.M. and at 8:00 P.M., on 07/04 at 7:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M. There is no documentation showing that staff notified nursing of R11's need for a pain pill, nor that R11 had ever received a pain pill during the ten hours from 8:00 P.M. to 6:00 A.M. when a nurse is not on duty.

On 07/05/12, R11 was observed sitting in a wheelchair in the dining room area at 10:55 A.M. R11 was noted to have what appeared to be a fever blister, scabbed over on the top left side of her upper lip. It also appeared that two new fever blisters were starting on her right upper and lower lip area. When the surveyor asked if R11 had been running a temperature, E1 (Assistant Administrator) stated that she didn't think so but would put something on R11's lip.

The Discharge Instructions dated 07/02/12 states that R11 is to be monitored for, "fevers above 101."

In continuing observation of R11 on 07/05/12, R11 remained in a wheelchair until she was assisted onto the couch at 1:00 P.M. by E3 and E7 (Direct Care staff). Prior to being transferred

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to the couch, R11 was not toileted after sitting in the wheelchair for two hours. E3 was present in the dining room at 12:50 P.M. and stated, "I'm not sure" when asked by the surveyor how direct care staff are toileting R11. E3 stated, "She (R11) is just peeing on herself pretty much, I'm not sure when PT (physical therapy) is coming in." When E3 was asked if the facility had a built up toilet for R11, she stated, "No." When E3 was asked if she had received training from nursing staff on transferring R11 to and from a wheelchair to the toilet or from the wheelchair to the couch, she stated, "No."

During the Daily Status Meeting on 07/06/12 at 4:45 P.M. with E1(Assistant Administrator) R11's post discharge plan of care was reviewed with E1 (Assistant Administrator). When E1 was asked if a plan of care had been developed and implement to address R11 post operative needs, she stated, "No." When E1 was asked if staff have been trained on how to properly assist R10 in transferring, she stated, "No." When E1 was asked if R11 was receiving structured physical therapy and exercises since her readmission back to the facility, E1 stated, "Well PT came in on 07/04/12 and stated that she did ROM (range of motion) and that R11 was not cooperative. They will not be back until next week sometimes." When E1 was asked if R11 had been administered a pain pill prior to physical therapy, E1 stated, "I'm not sure." When E1 was asked who is to administer R11's as needed pain medication since direct care staff are not medication trained and the nurse is not on duty twenty four hours a day, E1 stated, "I guess staff could call one of the nurses to come in if she needed one." When E1 was asked if R11 was

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continent prior to fracturing her hip, she stated, "Yes." The surveyor then informed E1 that R11 is now excoriated between her legs since returning form the hospital, staff are allowing her to be incontinent on herself in the bed and when up, E1 stated, "Well we just got a walker and a bedside commode for her today (07/06/12)." When E1 was asked if staff have been trained to toilet R11 and assist her with her ambulation with a walker, she stated, "No."

C) Based on observation, interview and record review the facility failed to ensure that an aggressive skin integrity plan is implemented for decubitus prevention for R8, R10 and R12.

1) The Braden Scale for Predicting Pressure Sore Risk dated 10/01/11 identifies that R10 has a total score of 17. This score indicates that R10 (total score of 18 or less) is at an increased risk for developing pressure ulcers Further review of this report does not identify that nursing staff has reviewed and/or updated this report on a quarterly basis since 10/01/11.

On 05/31/12 from 4:00 P.M. - 7:00 P.M. R10 remained in bed during this three hour observation block. She was not repositioned out of the bed to another alternative device as per her medical plan of care to assist in maintaining skin integrity.

R10 was observed propelling her wheelchair slowly through the dining room of the facility on 06/01/12 at 3:00 P.M. after returning home from Day Training. R10 stopped and talked with the surveyor and stated that she had a good day.

