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F 309	Continued From page 75 breakdown in communication between physicians and nurses. DSD stated he gave training to licensed staff related to med pass and documentation of insulin refusals during the month of 5/2015. The DSD stated his concern with the documentation in Resident 9's record was what prompted the in-service training. On 7/9/15 at 9:40 am, the Admin (appointed as both Administrator of the facility and CEO of the hospital) stated, in the recent past, the facility did not have capable nursing leadership and his expectation is for the CNO to provide oversight through explaining issues to him. The facility and making sure they were following regulations was not the number one item for him to address, and there were many issues to address in the five months he had been appointed the Admin/CEO. The Admin stated he had relied on the present medical staff to manage the facility.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow its Pressure	F 314		9/3/15

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Ulcer Management policy to ensure wound care assessments and measurements were updated weekly for one of 10 sampled residents (Resident 6) when the wound care assessment form did not show evidence of measurements and documentation for over two weeks.

This failure had the potential not to detect if the current plan of treatment is effective and to cause a decline in the residents health.

Findings:

A review of Resident 6's record indicated he was admitted to the facility on 6/12/15 with diagnoses that included insulin dependent diabetes, high blood pressure, amputation below the left knee, poor circulation in his legs, pressure ulcers (injury to the skin and underlying tissue from pressure) right foot in two toes)/arterial ulcers (from inadequate blood supply), and depression.

A physician's order, dated 6/12/15, indicated a diagnosis of pressure ulcer and included orders "to treat right foot second toe scab, apply Betadine (topical medication) daily ... ."

On 7/6/15 at 11 am, Resident 6's right foot ulcers were observed. Both ulcers appeared clean and dry, were circular and approximately 0.5 cm in width (the size of a pea). Resident 6 stated he had the ulcers for over six months and the ulcers were slow to heal.

Review of a document titled, "Photographic Wound Documentation," included a picture taken upon admission of Resident 6's wounds, and indicated a "Nursing Assessment on 6/12/15 at 2 pm, Wound location: right middle toe and big toe,

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F 314	Continued From page 77 size: .5 by .5 centimeters for both, wounds are dark." Page two of the form included columns with measurements on 6/12 and 6/19/15, indicating the wounds were still the same size and the treatment was the same. Documentation on page two indicated, 6/19/15: Toes have ulcer of same size, but appear to be drying out with Betadine treatment... will monitor. The column labeled 6/26/15 was not filled out and the record did not include further documentation about the pressure ulcer, arterial ulcer. On 7/8/15 at 11:40 am, Licensed Nurse A stated wound assessments are to be done weekly. On 7/7/15 at 5:05 pm, the Nurse Manager verified the wound assessment form was incomplete and did not reflect Resident 6's right foot ulcers and had not been re-assessed or updated. A policy, dated 2012, titled, "Pressure Ulcer Management" instructed to document on the wound flow sheet weekly.	F 314		
F 323 SS=E	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 observation, interview, and record	F 323		9/3/15

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review, the facility failed to ensure its Fall Policy was implemented, and that the environment was free of accident hazards to prevent a burn/fire hazard and accidents/falls for six of ten sampled residents (Residents 2, 3, 4, 5, 8, and 10) and one resident outside the sample (Resident 13) when:

1. Residents 2, 3, 4, 5, 8, and 10 suffered falls, and the facility fall policy was not followed, resulting in inadequate documentation, inadequate care planning review, and inadequate fall analysis.

These failures resulted in absent or inadequate fall assessments, nursing direction, and fall documentation that placed residents with the potential that falls with serious injury could result.

2. Resident 13 had a portable heater in her room.

This had the potential to subject Resident 13 to burn injuries and created a fire hazard, placing residents, visitors, and staff at risk for fire related injuries.

Findings:

1. a. Resident 2's record was reviewed. Resident 2 was admitted on 7/22/14 with diagnoses that included dementia, and diabetes that required use of insulin injections.

Resident 2's, Minimum Data Set (MDS), an assessment tool, dated 2/4/15, identified that he had severe cognitive impairment, communication difficulties, and behaviors that affected others including wandering and aggressive behaviors.

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These behaviors required frequent redirection and a behavior care plan that included supervision from a sitter (a non-certified/licensed staff). The MDS also identified Resident 2 as having diabetes and being a fall risk.

Resident 2's "Risk for Injury/Falls" care plan, initiated 7/22/14, did not identify new interventions to prevent falls, or dates of all actual falls.

On 6/28/15 at 9:30 pm, Resident 2 had a fall with an associated head injury that required an Emergency Room (ER) evaluation. On 5/16/15 at 5 pm, Resident 2 had an unwitnessed fall in the day room, when he had a hypoglycemic (low) blood sugar level. On 4/18/15 at 7 am, a fall flow sheet was started for Resident 2 indicating a fall had occurred. On 2/17/15 at 4:15 am, a nurses note identified that Resident 2 had an unwitnessed fall in his bedroom.

Resident 2's care plan and nursing notes did not reflect that the full fall policy was followed to include evaluation of new interventions, update of fall care plans, and 72 hour follow up, to prevent further falls on each fall occurrence.

On 1/2/15 Resident 2 had two falls. The date of this fall was written on the care plan, but no new interventions were identified.

On 7/13/15 at 2:30 pm, during an interview, and record review, Ward Clerk (WC) stated that she was also the Social Service Designee (SSD) and Medical Records Designee (MRD). MRD stated that Resident 2's records did not contain the required follow up documentation for his falls as directed by the fall policy and facility practice.

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b. Resident 3's "Risk for Injury/Falls" care plan, dated 11/24/14, did not identify new interventions to prevent falls, or dates of actual falls. The care plan continued to read, Resident 3 had "potential" for falls instead of "actual" falls.

On 5/11/15 at 11:05 am, a Certified Nursing Assistant (CNA) documented she found Resident 3 on the floor in her room, saying "ouch" and a bed alarm was now going to be put in place because Resident 3 does not use her call light before getting out of bed. The care plan already listed the bed alarm as an intervention and was to be implemented on 11/24/15.

On 7/13/15 at 2:30 pm, in a concurrent interview and record review, MRD stated that Resident 3's records did not contain documentation for her fall that would comply with the facility policy.

c. Resident 5's record was reviewed. Resident 5 was admitted to the facility on 12/12/14 with diagnoses that included a mood disorder and non insulin dependant diabetes.

On 6/29/15 at 11:30 am, during the initial facility tour with Restorative Nursing Assistant (RNA) 1, Resident 5 stated she had a fall that morning. RNA 1 confirmed that Resident 5 had a fall the morning of 6/29/15.

Resident 5's "Risk for Injury/Falls" care plan, dated 5/7/15 did not identify the fall of 6/29/15 or any new interventions to prevent further falls. The care plan continued to read, Resident 5 had "potential" for falls instead of "actual" falls. No nursing note was found in the record related to her fall on 6/29/15 in the am.

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On 7/13/15 at 2:30 pm, in a concurrent interview and record review, MRD stated that Resident 5's records did not contain the required follow up documentation for her fall.

d. A review of Resident 8's record indicated he was admitted to the facility on 3/23/15 with diagnoses which included diabetes and anemia (low iron blood levels), and heart failure.

The record indicated from 4/10 to 6/11/15, Resident 8 experienced six unwitnessed falls (4/10, 4/25, 5/2, 5/19, 5/22, and 6/11/15).

A review of the nurse's note dated 6/11/15 at 3:30 pm, indicated the following, "Per night nurse, resident had an unwitnessed fall from bed last night. No injuries noted. Vital Signs and neurological check have been within normal limits this shift, so far. Resident is alert, and somewhat resistive to care. Is weak with movement of limbs but this is normal for him. Speech is clear." A review of the record indicated a Neurological Check form had been initiated on 6/11/15 at 5:15 am.

A review of the record indicated the procedure for falls had not been followed, and did not show evidence of a "Fall Assessment Form" had been completed at the time when Resident had sustained an unwitnessed fall on 6/11/15, and the nurse had not documented the fall situation or completed information about the fall in the nurse's note. The cause of the fall was not evaluated to assess if a revision to the care plan was appropriate.

A review of care plans dated 4/13/15 and 5/12/15, titled, Risk for Injury/Falls, indicated resident would have no falls, no injury. The care plan was

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not updated after Resident 8 had fallen on: 5/19, 5/22, and on 6/11/15.

On 7/8/15 at 5 pm, the Nurse Manager verified the above findings and stated the current procedure for post fall follow-up had not been followed, and the care plan was not updated.

The facility's policy titled, "Fall Prevention," dated 2012, instructed, any resident who falls will be tracked using the indictment report system. The Director will review the fall the next day to evaluate the plan of care (poc) and update the current plan if ineffective. The poc will be updated with any additional or changes in interventions as the occur.