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During this conversation, the surveyor noted that R10's hair was oily and there was a strong urine/body odor emanating from R10. E2 (QMRP) was present in the dining room at this time and was asked by the surveyor to smell R10. E2 stated that she (R10), "smelled stale" and that she smelled like she had not been bathed for several days. E2 informed R10 that she needed to take a bath.

At 3:10 P.M., R10 was observed in the bathroom with E7 (Direct Care Staff) preparing for her shower. E3 (Direct Care Staff) assisted E7 in transferring R10 from the toilet to the shower chair. Staff stood R10 up off of the toilet and the surveyor observed a reddened area measuring about 3 cm. (centimeters) by 4 cm. in the right inner buttock near the coccyx (tailbone).

On 06/06/12, no documentation was noted within R10's Hab. Notes and/or RN Consultant notes identifying that nursing assessed the reddened area observed by the surveyor on 06/01/12. Further record review identifies that R10 has not been recently assessed by physical therapy (PT) on an annual basis.

Review of the Skin Assessments reports dated 03/08/12, 04/04/12 and 05/01/12 identifies that the RN Consultant has not assessed R10's skin on a weekly basis as per her care plan, but rather on a monthly basis. These reports also reflect that E4 (current LPN/Licensed Practical Nurse) completed these Skin Assessment reports, rather than the RN Consultant (E4).

On 06/01/12 at 2:15 P.M., E4/LPN handed the surveyor copies of weekly Skin assessments for

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R10, R8 and R12 dated back to February 2012. When asked by the surveyor if the facility had just located these assessments, E4 stated, "No, I just did them."

Per record review prior to 06/01/12, R12 had skin assessments dated 05/02/12, 04/10/12, 03/13/12 and 02/21/12. Her Medical Care Plan with a signature date of 02/26/11 states that she has problems with skin break down in the buttocks area. Approaches within this plan identifies that the, "RN Consultant is to complete weekly skin assessment and contact the Physician for recommendations/orders."

E4 (LPN) was interviewed at this time and stated, "I was not aware that Skin Assessments were to be done weekly." E4 also stated that he has been doing all of the nursing assessments and that the RN Consultant (E5) is to review and countersign. During this interview, E4 stated that he had not been completing weekly Skin Assessments for R10, nor R8 and R12.

On 05/31/12 from 4:00 P.M. - 7:00 P.M. R10 remained in bed during this three hour observation block. During the 5:00 P.M. meal on this date, R10 was not observed to eat in the dining room with the other individuals. At 6:15 P.M., E4 (LPN) stated that R10 was grumpy, so she had been put to bed. When E4 was asked if R10 had been up at any time since the surveyor entered the facility at 4:00 P.M., E4 stated, "No." When E4 was asked if R10 had eaten her evening meal, he stated, "Yes, she ate hundred percent of everything." When E4 was asked where R10 had eaten her meal, E4 did not promptly answer. E4 (who had cooked that

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evening) stated, "In bed. R10 is now refusing to eat in the dining room so we feed her in bed."

The Physician's Orders dated 06/01/12 states that R10 is to receive a Protein Supplement twice a day, may have finger foods at lunch and supper, at breakfast may have other nutritional substances, Regular diet, no restrictions.
.
R10's Medical Care Plan with a signature date of 11/19/10 identifies, "... 8) Monitor and assess nutritional and fluid needs by consulting with dietician 9) Supplements as ordered..."

R10's Annual Nutritional Assessment dated 11/05/10 states that her current weight is 126 pounds as compared to the prior years weight of 135 pounds. It is recommended within this assessment that staff, "Begin a journal of exactly what resident is eating and measurements..." There are two Quarterly Nutritional Progress notes completed by the dietician dated 02/08/2011 and 05/2011. No weights are noted on either of these two notes. Recommendations include that R10 be weighed and that staff continue to document her food intake.

In review of the weight record for the year 2012, no weights have been recorded for R10. As based on the the Quarterly Nutritional Progress Notations dated 02/08/11 and 05/2011 and the Annual Nutritional Assessment dated 11/05/10, the facility did not present evidence showing that R10 has been weighed since 11/05/10.

R10's Food Diary for June 2012 and May 2012 for the prior two weeks were reviewed. The Food Diary sheet contains a date and includes the

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W9999	Continued From page 93 following instructions for staff: 1) Document what was offered for each meal - include the amount that was offered specifically (1 cup milk, 1 slice of bacon) 2) How much was consumed specifically (1 cup of ....; 2 slices of bread, 8 oz (ounces)/1 cup of mil) etc. no %'s (percentages). 3) IF SHE REFUSES TO EAT DOCUMENT REFUSAL UNDER AMOUNT CONSUMED COLUMN. Look @ (at) menu for portion sizes. The following documentation was noted within this diary for the prior two weeks (06/06 - 05/23/12): 06/06/12 Blank 06/05/12 Blank 06/04/12 Blank 06/03/12 Lunch and supper have been filled in but there is no documentation for breakfast, snacks and or her Protein Supplement. 06/02/12 Lunch and supper have been filled in but there is no documentation for breakfast, snacks and or her Protein Supplement. 06/01/12 Blank 05/31/12 Breakfast, supper and one Protein Supplement are documented. 05/30/12 Blank 05/29/12 Blank 05/28/12 Blank 05/27/12 Blank 05/26/12 Breakfast, lunch and the Protein Supplement are documented. 05/25/12 Supper and the Protein Supplement for evening snack is documented. 05/24/12 Blank 05/23/12 Blank R10's Medication Administration Record for June and May of 2012 were reviewed to determine if her Protein Supplement is documented on this	W9999		

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form. Review of the MAR for these two months does not identify that nursing and/or direct care staff document on this form that R10's Protein Supplement is given twice daily as physician ordered.

The Quarterly Nursing Assessment dated 04/25/12 does not addresses R10's nutritional needs, inclusive of the Protein Supplements as per her medical plan of care to maintain skin integrity. Neither does this assessment reflect the need to obtain weights on R10 and/or the need for dietary consultation.

D) Based on record review and interview the facility failed to ensure that an aggressive fall prevention plan was implemented for R10.

The facility's undated Fall Policy states that in the event of a fall, the following steps will be implemented, "4) ...The RN Consultant will evaluate the resident within 24 hours of occurrence or sooner if condition worsens... 6) The RN Consultant will perform a complete assessment of the resident, review of all most recent diagnostic studies, complete appropriate fall risk identification forms to include the high risk assessment if appropriate. 7) If a resident strikes their head appropriate neurological monitoring will be maintained for the 24 hour period post fall. The resident will be charted on per the neurological assessment protocol and then every 8 hours for 72 hours post fall... 9) RN Consultant will review all falls and will be responsible for making any updates (if needed) to the individual's care plan to ensure that it will be updated to show what preventative measures that will or have

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been implemented."

A Medical Care Plan: High Fall Risk Hx (history) of Fractures with a signature date of 05/12/11 states that R10 is at a high risk factor and has repeated fractures. Approaches within this plan include: "1) Staff is (are) to instruct R10 to refrain from ambulating and transferring without assistant... 5) R10 requires stand by assistance from direct care staff during waking hours 6) At meal times, if R10 refuses to eat dinner and will not go to the dining room one direct care staff must continue to be a stand by assist with her 7) Until it (is) time for R10 to go to bed, a direct care staff must be a stand by assist with her..."

R10's Fall Risk Assessment dated 04/12/12 identifies that if an individual has a total score greater than 12, then they are at a High Risk for falls. R10 has a total score of 26.

In review of the Incident/Accident Reports for June 2012 and May 2012, R10 has had three incidents of falls on 06/07, 05/07 and 05/04/12. These reports do not identify that staff are maintaining stand by assistance for R10 as per her medical care plan to prevent falls and potential fractures. R10's medical care plan has not been updated by nursing to reflect her recent falls since 05/12/11. There is no documentation identifying what prevention measures have been implemented to prevent further falls as per the facility's Fall policy.