The facility's policy titled, "Falls - Patient," dated 1/12, indicated that any patient who falls will be routinely assessed by the charge nurse for at least three days to observe any signs of CNS (central nervous system) deterioration, and will document their findings in the appropriate flowsheet. The assessments will be done every shift, or more as the condition warrants.
e. Resident 4 was originally admitted to the facility on 3/15/10 with diagnoses of diabetes, weakness and vertigo (dizziness). On 6/27 and 7/3/15, Resident 4 slid out of her bed and was found on the floor without sustaining injuries. Resident 4 wore a pull alarm that did not alarm during either fall because the string attached to the bed was too long.

During a concurrent interview and record review with the NM on 7/6/15 at 10 am, she confirmed there was no follow-up charting which would include the resident fall flow sheet, neurological check flow sheet, and updating the fall care plan

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was completed following the unwitnessed 6/27/15 fall. The NM stated the neurological flow sheet completed following the 7/3/15 fall was incomplete.

f. Resident 10 was originally admitted to the facility on 11/1/13 with diagnoses of dementia and partial hemiplegia. Resident 10 expired on 5/13/15.

Resident 10 experienced two witnessed falls on 9/23 and 10/19/14. Resident 10 experienced two unwitnessed falls on 1/3 and 2/23/15.

During a concurrent interview and record review, with the NM on 7/7/15 at 4:30 pm, she confirmed the follow-up charting which would include the resident fall flow sheet, neurological check flow sheet and updating the fall care plan, were all incomplete following all four falls. The NM acknowledged that only the 10/19/14 fall had been documented on Resident 10's care plan.

During an interview with the Director of Staff Development on 7/8/15 at 4:30 pm, he acknowledged that there is inconsistent fall documentation throughout the facility and has provided a past in-service to try to remedy this in the past.

2. During an initial tour of the facility on 6/29/15 at 11 am with the Nurse Manager (NM), a portable radiator space heater was observed plugged in, extremely warm to the touch in Resident 13's room. The NM stated she was surprised to see this type of a device in a resident's room, as she thought they were not allowed in the facility. The NM then, immediately unplugged and removed the heater.

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F 323	Continued From page 84 During an interview, with the Director of Plant Operations on 7/1/15 at 10:30 am, he stated his staff completes daily walking rounds to identify and remove items like heaters that are brought in without permission by resident's family members. A document titled, "Trinity Hospital Department Safety Checks," dated 6/2015, indicated that a check of every room in every department had been completed to ensure compliance in regards to the facility's policy regarding floor heaters, power strips including safety checks on all electrical devices both hospital and personal owned.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		9/3/15

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F 329	Continued From page 85 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility physicians failed to provide sufficient physician's orders and blood sugar (BS) level parameters for diabetic residents, on insulin injections and oral anti-diabetic medications, to ensure adequate monitoring of the medication (insulin) effects for seven of ten sampled residents and one resident outside the sample (Resident 1, 2, 3, 4, 5, 6, 9 and 11). This failure resulted in licensed nurses (LNs) not having direction for physician notification of abnormal blood sugars that could result in potential adverse effects of the diabetic medications given or held, as well as the potential that doses of insulin prescribed were not appropriate for the residents. Findings: The American Diabetes Association (ADA) identifies Hypoglycemia as a BS below 70 mg/dl and Hyperglycemia as BS above 240 mg/dl, and that each individual may have differing symptoms as a result of these abnormal BS levels. The ADA also reports that BS goals for the elderly population are dependant on the complexity and existence of other medical conditions. The ADA identified general BS goal guidance in the elderly population for fasting (before eating) BS as 90 to 180 mg/dl and bedtime BS as 90 to 200 mg/dl.	F 329		

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The facility identified reference, "Nursing Care Plans," 8th Edition, is not specific for the elderly population or skilled nursing care, but read that diabetic care is needed for BS less than 70 mg/dl through a fast acting form of glucose (glucose gel or sugar). The reference identifies that higher levels of fast acting glucose would be needed if BS is less than 50 mg/dl. This reference reads "10 to 15 g (grams) of carbohydrate should raise blood glucose levels 30 to 40 mg/dl."

A facility Nursing Administrative policy, faxed after the survey exit, titled "Blood Glucose Testing using Precision Xceed Pro," dated 7/2013, read, "If patient test results fall outside critical ranges the operator will repeat the test, contact the physician with the results of both tests, and request orders for clinical laboratory testing of the patients blood." The policy read, "Critical whole blood glucose concentrations are usually defined by the physician for each patient. If the physician chooses not to identify glucose "action limits," the following laboratory values are used: Low Limit: 40 mg/dl or less, High Limit 440 mg/dl or more."

LN 1 identified that she did not have physician ordered BS parameters or directions for diabetic care, if abnormal BS results, for Residents 1, 2, 3, 5, 9 and 11. LN 1 stated that Resident's 6 and 9 were considered "brittle diabetics" (meaning very unstable BS control).

a. Resident 2's record was reviewed. Resident 2 was admitted on 7/22/14 with diagnoses that included diabetes that required use of insulin injections.

Resident 2's physician orders, reviewed monthly

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since Resident 2's admission 7/22/14 through 6/2015, contained no BS parameters for physician notification of high or low BS, and no instruction from the physician on diabetic care when abnormal BS were obtained. Resident 2 was ordered Humalog (a short acting insulin injection) with dosage based on his blood sugars taken three times a day before meals (a sliding scale), and routine Lantus (a long acting insulin injection) every morning.

On 7/13/15, Resident 2's Medication Administration Records (MARs) for 3/1/15 to 6/30/15 revealed that he had low BS (below 60 mg/dl) 24 times and seven of these were below 40 mg/dl with the lowest recorded of 32 mg/dl. On 7/13/15 at 3 pm, during a concurrent interview and record review with Medical Records Staff (MRS) she stated that none of the 24 reviewed episodes of low BS had licensed nursing documentation of physician notification or narrative nursing notes related to any actions and follow up to the abnormal BS levels.

b. Resident 3's record was reviewed. Resident 3 was admitted to the facility on 11/20/14 with diagnoses that included dementia and diabetes which required treatment with insulin. A review of her 6/2015 MAR identified six episodes where evening blood sugar exceeded 300 mg/dl.

No physician ongoing instruction for management of low or high blood sugars or parameter notification instructions were found in her physician orders, MAR, or Diabetic care plan since admission on 11/20/14.

c. Resident 5's record was reviewed. Resident 5 was admitted to the facility on 12/14/14 with

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F 329	Continued From page 88 diagnoses that included a mood disorder and non insulin dependant diabetes. She had an order for daily blood sugar checks initiated on 1/22/15. No physician orders were written for BS physician notification parameters or care for high or low BS. d. Resident 9's record was reviewed. Resident 9 was admitted on 7/3/13 with diagnoses that included chronic pain and insulin dependent diabetes. A nurses note, dated 7/3/15 at 12 pm, "Resident blood sugar dropped to 48. She refused any juice or snack." The next nurses note was not written until 7/3/15 at 8 pm (eight hours later) and read, "Resident's 5 pm BS was > (greater than) 500. Previous nurse called MD and received order for one time dose 12 units Novolog (insulin injection) and re-check BS in one hour. At 6:10 pm BS was still still > 500. Attempted to contact MD. Was finally able to talk with MD and received order for one time dose of 4 units Novolog SQ (subcutaneous) and to re-check BS at 9 pm. Order to contact MD if still > 500. Res not c/o (complaining of) any s/sx (signs or symptoms) of hyperglycemia. Does not appear hot. Will monitor." The 7/3/15 nurses progress notes do not reflect that the MD was notified of the low BS and Resident 9's refusal of juice or snacks at 12 noon as per her care plan and physician orders written 7/1/15 to contact physician if BS is below 60 mg/dl. The 7/3/15 note does not reflect how her BS went for 48 to > 500 mg/dl in five hours. There were no further ordered parameters.	F 329		

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F 329	Continued From page 89 e. Resident 11's record was reviewed. Resident 11 was admitted to the facility on 4/5/14 with diagnoses that included diabetes that required insulin coverage. Resident 11 did not have parameters for BS directed by the physician for notification and care on her orders or MAR since admit. On 7/1/15 at 2:25 pm, the CNO was interviewed regarding facility provided diabetic care. She stated that diabetic care is individualized by the physician. The facility did not have any set protocols or policies specific for diabetic care. CNO stated that most diabetic residents had orders to notify the physician when BS is below 60 mg/dl and treatment is normally needed if BS is below 60 or above 400 mg/dl. CNO stated it was not uncommon in the facility to have residents with low blood sugar in the 30's and that the staff did not always need to notify the physicians to manage the situation. On 7/1/15 at 7:15 pm, the CNO acknowledged the facility had failed in the management of diabetic patient's care. On 7/1/15 at 7:15 pm, CNO provided evidence that she had obtained physician's orders for BS parameters, on all diabetic residents (Resident's 1, 2, 3, 4, 5, 6, 9 and 11). She stated that she had posted a notice to all nursing personal of the needed changes. f. Resident 1 was originally admitted to the facility on 8/9/11, with diagnoses of diabetes, stroke and generalized pain. Resident 1's physician's orders included Lantus (a long acting medication that treats high blood sugar levels) 5 units subcutaneous each night with blood sugar finger stick testing to be done every Monday at noon. The orders did not contain	F 329		

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any parameters to instruct the staff as to what to do in the cases of a high or low blood sugar levels.

g. Resident 4 was originally admitted to the facility on 3/15/10, with diagnoses of diabetes, weakness and vertigo (dizziness).

Resident 4's orders included; glipizide (a medication that treats high blood sugar levels) 2.5 milligrams each morning with blood sugar finger stick testing to be done every Monday and Thursday mornings. The orders did not contain any parameters to instruct the staff as to what to do in the cases of a high or low blood sugar levels.

During a concurrent interview and record review, with Licensed Nurse 1 on 7/6/15 at 9 am, she confirmed that Resident 1 and 4's physician's orders did not contain treatment parameters associated with their blood sugar monitoring.

h. A review of Resident 8's record indicated he was admitted to the facility on 3/23/15, with diagnoses which included insulin dependent diabetes and anemia.

A review of physician's orders, dated 6/7/15, indicated Resident 8 was to have blood sugar testing three times a day before meals, and receive Humalog insulin (a fast acting insulin that lowers blood sugar) based on the results of blood sugar test. The physician ordered increasing amounts (sliding scale) of Humalog starting with three units of Humalog when the blood sugar level was above 150, increasing progressively up to Humalog eight units for a blood sugar level of 401 and higher. The orders did not contain any

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parameters to instruct the staff in the appropriate interventions when Resident 8 had a high or a low blood sugar level.

i. A review of Resident 6's record indicated he was admitted to the facility on 6/12/15, with diagnoses that included insulin dependent diabetes and high blood pressure.

A review of physician's orders, dated 6/12/15, indicated Resident 6 was to receive a long acting insulin twice daily, Levemir. The physician ordered additional insulin, Novolog, (a fast acting insulin) based on his blood sugar test results four times daily. The insulin orders for Resident 6 were adjusted multiple times, from 6/12/15 to 6/30/15. The physician orders indicated to "notify the physician for a blood sugar less than 60." The orders did not contain specific parameters or instructions to the staff for what to do when Resident 8 had a high or a low blood sugar level, until 7/1/15 at 5:10 pm, when an order was given to call the physician if Resident 6's blood sugar was less than 60 or over 500; and to give Glucose Gel (a concentrated sugar gel) or orange juice for blood sugar less than 60.

A review of the 6/2015 Medication Administration Record (MAR) indicated Resident 8's BS levels fluctuated from 23 to 500.

On 7/2/15 at 12:30 pm, LN 3 stated Resident 6 had difficult to treat blood sugar levels and it was not clear what steps to take when his blood sugar dropped to low levels, or when to notify the physician. She stated she would take care of the situations based on what she knew as a nurse.

On 7/6/15 at 10 am, LN 1 stated, Resident 6 had

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F 329	Continued From page 92 "wild blood sugar levels" and his blood sugar level would be low and then high all within a few hours. She stated she did not always have the time or the help to call the physician with the results of a low or high blood sugar until much later, or she would tell him the next time when he came in to the facility. On 7/12/15 at 3 pm, a concurrent review of Resident 6's record was conducted with the Nurse Manager. The Nurse Manager confirmed the above findings. She stated the nurses were able to use their judgment to make decisions within facility policy or physician's orders.	F 329		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent a significant medication error for one of 10 sampled residents, Resident 6, when the facility failed to ensure Resident 6 received: The correct dose of Insulin; A heart medication (Carvedilol); and Eye drops (Travoprost Solution) to treat his increased eye pressure (regulates the flow of fluid within the eye to maintain a normal pressure and prevent loss of vision), as ordered, and continued to receive Carvedilol (can reduce blood pressure, BP), despite specific instructions (parameters) given by the physician for when not to give the medication.	F 333		9/3/15

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F 333	Continued From page 93 These failures put Resident 6 and other residents who receive medications at risk for health complications when medications were not provided, as ordered. Findings: A review of Resident 6's record indicated he was admitted to the facility on 6/12/15 with diagnoses that included insulin dependent diabetes, high blood pressure, elevated internal eye pressure, amputation below the left knee, poor circulation in his legs, pressure ulcers right foot (two toes), and depression. a. A review of physician's orders indicated Resident 6 was to receive Levemir, a long acting insulin twice daily. On 7/1/15, the physician ordered Levemir insulin 18 units twice daily. On 7/5/15 at 10 am, the physician ordered a reduction in Levemir to 15 units twice daily. The order was noted at 11:30 am by Licensed Nurse (LN) A. On 7/6/15, the 7/2015 Medication Administration Record (MAR) was reviewed and indicated that Resident 6 received on 7/5/15 at 8 pm, Levemir 18 units, not the lesser dose of 15 units, as ordered earlier at 10 am, by the physician. The 7/2015 MAR did not show evidence that the new order for Levemir had been recorded on the 7/2015 MAR. One dose of insulin was incorrect. On 7/6/15 at 9:30 am, LN A confirmed the above finding and stated she noted the physician's order and did not record the new order for Levemir 15 units on the 7/2015 MAR.	F 333		

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F 333	Continued From page 94 On 7/6/15 at 10:30 am, the Nurse Manager confirmed the above finding and stated the nurse on 7/5/15 at 8 pm had administered an incorrect dose of insulin and the physician's orders had not been followed. b. A review of Resident 6's physician's orders for 6/12/15 included Carvedilol twice daily. On 6/13/15, the physician wrote parameters (when not to give) for Carvedilol, "hold for systolic BP less than 110" (a measurement of the pressure on the arteries during heart contraction). The 6/2015 MAR indicated Resident 6 did not receive four doses of Carvedilol on 6/13 and 6/14 at 8 am, and on 6/18 and 6/19/15 at 8 pm. The MAR and the record did not contain documentation or evidence of why the medication was not administered. The 7/2015 MAR indicated, in the directions, to give "Carvedilol twice daily and to "Hold for systolic BP less than 100." The 7/2015 MAR did not reflect the correct instructions, as ordered by the physician on 6/13/15. The 7/2015 MAR indicated on 7/1 at 8 am (BP 100/60), 7/3 at 8 am (BP 102/60) and 8 pm (BP 106/69), that Resident 6's systolic BP was less than 110, and he continued to receive Carvedilol when it should have not been given, per physician instructions. On 7/6/15 at 2:30 pm, the NM confirmed the above findings and stated the 7/2015 MAR did not correctly reflect the physician's orders to not give Carvedilol if systolic BP was less than 110, and Resident 6 had received Carvedilol when his BP was too low.	F 333		

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F 333	Continued From page 95 c. A review of Resident 6's physician's orders, dated 6/12/15, included an order for Travoprost Solution, one drop in both eyes at bedtime (hs). A review of the 6/2015 MAR indicated Resident 6 did not receive his eye drops from 6/16 through 6/30/15, for 15 days. On the back of the 6/15 MAR the nurses had indicated that Travoprost was out of stock. On 7/13/15 at 1:55 pm, the Director of Pharmacy confirmed the above findings, and stated Travoprost had not been given, as ordered.	F 333		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		9/3/15

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F 353	Continued From page 96 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff to attain and maintain residents highest practicable, physical, mental and psychosocial well-being as determined by residents individual plans of care when the facility did not have an RN for 8-consecutive hours a day, 7-days a week. Failure to have sufficient nursing staff and RN oversight contributed to inadequate supervision and a hazardous environment for residents and unwitnessed falls; substandard quality of care for Diabetic residents, and medication errors lacing residents at risk for serious adverse clinical outcomes. Findings: On 7/6/15 at 9:50 am Licensed Nurse (LN) 1 stated she had worked 22 hours straight, from 7/4 to 7/5/15, because the facility did not have a nurse to work and cover all the shifts. She stated she was late to work this morning and was tired. On 7/6/15 at 2:20 pm, LN 1 stated in the past she has worked 24 straight and covered two nursing shifts. On 7/6/15 at 3:30 pm, LN 3 stated she had worked four 12 hour shift in a row, or 48 hours in a week because there were not enough nurses to allow time off. She stated the nurses frequently worked 16 hours straight to cover the nursing shifts. On 7/6/15 at 3 pm, the Nurse Manager (NM)	F 353		

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F 353	Continued From page 97 stated that nurses should not work that much, "you can't do that, they are not robots." A review of the nursing schedule for June 2015 indicated the facility had on the schedule one Registered Nurse, (LN 2), who worked three shifts per week. On 7/8/15 at 2 pm, an interview was conducted with the Chief Nursing Officer (CNO). The CNO stated that she provided oversight when she could and she still had responsibilities at the hospital and clinic. She stated she was not always available and the hospital registered nurses were not always available and were not always interested in the issues the facility might have. The CNO stated the nurses at the facility should not have made the mistakes that have been identified during the survey.	F 353		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced	F 354		9/3/15

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by:
Based on interview and record review, the facility did not have the services of a registered nurse (RN) for at least eight-hours a day, seven-days a week.