The Accident/Incident Report dated 06/07/12 states that on this date at 11:00 P.M., R10 was getting up to use (the) R.R. (restroom) and sustained a rug burn on the R (right) side of

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forehead. A Neuro Check List was started at 11:00 P.M. on 06/0712 and continued until 5:30 A.M. The Neuro Check List states that the individual's blood pressure, pulse and resp. (respirations) are to be taken every thirty minutes for the first hour, every hour for the next four hours and then every 2 hours for the next eight hours. The following documented times with vitals were noted for 11:00 P.M., 11:30 P.M. for the first hour, 12:30 A.M., 1:30 A.M., 2:30 A.M., 3:30 A.M. for the next four hours and then stopped at 5:30 A.M. The slots for the 7:30 A.M., 9:30 A.M. and 11:30 AM documentation for further neuro checks are blank. There are no further slots on this check list for staff to document that they continued to check on R10 for the next forty eight hours. Review of this report, R10's Hab. Notes and RN Consultant notes do not identify that nursing staff completed or ensured the completion of the Neuro Check List after this fall as per the facility's policy.

The Incident/Accident Report dated 05/04/12 at 9:00 AM identifies that R10 was in her wheelchair looking at the movies and got out of her wheelchair. The nature of the incident is filled in as a, "fall." R10 sustained a rug burn to the right side of her head as a result of this fall. This report was prepared by E3 (Direct Care Staff). No documentation is noted within this report identifying that neuro checks were completed during the next thirteen hours as per the facility's Neuro Check list. There is no documentation contained within this report, nor in R10's Hab. Notes and/or RN Consultant notes identifying that she was assessed by nursing after this fall.

E3 (Direct Care staff) was interviewed on

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W9999	Continued From page 97 06/05/12 at 1:30 P.M. and stated, "R10 was in the living room organizing her movies. I was getting everyone on the bus for work when she fell out of the wheelchair on 05/04/12." When E3 was asked what staff was providing stand by assistance to R10 on this date, she stated, "I don't recall who the staff was that was here but they weren't in the living room with R10 when she fell out of her wheelchair." The Incident Accident Report dated 05/07/12 (5 AM) states, "Staff (E14) found R10 out of bed sitting in the floor. No injuries noticed but staff will continue to monitor." No documentation is contained on this report nor in R10's Hab. Notes and/or RN Consultant notes identifying that staff continued to monitor her or that she was assessed by nursing after this fall. No Neuro Check List was located for R10 corresponding with this date. E5 (RN Consultant) was interviewed via telephone on 06/08/12 at 10:30 A.M. and stated, "I am monitoring the assessments and the reports that are completed by E4 (LPN)." When E5 was asked if he as the RN Consultant has updated R10's plan of care to address her falls and/or her Fall Risk assessment, he stated, "No, if updates are made, E4 is to complete those. I am only monitoring what he completes." E5 then stated that R10's plan for falls and Fall Risk assessment should be updated to reflect her falls during the past 90 days. E) Based on Observation, interview and record review the facility has failed to ensure that R1's medical plan for weight monitoring and	W9999		

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maintaining continuous 02 (oxygen) is implemented by all staff.

The Physician's Orders sheet dated 06/01/12 identifies that R1 has diagnoses of COPD (Chronic Obstructive Pulmonary Disease), Chronic Respiratory Failure, Hyperapnea and Obstructive and Acute Bronchitis. These orders also identify that R1 requires continuous oxygen 2-3 L (liters) per concentrator and portable 02 (oxygen).

R1's medical plan of Care for COPD dated 09/24/10 states that R1 is to, "Maintain continuous oxygen and nebulizer treatments." Approaches within this plan includes staff assistance in maintaining his oxygen administration devices and for staff to ensure that his physician's orders for continuous oxygen are followed.