This failed practice could potentially place residents at risk for not be able to attain and maintain their highest practicable, physical, mental and psychosocial well-being leading to negative clinical outcomes.

Findings:

On 7/6/15 at 9:50 am, Licensed Nurse (LN) 1 stated she had worked 22 hours straight, from 7/4 to 7/5/15, because the facility did not have a nurse to work and cover all the shifts. She stated she was late to work this morning and was tired. On 7/6/15 at 2:20 pm, LN 1 stated in the past she has worked 24 straight and covered two nursing shifts.

On 7/6/15 at 3:30 pm, LN 3 stated she had worked four 12 hour shift in a row, or 48 hours in a week because there were not enough nurses to allow time off. She stated the nurses frequently worked 16 hours straight to cover the nursing shifts.

On 7/6/15 at 3 pm, the Nurse Manager stated that nurses should not work that much, "you can't do that, they are not robots."

A review of the nursing schedule for June 2015 indicated the facility had on the schedule one Registered Nurse, (LN 2), who worked three shifts per week.

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F 354	Continued From page 99 On 7/8/15 at 2 pm, an interview was conducted with the Chief Nursing Officer (CNO). The CNO stated that she provided oversight when she could and she still had responsibilities at the hospital and clinic. She stated she was not always available and the hospital registered nurses were not always available and were not always interested in the issues the facility might have. The CNO stated the nurses at the facility should not have made the mistakes that have been identified during the survey. The State Survey Team recommends the waiver should NOT be granted or continued based upon survey findings.	F 354		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		9/3/15

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F 356	Continued From page 100 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet all the regulations related to posting of the Nurse Staffing Information (the total number and actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nurse Aides) on a daily basis, as required for public review, at the beginning of each shift, which made the data unavailable to residents and visitors. This failure had the potential to give residents and visitors incorrect staffing information and a false impression of the overall care being provided within the facility. Findings: Throughout the survey, 6/29-7/13/15 the Nurse Staffing Information was reviewed. The facility had three separately posted pieces of information that all related to the Nurse Staffing Information; 1. The facility's census hand written on a white board. 2. The facility's printed staffing formula (which does not change from day to day).	F 356		

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F 356	Continued From page 101 3. A clipboard on which all staff signed-in that listed their assignments. All this information was reviewed with the Unit Secretary (US), on 7/7/15 at 8:30 am, who stated that she was the one responsible for maintaining this daily posting of information. The complete regulation was reviewed with the US, who acknowledged that multiple pieces were missing (facility's name, the total number and the actual hours worked by licensed and unlicensed staff that is directly responsible for resident care per shift, resident census). The US confirmed that she had not had time to do the daily staffing calculations as required for a few weeks. The US confirmed that this system is not very readable or user friendly and would be very confusing for someone to trying to follow it.	F 356		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to provide its residents with palatable meals that were served at preferred temperatures, when 6 of 7 confidential residents and one of 10 sampled residents (Resident 7) complained of cold breakfast items being served. This failure had the potential to affect residents'	F 364		9/3/15

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F 364	Continued From page 102 quality of life and had the potential for decreased meal consumption and weight loss. Findings: a. During confidential interviews, on 6/30/15 at 1:35 pm, 6 of 7 residents complained about the palatability of breakfast food based on it not being served at their preferred temperature. b. During an interview on 7/6/15 at 1:45 pm, Resident 7 reported that she is frequently served cold fried eggs in the morning for breakfast. She reports that they arrive cold and if the staff attempts to re-heat them in the microwave, then they are usually ruined or overcooked. Resident 7 was re-admitted to the facility on 1/20/15, with diagnoses that included generalized pain and anemia. The facility's Minimum Data Set (an assessment tool), dated 4/14/15, described Resident 7 as being alert, oriented with no cognitive deficits. According to the California Retail Food Code, dated 1/2015, if the temperature of food is not correct than it will become less palatable.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		9/3/15

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility kitchen failed to use non-expired sanitizing test strips, for measuring the concentration of quaternary ammonia sanitizing solution (used for sanitizing food preparation areas). This failure had the potential for false test results and inadequate sanitization of food preparation surfaces.

Findings:

During an observation on 7/1/15 at 8 am in the kitchen, food preparation surfaces were being cleaned and sanitized by dietary staff using a solution identified as Ecolab Oasis 146 Multi-Quat Sanitizer.

The products Use Guide was reviewed. It read, "To test the solution hold a QT-40 test strip for 10 seconds to assure that the dispensed concentration is between 150-400 ppm (parts per million), preferably at least 300 ... Oasis 146 Multi-Quat Sanitizer is suppose to be able to stay in the sanitizing range for 2 to 4 hours. This will depend on the number of towels and amount of soil that has diminished the effectiveness. Be sure to check. Change when necessary."

On 7/1/15 at 8 am during an interview and concurrent observation, the Dietary Services Manager (DSM) was asked to test the concentrations of sanitizing solutions that were used for sanitizing the food preparation counters. The DSM used Hydrion QT-40 Quaternary

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F 371	Continued From page 104 (QUAT) Test Paper (the test paper strips use color code matching to measure the concentration of quaternary ammonium sanitizer solutions) to test the buckets of sanitizing solution. The test strips were then matched to the color codes on the containers and determined the concentrations of the solutions in the buckets was at 500 ppm (parts per million). She stated this process was done several times a day to ensure solutions remain at proper concentrations. The log she had posted had the previous used test strips taped to the times of day to test. The expiration date on the container of test strips that were used was 2/23/13. The DSM confirmed that the test strips were expired. DSM then searched the kitchen and found five more unopened test strip containers that had expired as well. DSM acknowledged that she needed to purchase unexpired product to ensure accurate testing. She did not acknowledge that the results of 500 ppm was actually higher than manufacturer recommendation.	F 371		
F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		9/3/15

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F 425	Continued From page 105 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement procedures to ensure the accurate administration and availability of medications for eight of 10 sampled residents (Resident 1, 2, 3, 4, 5, 6, 8, 9) and three residents outside the sample (Resident 11, 12, and 13) when: 1. The facility failed to have ordered eye drop medication available for administration for Resident 6, for 15 days. This resulted in Resident 6 not receiving necessary medication for his eye condition, and had the potential for Resident 6's eye condition to worsen and for other ordered medications to be unavailable for residents. 2. The facility failed to ensure prescribed insulin and anti-diabetic medications using blood sugar (BS) testing included physician directed parameters (Residents 1, 2, 3, 4, 5, 6, 8, 9, and 11). This contributed to substandard quality of care and immediate jeopardy to all diabetic residents placing them at risk for adverse clinical outcomes (dizziness, falls, seizures, coma and death) of	F 425		

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abnormal BS levels, due to hypoglycemia (not enough BS) or hyperglycemia (too much BS). Refer to F 428.

3. Licensed Nurse (LN) 1 did not mix medication (MiraLax) with the correct amount of water, as ordered by the physician, then left the mixed medication with residents to ingest the medication independently, thus not observing the completion of their medication administration (Residents 9, 12 and Resident 13).

This resulted in Residents 9, 12, and 13 receiving incorrectly mixed laxative medication and had the potential for residents who receive medications to not receive the ordered dose of medications, as needed, placing residents at risk for health complications when medications were not provided, as ordered.

Findings:

1. A review of Resident 6's record indicated he was admitted to the facility on 6/12/15, with diagnoses that included insulin dependent diabetes, high blood pressure, and elevated internal eye pressure.

A review of Resident 6's physician's orders, dated 6/12/15, included an order for Travoprost Solution (reduces pressure inside the eye), one drop in both eyes at bedtime (hs).

A review of the 6/2015 MAR indicated Resident 6 did not receive his eye drops from 6/16 through 6/30/15, for 15 days. On the back of the 6/2015 MAR the nurses documented the Travoprost was out of stock.

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F 425	Continued From page 107 On 7/13/15 at 1:55 pm, the Director of Pharmacy confirmed the above findings, and stated Travoprost had not been given, as ordered. 2. The physician's orders and Medication Administration records (MARs) for Residents 1, 2, 3, 4, 5, 6, 8, 9, and 11 were reviewed. There were no specific physician directed parameters for prescribed insulin and anti-diabetic medications using blood sugar (BS) testing as follows: a. A review of physician's orders indicated Resident 6's blood sugar (BS) was to be tested four times daily, and instructed to administered insulin based on the result of the BS testing (sliding scale). The record did not indicate that the physician, nurse, or pharmacist had identified and the physician had not ordered parameters (specific BS levels) when the nurse should notify the physician and/or provide treatment when Resident 6 experienced hyperglycemic (high BS levels) or hypoglycemia (low BS levels). Resident 6 experience multiple episodes of both low and high blood sugar levels. b. A review of Resident 8's record indicated he was admitted to the facility on 3/23/15, with diagnoses which included insulin dependent diabetes, anemia (low iron blood levels), and heart failure, and was transferred to the hospital on 6/23/15. A review of physician's orders dated 6/7/15, indicated Resident 8 was to have blood sugar testing three time a day before meals, and receive Humalog insulin (a fast acting insulin that lowers blood sugar) based on the results of blood sugar test. The physician ordered increasing	F 425		

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amounts (sliding scale) of Humalog starting with three units of Humalog when the blood sugar level was above 150, and increased in progressively up to a blood sugar level of 401 and higher was to receive Humalog eight units. The orders did not contain any parameters to instruct the staff in the appropriate interventions when Resident 8 had a high or a low blood sugar level.

On 7/8/15 at 3 pm, a concurrent review of Resident 6 and 8's record was conducted with the Nurse Manager. She confirmed the above findings and stated all diabetic residents need specific parameters for insulin administration.
c. Resident 2's record was reviewed. Resident 2 was admitted on 7/22/14, with diagnoses that included dementia and diabetes which required use of insulin injections.

Resident 2's physician orders, reviewed monthly since Resident 2's admission 7/22/14 through 6/2015, contained no BS parameters for physician notification of high or low BS, and no instruction from the physician on diabetic care when abnormal BS were obtained. Resident 2 was ordered Humalog (a short acting insulin injection) with dosage based on his blood sugars taken three times a day before meals (a sliding scale), and routine Lantus (a long acting insulin injection) every morning.

d. Resident 3's record was reviewed. Resident 3 was admitted to the facility on 11/20/14, with diagnoses that included dementia and diabetes which required treatment with insulin. A review of her 6/2015 MAR identified six episodes where her evening blood sugar level exceeded 300 mg/dl.

Resident 3's MDS, dated 5/5/15, identified that

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she had severe cognitive deficits, resists care, is verbally and physically abusive toward staff, and has had falls.

No physician ongoing instruction for management of low or high blood sugars or parameter notification instructions were found in her physician orders, MAR, or Diabetic care plan since admission on 11/20/14.

e. Resident 5's record was reviewed. Resident 5 was admitted to the facility on 12/14/14 with diagnoses that included a mood disorder and non insulin dependent diabetes.

A physician's order for daily BS checks was initiated on 1/22/15. No physician orders were written for BS physician notification parameters or care for high or low BS.

The Diabetes care plan did not identify notification parameters or treatment for high or low BS. The diabetes care plan included that no falls will occur, though Resident 5 had multiple falls, including a fall she reported had occurred in the am on 6/29/15. On 6/29/15 at 11:30 am during entrance tour, RNA 1 confirmed Resident 5 had a fall that am.

f. Resident 9's record was reviewed. Resident 9 was admitted on 7/3/13 with diagnoses that included chronic pain and insulin dependent diabetes.

There were no physician orders were written for BS physician notification parameters or care for high or low BS.

g. Resident 11's record was reviewed. Resident

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F 425	Continued From page 110 11 was admitted to the facility on 4/5/14 with diagnoses that included diabetes that required insulin. Resident 11 did not have parameters for BS directed by the physician for notification and care on her orders or MAR since admission. h. Resident 1 was originally admitted to the facility on 8/9/11 with a diagnosis of diabetes. Resident 1's physician's orders included: Lantus (a long acting medication that treats high blood sugar levels) 5 units subcutaneous each night with blood sugar finger stick testing to be done every Monday at noon. The orders did not contain any parameters to instruct the staff as to what to do in the cases of a high or low blood sugar levels. i. Resident 4 was originally admitted to the facility on 3/15/10 with diagnoses of diabetes, weakness and vertigo (dizziness). Resident 4's orders included: glipizide (a medication that treats high blood sugar levels) 2.5 milligrams each morning with blood sugar finger stick testing to be done every Monday and Thursday mornings. The orders did not contain any parameters to instruct the staff as to what to do in the cases of a high or low blood sugar levels. During a concurrent interview and record review, with Licensed Nurse 1 on 7/6/15 at 9 am, she confirmed that Resident 1 and 4's physician's orders did not contain treatment parameters associated with their blood sugar monitoring. On 7/1/15 at 2:25 pm, the CNO was interviewed regarding facility provided diabetic care. She stated that diabetic care is individualized by the	F 425		

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physician. The facility did not have any set protocols or policies specific for diabetic care.

On 7/1/15 at 7:15 pm, the CNO acknowledged the facility had failed to ensure the management of diabetic patients' care. On 7/1/15 at 7:15 pm, CNO provided evidence that she had obtained physician's orders for BS parameters, on all diabetic residents, and updated all diabetic resident care plans (Resident's 1, 2, 3, 4, 5, 6, 8, 9 and 11).

3. According to the Institute for Safe Medication Practices (ISMP), medications should not be left at the bedside because this could result in the accidental access and ingestion of unintended medications, especially if an unintended resident was to wander into the room.

a. On 6/30/15 at 7:50 am, 7:55 am, and 8:25 am, Licensed Nurse (LN) 1 was observed administering medications to Residents 9, 12, and 13. All three residents received MiraLax Powder (a medication given to prevent constipation) 17 g (grams) mixed into a styrofoam cup with fluid to drink. After providing the medication to the three residents, LN 1 left the room and did not observe the residents to ensure that they drank all of the provided medication.

During a concurrent interview with LN 1 on 7/6/15 at 9 am, she acknowledged she left the MiraLax with the three residents to finish independently, thus not observing the completion of their medication administration.

b. On 6/30/15 at 7:50 am, Licensed Nurse (LN) 1 was observed administering medications to Resident 9. MiraLax Powder 17 grams (a

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medication given to prevent constipation) was mixed into a styrofoam cup with water and provided to Resident 9 to drink.

A review of Resident 9's physician's orders dated 4/24/14, that read, "MiraLax Powder, give 17 grams orally in the morning... mix well in 8-ounces of water."

c. On 6/30/15 at 8:25 am, LN 1 was observed administering medications to Resident 13. MiraLax Powder 17 grams was mixed into a styrofoam cup with apple juice from a small single serve box and provided to Resident 13 to drink.

A review of Resident 13's physician's orders dated 4/15/14, that read, "MiraLax Powder, give 17 grams orally once a day... mix with 8-ounces of water or juice."

During a concurrent interview and record review, with LN 1 on 7/6/15 at 9 am, she verified that Resident 9 and 13's medication administration record and physician order's instructed to mix the MiraLax in 8-ounces of fluid. LN 1 acknowledged that she had mixed Resident 9's medication in a 5-ounce styrofoam cup and that the juice box that she used to mix Resident 13's medication contained only 4.23 ounces of juice. LN 1 stated that she had not realized that the facility's styrofoam cups were only 5-ounces. LN 1 acknowledged that she had not followed the physician's orders in regards to the amount of fluid that she had mixed both medications with.

The facility's policy titled, "Medication Regulations," dated 6/2012, indicated that no over the counter or prescription medications may be left at the resident's bedside.