On 05/31/12 at 5:30 P.M., R1 was outside the facility in the parking lot. R1 was not wearing his nasal cannula, nor was his portable oxygen pack on his back. No staff were present in the outside area during this observation. After walking around a few moments, R1 began picking up cigarette butts in the parking lot. When the surveyor asked R1 what was he doing, he stated, "Nothing!" R1 then threw the cigarette butts in the grass. R1 was asked if he had been outside smoking and he stated, "No, I don't have none (cigarettes)." R1 then walked to the back door and went into the facility. E11 (Direct Care staff) and E4 (LPN) were present in the dining room when R1 entered the facility. Neither of the staff immediately prompted R1 to put his oxygen back on until brought to their attention by the surveyor.

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W9999	Continued From page 99 When E4 (LPN) was asked at this time (5:40 P.M.) if R1 is to wear his oxygen when he is outside the facility, he stated, "R1 is to wear his oxygen all the time except when he is smoking a cigarette. Sometimes it seems like he doesn't want to wear it. It's getting to be a problem." In review of the Nurse's Notes from 04/01 - 06/31/12 there is only one entry dated 04/27/12 reflecting R1's failure to wear his oxygen and his complaints of being tired. Further review of R1's record identifies an addendum to his "Impaired Gas Exchange Care Plan" (undated) which states that staff are to: " Monitor weight: If client has a 2 pound weight gain in 1-3 days or 5 pound weight gain in 1 week notify the physician and RN." The data collection sheets for April 2012 and May 2012, entitled Monitor weight r/t (related to) current medical condition identifies that staff are to weigh R1 daily. It also states that the RN Consultant will monitor R1's weight weekly and report significant weight gain or weight loss to the Physician. In reviewing this sheet it is noted that R1 was only weighed 7 out of 30 days in April 2012 and 29 out of 31 days in May 2012 as opposed to being weighed daily by staff. Documentation for May 2012 identifies that R1's weight was 104 pounds on 05/13. On 05/14 he weighed 107 which is a gain of 3 pounds. There is no documentation on this form to indicate that staff notified the RN Consultant and/or the physician or that the RN Consultant is monitoring R1's weights weekly. On 05/22 R1 weighed in at 106.7 and on 05/23, R1 weighed in at 110.4 pounds which is a weight gain of 3.7 pounds.	W9999		

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Again, there is no documentation on this form indicating that staff notified the RN Consultant and/or the physician or that the RN Consultant is monitoring R1's weights weekly.

The data collection sheet for May 2012 for monitoring R1's weight identifies the dates of 06/01 - 06/13/12. There are only 5 weights documented for these thirteen days listed. On 06/01, R1 weighed in at 108.6 pounds and on 06/02 weighed in at 104.7 (indicating a 3.9 pound gain). The 06/04 listing is blank and on 06/05, staff documented that R1 weighed in at 110.4 pounds (indicating a 5.7 pound weight gain since weighing in on 06/03 at 104.7 pounds.) After staff documented his weight of 108 pounds on 06/06/12, no further documentation is noted for the month. There is no documentation on this form indicating that staff notified the RN Consultant and/or the physician or that the RN Consultant is monitoring R1's weights weekly.

Review of the RN Consultant notes from April 2012 - June 2012 identifies that E5 (RN Consultant) has not documented weekly monitoring of R1's weight gain fluctuations as documented on the data collection sheets for these months.

E1 (Assistant Administrator) was interviewed on 06/07/12 at 11:15 A.M. and stated, "We are (indicating herself and E10/QMRP who was present at the table during this interview) responsible to make sure that staff and nursing staff are monitoring R1's weight." When E1 was asked why the RN Consultant had not been monitoring R1's weights weekly, she stated, "E5 has turned in his resignation and is only filling in

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on days when E4 (LPN) is unavailable. We are in the process of hiring a new RN Consultant.

F) Based on interview and record review, the facility failed to ensure that medications are administered as ordered by the physician.