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F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT 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 interview, and record review, the facility failed to ensure its pharmacist identified in the monthly medication regimen review an ongoing error in the prescribing of insulin and anti-diabetic medications using blood sugar (BS)testing without physician directed parameters for physician notification of abnormal BS levels, which could be an adverse effect of the medications prescribed for seven of ten sampled residents and one resident outside the sample (Resident 1, 2, 3, 4, 5, 8, 9, and 11). This contributed to substandard quality of care and immediate jeopardy to all diabetic residents placing them at risk for adverse clinical outcomes (dizziness, falls, seizures, coma and death) of abnormal BS levels, due to hypoglycemia (not enough BS) or hyperglycemia (too much BS). Findings: The physician's orders and Medication Administration Records (MARs) for Residents 1,	F 428		9/3/15

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F 428	Continued From page 114 2, 3, 4, 5, 6, 8, 9, and 11 were reviewed. There were no specific physician directed parameters for prescribed insulin and anti-diabetic medications using blood sugar (BS) testing. A review of the facility records of the pharmacist's monthly resident medication regimen review disclosed that a lack of BS parameters were not identified as an irregularity for the diabetic residents reviewed. The pharmacist who conducted these reviews no longer worked for the facility and could not be interviewed. A facility Nursing Administrative policy, titled, "Blood Glucose Testing using Precision Xceed Pro (a device to monitor blood sugars)," dated 7/2013, read, "If patient test results fall outside critical ranges the operator will repeat the test, contact the physician with the results of both tests, and request orders for clinical laboratory testing of the patients blood." The policy read, "Critical whole blood glucose concentrations are usually defined by the physician for each patient. If the physician chooses not to identify glucose "action limits," the following laboratory values are used: Low Limit: 40 mg/dl or less, High Limit 440 mg/dl or more." On 7/1/15 at 12:50 pm, LN 1 was asked how she cared for residents with low BS, who do not have physician prescribed parameters and directions. LN 1 stated that she would use a glucose gel tube (15 grams glucose) for blood sugars between 23 and 60 mg/dl, and if greater than 60 mg/dl would give a fast acting sugar such as orange juice or sugar packets, followed with a sandwich. LN 1 stated that she had problems with documenting her diabetic care due to her workload priorities and time. LN 1 stated that she	F 428		

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F 428	Continued From page 115 used her own judgement on what to do with residents with low BS. She stated that the physicians are not always called for notification and direction. LN 1 identified that she did not have physician ordered BS parameters or directions for diabetic care, if abnormal BS results, for Residents 1, 2, 3, 5, 9 and 11. LN 1 stated that Resident's 6 and 9 were considered "brittle diabetics" (meaning very unstable BS control). On 7/1/15 at 2:25 pm, the CNO was interviewed regarding facility provided diabetic care. She stated that diabetic care was individualized by the physician. The facility did not have any set protocols or policies specific for diabetic care. CNO stated that most diabetic residents had orders to notify the physician when BS was below 60 mg/dl and treatment is normally needed if BS was below 60 or above 400 mg/dl. CNO stated it was not uncommon in the facility to have residents with low blood sugar in the 30's and that the staff did not always need to notify the physicians to manage the situation. On 7/1/15 at 7:15 pm, the CNO acknowledged that the facility had failed in the management of diabetic residents' care. On 7/1/15 at 7:15 pm, CNO provided evidence that she had obtained physician's orders for BS parameters, on all diabetic residents. She stated that she had posted a notice to all nursing personnel of the needed changes. 6. A review of Resident 8's record indicated he was admitted to the facility on 3/23/15, with diagnoses which included insulin dependent diabetes, anemia (low iron blood levels), and heart failure, and was transferred to the hospital on 6/23/15.	F 428		

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F 428	Continued From page 116 A review of physician's orders dated 6/7/15, indicated Resident 8 was to have blood sugar testing three time a day before meals, and receive Humalog insulin (a fast acting insulin that lowers blood sugar) based on the results of blood sugar test. The physician ordered increasing amounts (sliding scale) of Humalog starting with three units of Humalog when the blood sugar level was above 150, and increases progressively up to a blood sugar level of 401 and higher was to receive Humalog eight units. The orders did not contain any parameters to instruct the staff in the appropriate interventions when Resident 8 had a high or a low blood sugar level. On 7/8/15 at 3 pm, a concurrent review of Resident 6 and 8's record was conducted with the Nurse Manager. She confirmed the above findings and stated all diabetic residents needed specific parameters for insulin administration and she confirmed that Resident 6 and 8's pharmacist had not identified these concerns during the most recent pharmacy review. 7. Resident 1 was originally admitted to the facility on 8/9/11, with diagnoses of diabetes, catastrophic stroke and generalized pain. Resident 1's record contained a care plan titled, "Diabetes," which was initiated on 12/14/11, that indicated a goal to was to have his blood sugars remain within physician ordered parameters. Resident 1's physician's orders included; Lantus (a long acting medication that treats high blood sugar levels) 5 units subcutaneous each night with blood sugar finger stick testing to be done	F 428		

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F 428	Continued From page 117 every Monday at noon. The orders did not contain any parameters to instruct the staff as to what to do in the cases of a high or low blood sugar levels. 8. Resident 4 was originally admitted to the facility on 3/15/10, with diagnoses of diabetes, weakness and vertigo (dizziness). Resident 4's record contained an undated care plan titled, "Diabetes," that indicated a goal to have her blood sugars remain within physician ordered parameters. Resident 4's orders included; glipizide (a medication that treats high blood sugar levels) 2.5 milligrams each morning with blood sugar finger stick testing to be done every Monday and Thursday mornings. The orders did not contain any parameters to instruct the staff as to what to do in the cases of a high or low blood sugar levels. During a concurrent interview and record review, with Licensed Nurse (LN) 1 on 7/6/15 at 9 am, she confirmed that Resident 1 and 4's pharmacist had not identified these concerns during the most recent pharmacy review.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		9/3/15

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F 431	Continued From page 118 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor the temperature in the medication storage area at the nurse's station. This failure had the potential for stored medications to become ineffective and deteriorate due to lack of monitoring. Findings:	F 431		

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F 431	Continued From page 119 During a concurrent interview and observation, with Licensed Nurse (LN) 1 on 7/1/15 at 10:45 am, the alcove directly adjacent to the nurse's station used as for medication storage area was inspected. LN 1 stated that the facility did not routinely monitor or document the temperatures in this area. LN 1 further acknowledged that there was currently no thermometer present in that area. On 7/13/15 at 2:50 pm, LN 1 pointed out that a thermometer had been installed and the facility was in the process of developing a flowsheet to monitor the temperature each shift. The facility policy titled, "Drug Storage Area Inspections," dated 6/2012, indicated that drug storage areas will be inspected on a regularly scheduled basis. According to the United States Pharmacopoeia guidelines; the facility should ensure that medications and biological's are stored at the appropriate temperature, a medication storage room should be 59° F (Fahrenheit) to 85° F.	F 431		
F 457 SS=B	483.70(d)(1)(i) BEDROOMS ACCOMMODATE NO MORE THAN 4 RESIDENTS Bedrooms must accommodate no more than four residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility allowed two of ten resident	F 457		9/3/15

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F 457	Continued From page 120 bedrooms to accommodate more than four residents. This had the potential for inadequate care to be delivered to the residents in those rooms. (Rooms 227 and 232) Findings: During an observation on 6/29/15 at 10:30 am, resident Rooms 227 and 232 were observed to contain five beds each. Room 227 was currently occupied by four residents, with 1 empty bed prepared to accommodate a resident. Room 232 had 2 residents with 3 beds prepared to accommodate residents. Room 227 allowed 91.55 square feet per resident and Room 232 allowed 91.12 square feet per resident. The residents in Rooms 227 and 232 had sufficient privacy and adequate space for their personal belongings and furniture. There was reasonable space for the provision of nursing care and services without the overcrowding of overbed tables, televisions, wheelchairs, oxygen concentrators, and ample space for the use of lift equipment. No resident complaints were identified. On 6/29/15 at 9:45 am, the Chief Nursing Officer confirmed that resident Rooms 227 and 232 accommodated, or were prepared to accommodate, five residents each and presented a waiver which had been granted by the Centers for Medicare and Medicaid Services (CMS) dated 10/18/14. Recommendation by State Survey Team: Facility to re-apply for waiver to CMS and the waiver could be continued based upon above findings.	F 457		

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F 461	Continued From page 121	F 461		
F 461 SS=D	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had one of ten rooms that did not have a window to the outside of the facility. This had the potential for a decline in the residents health and mood due to a lack of	F 461		9/3/15

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F 461	Continued From page 122 orientation to day/night and a general awareness of space outside the facility. (Room 223). Findings: On 6/29/15 at 9:45 am, the Chief Nursing Officer stated during the entrance conference that she was aware that one room in the facility may not contain a window to the outside of the facility (Room 223). During an observation on 6/29/15 at 10:45 am, Resident 1 was observed in Room 223, this room had a window which opened into a solarium (a room fitted with extensive areas of glass to admit sunlight) style room that was used as an employee break area. The room had functioning window blinds to provide adequate privacy to Resident 1. There was sufficient privacy and adequate space for his personal belongings and furniture. There was reasonable space for the provision of nursing care and services without the overcrowding of overbed tables, televisions, wheelchairs, oxygen concentrators, and ample space for the use of lift equipment. No resident or family complaints were identified. Recommendation by State Survey Team: Facility to apply for waiver/variance to CMS and the waiver could be granted based upon above findings.	F 461		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system	F 463		9/3/15