The facility's undated policy and procedures entitled, "Medication Administration Errors" states, "Medication errors shall be reported immediately to the Pharmacist, RN (Registered Nurse) Consultant, Physician, and Management for orders and follow-up procedures." This policy goes on to state that, "Reporting of medication errors ensures prompt attention in treating the consequences of errors in administering medication."

In reviewing the Medication Error Reports submitted by the facility, only four reports were given to the surveyor for the months of April, May and June 2012. The Medication Error Reports identifies that all the medication errors occurred in April 2012. In reviewing these reports the following was noted:

04/04/12 Staff (E17) omitted to give R2 his Calcium 600/Vitamin D tablet and his Docusil 100 mg (milligram) capsule at the 7:00 A.M. medication pass. This report states that the "contributing factors" for the omission was based on, insufficient staff, increased workload and lack of staff concentration;

04/12/12 R10 refused to take her 7:00 A.M. medications which includes Aspirin 81 mg, Vitamin C 500 mg, Celebrex 200 mg, Daily

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W9999	Continued From page 102 Vitamin, Bactriban Cream 2%, Carbamezapine tablet 200 mg, Divalproex 500 mg EC (2 tablets), Docusil 100 mg, Potassium Chlorize 10 meq Cr, sodium Chloride 1 GM, Ranitidine 150 mg, Haloperidol 2 mg, Lorazepam 1 mg, Oysco 500, Ferrous Sulfate 325, Furosemide 40 mg, B12 sub 1000 mcg and Folic Acid 1 mg. There is no documentation on this report that the physician was notified of her refusal and/or that staff monitored for adverse effects of her not taking her medications; 04/14/12 Staff (E14) omitted to give R6 (discharged 05/18/12) her Mytab Gas chewable tablet 125 mg (Simethicone) at the 7:00 A.M. medication pass. This report states that the "contributing factors" for the omission was based on, "lack of staff concentration." There is no documentation on this report that the physician was notified of the omission; and 04/18/12 Staff (E13) gave R5 her 8:00 P.M. dosage of Clonazepam (no dosage specified on the report) during the 4:00 P.M. medication pass. This report states that the, "contributing factors" for the error was based on, "lack of staff concentration." R5's Medication Record dated 04/01 - 04/30/2012 identifies that R5 is to receive Clonazepam 1 mg by mouth at bedtime. The entry for 8:00 P.M. (2000) on 04/18/12 shows that E11 (Direct Care staff) administered R5's 8:00 P.M. dosage of Clonazepam even though E13 (Direct Care staff) had already given R5 her medication at 4:00 P.M. in error. No additional Medication Error report is noted for 04/18/12 with the exception of the 4:00 P.M. medication error. There is no	W9999		

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documentation on this report that the pharmacist, RN Consultant and/or the physician were notified of the medication error for orders and follow-up procedures as per the facility's policy.

The Physician's Orders dated 05/01/2012 states that R8 has orders for, "Novalin R Inj (injection) - U (units) -100 per sliding scale: 201 - 250 3U, 251 - 300 6U, 301-350 9U, 351 - 400 12U, 400 - Notify physician."

In review of Blood Sugar monitoring sheet for April 2012 and as based on review of the MARS for April it is noted that R8 did not receive her Novalin Injection per sliding scale as physician ordered on 04/01, 04/16, 04/25, 04/28 and on 04/29. The following documentation was noted:

04/01 Prior to bedtime, R8's BS was 214 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 3 Units of Novalin as ordered by the physician;
04/16 Prior to the evening meal (dinner), R8's blood sugar was 287 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 6 Units of Novalin as ordered by the physician;
04/25 Prior to bedtime, R8's BS was 224 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 3 Units of Novalin as ordered by the physician;
04/28 (Saturday) Prior to lunch, R8's BS was 201 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 3 Units of Novalin as ordered by the physician; and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 104 04/29 (Sunday) Prior to lunch, R8's BS was 201 as documented on the Blood Sugar monitoring sheet. The April MARS does not reflect that she received 3 Units of Novalin as ordered by the physician. No medication error reports were provided by the facility for the above mentioned dates for R8 for April 2012. There is no documentation noted within the Hab Notes and/or RN Notes identifying that the physician was notified that R8 did not receive her Novalin on 04/01, 04/16, 04/25, 04/28, nor 04/29/12. R8's Blood Sugar monitoring sheet for May 2012 and per review of the MAR for May, 2012, it is noted that she did not receive her Novalin Injection per sliding scale, as ordered by the physician during the weekend on 05/05 and 05/06/12. It is also noted that R8 was administered 6 Units of Novalin for a blood sugar reading of 242 on 05/19/12. R8's Physician Orders dated 05/01/2012 states that she is to receive 3 Units of Novalin for a blood sugar of 242, rather than 6 Units. No medication error reports were provided by the facility for the above mentioned dates for R8 for May 2012. There is no documentation within R8's Hab Notes and/or RN Notes stating that the physician was notified that she did not receive her Novalin on 05/05 nor 05/06 as per the facility's policy. In reviewing the facility staff's time cards it was noted that on 06/17/12, nursing staff did not clock in to administer morning medications until 9:42 A.M. as verified per E4's (LPN's) time card.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G277	A. BUILDING _____ B. WING _____	C 07/31/2012

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W9999	Continued From page 105	W9999		

Further review of the time cards did not identify that any other nursing staff had been at the facility on 06/17/12 to administer the morning medications.

E1 (Assistant Administrator) was interviewed on 07/10/12 at 10:45 A.M., "As of 06/17/12 we did not have an RN (Registered Nurse) Consultant and nursing staff had to pass medications. E4's (LPN's) time card was reviewed with E1 at this time. During this interview, E1 confirmed that E4 did not arrive to the facility to pass the morning medications until 9:42 A.M. When the surveyor asked E1 for the Medication Error reports for 06/17/12, she stated, "I don't know. I'm not sure that any report was done."

In reviewing the Medication Administration Records (MARs) for June 2012 and as verified per the individual's Physician's Order for June 2012, the following nine individuals did not receive their following 7:00 A.M. medications (R1, R2, R3, R5, R9, R10, R11, R12 and R13) until after 9:42 A.M. on 06/17/12:

R1 did not receive his Ecpirin 325 mg (milligrams), Lisinopril 5 mg, Prednisone 5 mg, Budesonide Sus (suspension) 0.25 mg/2 (use in nebulizer), Metformin 100 mg, Mucinex 600 mg, Oyst-Cal-D 500 mg, Antacid Plus (one tablespoon before meals), Ascensia Contour strips before meals, Glimepiride 4 mg, Ipratropium Solution/Albuterol (use in nebulizer every 8 hours), Januvia 50 mg, and Metroprolol 25 mg ER (extended release) between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician;

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W9999	Continued From page 106	W9999		

R2 did not receive his Docusil 100 mg and Cal Carb 600/Vitamin D between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician;

R3 did not receive his Allergy Relief 10 mg, Risperidone 1 mg, Ferrous Sulfate tablet 325 mg, Ranitidine 150 mg, Risperidone 7 mg and Lorazepam 1 mg between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician;

R5 did not receive Gabapentin 300 mg, Lisinopril 5 mg (check blood pressure prior to administering), Carbamazepine 200 mg (two tablets), Senna S tablet 8.6-50 mg, Metamucil caplet (two), Ranitidine 150 mg, Diphenhydramine capsule 25, Urea Cream 20% and Acetaminophen 325 mg between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician;

R9 did not receive Levothyroxin 50 MCG (micrograms), Zetia 10 mg, Benzotropine tablet 0.5 mg, Levetiraceta 500 mg, and Escitalopram 20 mg between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician;