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F 463	Continued From page 123 from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's call light system in one of five resident bathrooms was not functioning. This had the potential to result in accidents with injuries and unmet toileting needs if residents were unable to get assistance when needed. Findings: During the environmental tour on 7/1/15 starting at 9 am, with the Director of Plant Operations (DPO), it was noted that the call light system in the shared bathroom for Rooms 230 and 232 was not functioning. The DPO stated that he was aware of this problem and was in the process of repairing the system. He had installed a manual bell attached to the wall for residents to use if assistance was needed. During an interview on 7/1/15 at 10:30 am, Licensed Nurse (LN) 1 was knowledgeable about the manual bell in this bathroom and that the staff had been instructed to listen for it and assist as needed. LN 1 reported that of the five residents who were assigned to use this bathroom, only three could independently use the bathroom without needing staff assistance.	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		9/3/15

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F 465	Continued From page 124 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for its residents, staff and visitors when multiple environmental concerns were observed throughout the survey. This had the potential for accidents and or injuries, emotional distress and the spread of infection to residents, staff and visitors. Findings: 1. On 7/1/15 starting at 9 am, concurrent observations and interviews were conducted during the general environmental tour of the facility with the Director of Plant Operations (DPO) and the Lead Technician (LT). The following items were noted and verified with the DPO and LT: a. Patio screen door leading to the outside fenced in courtyard had multiple rips and tears, which could potentially allow insects to enter the facility. b. A garden hose was left laying across the fenced in courtyard which could pose a potential trip hazard. c. Two buckets of exterior paint were on the ground near the outside employee break area. d. One large oxygen cylinder was not properly	F 465		

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F 465	Continued From page 125 chained and/or secured in the outside locked medical gas storage area. e. Propane BBQ grill left inside the fenced in courtyard area. The DPO stated that this item should have been removed following the resident's BBQ on 6/30/15. g. Three outside unlocked and unsecured sheds; two contained resident care equipment (extra bedside commodes, walkers, beds, etc...) and one contained activities supplies. h. The activities shed contained two empty or partially empty helium tanks. According to the written safety information provided by the DPO, helium tanks needed to be stored in a cool, dry and well-ventilated area.	F 465		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's Administrator (Admin, also the hospital's Chief Executive Officer, CEO) failed to effectively administer resident care and services to attain residents' highest practicable level of physical, mental, and psychosocial well-being by failing to ensure: The facility had current policies and procedures (P&P) for resident care, the implementation of such policies to provide of quality of care to its	F 490		9/3/15

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F 490	Continued From page 126 residents, and to have an effectively functioning Quality Assurance (QA) committee which identified the deficient areas in the delivery of services and resident outcomes. These failures contributed to an immediate jeopardy (IJ) situation, substandard quality of care, and avoidable harm to residents. Refer to F157, F226, F271, F279, F281, F309, F314, F323, F329, F333, F353, F354, F371, F425, F428, F465, F493, F501, F505, F514, and F520. Findings: A review of the facility's undated, "Bylaws" indicated on page 18, The Chief Executive officer shall report to the Board (Governing Body) and is responsible for implementation of policies which provide the framework for patient care and overall operation of the facility. A review of the Skilled Nursing Manual approval sheet indicated the last review of the facility policies was conducted on 7/6/12, and the policies for the facility had not been recently reviewed and were not current. On 7/9/15 at 9:40 am, the Admin stated the facility did not have in the recent past capable nursing leadership. The expectation was for the Chief Nursing Officer to provide oversight through explaining issues to him. The facility was not the number one item for him to address and make sure they were following regulations, and there were many issues issues to address in the five months he had been appointed the Admin/CEO of the facility and hospital. He stated he had relied	F 490		

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F 490	Continued From page 127 on the present medical staff to manage the facility. He stated the facility should be a part of the hospital wide QI system.	F 490		
F 493 SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Governing Body (GB), failed to ensure its legal responsibility for the management and operation of the facility, and that the Administrator (Admin) effectively administered the facility and implemented resident care policies and procedures. These failures contributed to an immediate jeopardy (IJ) situation, substandard quality of care, and avoidable harm to residents. Refer to F157, F226, F271, F279, F281, F309, F314, F323, F329, F333, F353, F354, F371, F425, F428, F465, F490, F501, F505, F514, and F520. Findings:	F 493		9/3/15

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F 493	Continued From page 128 A undated document titled, "The Responsibility and Accountability of the Medical Director of Skilled Nursing (MDSN) to the Medical Staff and Administration" was reviewed and included: All activities performed within the hospital are ultimately the responsibility of the hospital governing body. Each organizational entity of the hospital is accountable to the Board via Administration. A document titled, "Mountain Communities Healthcare District, Bylaws" indicated on page 9, Board meetings of the member of the Board (Gov Body) are held monthly. The Board shall be responsible for the operation of the facility. Attending is Medical Staff representation, Chief Executive Officer, and other staff. The GB (Board) meeting notes from 1/2015 through 6/2015 were reviewed on 7/8/15 at 3:15 pm. The notes indicated the facility's census was reviewed at each meeting and the next planned activity or outing was reviewed. The facility Nurse Manager was present on 1/7/15, the Chief Nursing Officer was present on 4/29/15 and 6/24/15. The notes did not include a discussion or identify issues regarding resident care or the facility's quality concerns. On 7/8/15 at 3:20 pm, the Executive Assistant confirmed the notes accurately and reflected the Boards discussions.	F 493		
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.	F 501		9/3/15

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F 501	Continued From page 129 The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and policy review, the Medical Director (MD) failed to ensure that resident care policies and procedures (P&Ps) were implemented and oversight and coordination of medical care was provided that promoted optimal resident outcomes when the MD failed to: Provide oversight and ensure the facility's ability to provide safe and appropriate care for diabetic residents. Ensure that staff was knowledgeable and appropriately trained to provide diabetic care. Provide oversight and ensure that resident's diabetic care plans were developed, reviewed, and revised. Provide oversight and ensure the facility's P&P for falls were followed, care plans were developed, reviewed, and revised, and all residents received appropriate post-fall care. Ensure the Quality Assurance (QA) Committee developed action plans to identify failed facility systems which included: diabetic care, post fall follow-up, incomplete physician orders, and incomplete drug regime review and pharmacy oversight. Ensure the facility's policies were reviewed, and	F 501		

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F 501	Continued From page 130 updated for administrative, operational and patient care delivery. These failures contributed to an immediate jeopardy (IJ) situation, substandard quality of care, and avoidable harm to residents. Refer to F157, F226, F271, F279, F281, F309, F314, F323, F329, F333, F353, F354, F371, F425, F428, F465, F490, F493, F505, F514, and F520. Findings: A undated document titled, "The Responsibility and Accountability of the Medical Director of Skilled Nursing to the Medical Staff and Administration" was reviewed and directed the following: The MD has control or responsibility over the skilled nursing unit. The director must do a certain degree of supervision. The MD: 1. Regularly assesses the activities of the skilled nursing unit by personal observation and evaluation. 2. Regularly consults with supervisors and staff. 3. Administers policies that have been established. 4. Maintains a cognizance (understanding) of all pertinent local, stated and federal statutes that apply to the operation of the skilled nursing unit in compliance with these statutes. On 7/8/15 at 1 pm, the MD stated his role included to review the policy manual and look at changes in policies. A concurrent review with the MD of the Skilled Nursing Manual approval sheet indicated the last review of the facility policies	F 501		

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F 501	Continued From page 131 was conducted on 7/6/12. MD acknowledged the policy review was not current. MD stated he was not aware there was confusion about diabetic treatment or orders, and that no one had brought that concern to his attention. He stated diabetic care was important to address. He stated the previous nursing director and managers were marginal and there has been a lack of leadership. He stated sometimes care issues were brought to the medical staff, and falls and infection control issues were reviewed quarterly. When asked about the facility's quality program (QI) he stated there were meetings in the past and there had not been a meeting for months. He stated there were concerns about the licensed nurse (LN) coverage and the LN's having to use their own judgement to make decisions, and not having clear orders or instructions to treat residents. MD stated leadership in nursing had been an issue.	F 501		
F 505 SS=E	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promptly notify the physician of abnormal blood sugar (BS) levels for four of ten sampled residents (Residents 2, 3, 5, and 9). This failure placed Residents 2, 3, 5, and 9 at risk for adverse clinical outcomes (dizziness, falls, seizures, coma and death) of abnormal BS levels, due to hypoglycemia (not enough BS) or hyperglycemia (too much BS).	F 505		9/3/15

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F 505	Continued From page 132	F 505		

Findings:

A facility policy titled, "Notification of Patient/Resident's Physician," reviewed 1/2012, read, "All attempts to notify physicians shall be noted in the resident's health record .... Immediately notify of significant abnormal lab results."