R10 did not receive Aspirin 81 mg, C-500 mg, Celebrex 200 mg, Daily Vitamin tablet, Bactroban Cream 2%, Carbamazepine tablet 200 mg, 2 tablets of Divalproex 500 mg EC (enteric coated), Docusil 100 mg, Potassium Chloride 10 MEQ Cr (milliequivalent of Chromium), Sodium Chloride 1 GM (gram), Ranitidine 150 mg, Haloperidol 2 mg, Lorazepam 1 mg, Oysco 500 tablet, Ferrous Sulfate table 325 mg, Furosemide 40 mg, B-12 sub (sublingual) 1000 MCG and Folic Acid tablet 1 mg between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician;

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W9999	Continued From page 107	W9999		

R11 did not receive Allergy Relief 10 mg, Folic Acid 1 mg, Lisinopril 25 mg, Ferrous Sulfate 325, Metformin 500 mg (two tablets), Atenolol 25 mg, Pravastatin 40 mg and Ciproflaxin 500 mg;

R12 did not receive Metroprolol 100 ER (extended release), Vitamin E 400, Potassium Chloride Cap (capsule) 10 MEQ Cr, Terazosin 1 mg, Docusil 100 mg, Nabumetone 750 mg, Oxybutynin 5 mg, Calcium Carbonate 600/Vit (Vitamin) D, Arthritis Pain tablet 650 mg, Amlodipine 10 mg, Hydrochlorothiazide tablet 25 mg and Multiday Plus Mineral tablet between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician; and

R13 did not receive Asprin 81 mg, Ferrous Sulfate 325 mg, Levothyroxin 137 MCG, Therapeutic lotion, Dorzol/Timolol Sol. (solution) 2.0 5% OP (ocular pressure) one drop to her left eye, Fiber Laxative 625 mg tablet, Naproxen 250 mg, Ureacin-20 cream to her feet, Lactulose Sol 10 gm/15 (two tablespoons), Sodium Chloride tab 1 gm (two tablets), Lotemax Sus (suspension) 0.5% one drop to left eye and Lisinopril 10 mg. between the hours of 6:00 A.M. - 8:00 A.M., as ordered by the physician.

E4 (LPN) was interviewed on 07/10/12 at 4:35 P.M. and stated, "On the 17th (June 17th, 2012) I passed meds late." When E4 was asked if he had completed medication error reports for the nine individuals who received their morning medications late, he stated, "No, it slipped my mind." When E4 was asked if he had notified the physician regarding passing the medications late and/or the medication errors, he stated, "No, I

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W9999	Continued From page 108 didn't notify the physician."	W9999		

G) Based on interview and record review the facility has failed to ensure that individuals receive their annual TB (Tuberculosis) vaccine as ordered by the physician for Tuberculosis prevention and control of 4 individuals. (R1, R8, R11 and R12).

R12's Physician Orders dated 06/01/2012 identifies that she has standing orders for, "TB (Tuberculosis) testing is to be done yearly, positive reactors are to have chest x-rays as needed." Further review of these orders does not identify that R12 is a positive reactor to this test, nor are any allergies identified.

Review of the form entitled, "Administration of TB Vaccine Information" identifies that R12 received the vaccine on 09/21/10. No current TB vaccination information was noted within R12's record for 2011.

During reviews of R1's, R8's and R11's records, the "Administration of TB Vaccine Information" all state that the individuals received their vaccination on 09/21/10.

E1 (Assistant Administrator) was interviewed on 06/07/12 at 11:15 A.M. and stated, "The TB test are to be done annually. I wasn't aware that they hadn't been done. I already called the pharmacy to make sure that they order the TB medication for us." When E1 was asked who was responsible to ensure that the individuals receive their TB vaccine annually, she stated, "It is a nursing function, but myself and the QMRP (E10)

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W9999	Continued From page 109 are ultimately responsible to ensure that it is done." (A)	W9999		