The American Diabetes Association (ADA) identifies Hypoglycemia (low blood sugar) as a blood sugar (BS) below 70 milligrams per deciliter (mg/dl) and Hyperglycemia (high blood sugar) as BS above 240 mg/dl, and that each individual may have differing symptoms as a result of these abnormal BS levels. The ADA indicates BS goals for the elderly population are dependant on the complexity and existence of other medical conditions and identifies general BS goal guidance in the elderly population for fasting (before eating) BS as 90 to 180 mg/dl and bedtime BS as 90 to 200 mg/dl.

A facility Nursing Administrative policy, titled, "Blood Glucose Testing using Precision Xceed Pro (a device for measuring level of sugar in the blood)," dated 7/2013, read, "If patient test results fall outside critical ranges the operator will repeat the test, contact the physician with the results of both tests, and request orders for clinical laboratory testing of the patient's blood. Critical whole blood glucose concentrations are usually defined by the physician for each patient. If the physician chooses not to identify glucose action limits, the following laboratory values are used: Low Limit: 40 mg/dl or less, High Limit 440 mg/dl or more."

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F 505	Continued From page 133 On 7/1/15 at 12:50 pm, LN 1 was asked how she cares for residents with low BS, who do not have physician prescribed parameters and directions for care. LN 1 stated she would use a glucose gel tube (15 grams of glucose) for blood sugars between 23 and 60 mg/dl, if greater than 60 mg/dl, would give a fast acting sugar such as orange juice or sugar packets, followed with a sandwich. LN 1 stated it was often difficult to contact a Registered Nurse (RN) to ask what to do for residents with low BS, that she had no facility guidance, or standard protocols on diabetic care, that the skilled nursing unit went a few months without a full time RN charge nurse and does not staff a charge RN on weekends. She stated that the charge RN would usually make the calls to the physician when on duty. She stated that the Chief Nursing Officer (CNO) was often unavailable. LN 1 stated that she had problems with documenting her diabetic care due to her workload priorities and time. LN 1 stated she used her own judgement on what to do with residents with low BS. She stated the physicians were not always called for notification and direction. a. Resident 2's record was reviewed. Resident 2 was admitted on 7/22/14 with diagnoses that included dementia and diabetes that required use of insulin injections. Resident 2's physician orders, reviewed monthly since Resident 2's admission from 7/22/14 through 6/2015, contained no BS parameters for physician notification of high or low BS, and no instruction from the physician on diabetic care when abnormal BS results were obtained. Resident 2 was ordered Humalog (a short acting	F 505		

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F 505	Continued From page 134	F 505		

insulin injection) with dosage based on his blood sugars taken three times a day before meals (a sliding scale), and routine Lantus (a long acting insulin injection) every morning.

Resident 2's "Diabetes" care plan, initiated 7/22/14, identified goals included, "Blood Sugar will remain within physician parameters." No BS parameters were identified on the care plan or physician orders. Interventions listed on the care plan included "Labs as ordered. Report abnormal values promptly."

On 7/13/15, Resident 2's Medication Administration Records (MARs) from 3/1/15 to 6/30/15 were reviewed and they indicated Resident 2 had low BS (below 60 mg/dl) 24 times, seven of these were below 40 mg/dl with the lowest recorded of 32 mg/dl.

On 7/13/15 at 3 pm, during a concurrent interview and record review with Medical Records Staff (MRS), she stated none of the 24 reviewed episodes of low BS had licensed nursing documentation of physician notification or narrative nursing notes related to any actions and follow up to the abnormal BS levels. Resident 2 did not have an order to obtain BS prior to bed. Of the 24 low BS (below 60) reviewed, 18 were at the 7 am BS test.

b. Resident 3's record was reviewed. Resident 3 was admitted to the facility on 11/20/14 with diagnoses that included dementia and diabetes which required treatment with insulin.

A review of her 6/2015 MAR identified six episodes where evening BS levels exceeded 300 mg/dl. There was no documented physician

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F 505	Continued From page 135 notification. No physician instruction for management of low or high blood sugars or parameter notification instructions were found in her physician's orders, MAR, or Diabetic care plan since admission on 11/20/14. c. Resident 5's record was reviewed. Resident 5 was admitted to the facility on 12/14/14 with a diagnosis of non insulin dependant diabetes. She had an order for daily blood sugar checks initiated on 1/22/15. No physician orders were written for BS physician notification parameters or care for high or low BS. Her current diabetes care plan did not identify notification parameters or treatment for high or low BS. There was no documentation of physician notification for abnormal BS levels. d. Resident 9's record was reviewed. Resident 9 was admitted on 7/3/13 with a diagnosis of insulin dependent diabetes. Resident 9's nurses notes, dated on 4/9/15 at 3 pm, indicated Resident 9's BS was 22 mg/dl, the physician was notified, and she was sent to hospital for evaluation. On 4/13/15 at 2:20 am, a nurses note indicated Resident 9 was requesting that her BS be checked. Her BS was 45 mg/dl. There were no nurses notes on 4/13/15 to indicate that the physician was notified or what further care was provided. A nurses note, dated 7/3/15 and timed 12 pm,	F 505		

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F 505	Continued From page 136 indicated, "Resident blood sugar dropped to 48. She refused any juice or snack." The next nurse's note was not written until 7/3/15 at 8 pm (eight hours later) and read, "Resident's 5 pm BS was greater than 500. Previous nurse called MD (physician) and received order for one time dose 12 units Novolog (insulin injection) and to re-check BS in one hour. At 6:10 pm, BS was still greater than 500. Attempted to contact MD. Was finally able to talk with MD and received order for one time dose of 4 units Novolog SQ (subcutaneous - under the skin) and to re-check BS at 9 pm. Order to contact MD if still greater than 500. Resident not complaining of any signs or symptoms of hyperglycemia. Does not appear hot. Will monitor." The 7/3/15 nurses progress notes did not reflect that the MD was notified of the low BS and Resident 9's refusal of juice or snacks at 12 noon, per her care plan and physician orders, written 7/1/15, to contact the physician if BS was below 60 mg/dl. On 7/1/15 at 2:25 pm, the CNO was interviewed regarding facility provided diabetic care. She stated diabetic care was individualized by the physician. The facility did not have any set protocols or policies specific for diabetic care. The CNO stated most diabetic residents had orders to notify the physician when BS was below 60 mg/dl and treatment was normally needed if BS was below 60 or above 400 mg/dl. The CNO stated it was not uncommon in the facility to have residents with low blood sugar in the 30s and the staff did not always need to notify the physicians to manage the situation.	F 505		
F 514	483.75(l)(1) RES	F 514		9/3/15

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F 514 SS=E	Continued From page 137 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate medical records for 9 of 10 sampled residents (Residents 1, 2, 3, 4, 5, 6, 8, 9, and 10) and one resident outside the sample (Resident 11) when the residents' records were incomplete, not accurate, and did not clearly reflect the resident's status as follows: 1. a. For Resident 6, the Medication Administration Record (MAR) was incomplete and did not include the appropriate document information including: resident's name, medication allergy, room number, the document month, and page number, an error in transcribing the physician's order for BP (blood pressure) medications (carvedilol and lisinopril), the results of diabetic testing, the amount of insulin given based on the testing results, the injection site of the insulin, and which staff administered the	F 514		

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F 514	Continued From page 138 insulin. b. For Resident 8, the amount of ordered Coumadin (a blood thinner) was transcribed incorrectly and the administered dose was unclear. 2. For Resident 1, the 6/2015 MAR, related to the administration of his Fentanyl (powerful narcotic) pain patch, was inconsistent and/or missing information. 3. For Resident 10, documentation of the disposition of the resident's personal property following their death was not complete. 4. For Residents 4 and 10, documentation following falls was not complete. 5. For Resident 2, physician notificaiton of abnormal blood sugar (BS) levels was not documented. 6. For Residents 3, 5, 9 and 11, medical records contained ommissions of documentation on the MAR (initials for administration and allergies), inadequate documentation of falls/bed alarm, nutritional supplement administration, and abnormal blood sugar level parameters and/or physician notification of abnormal values. These failures had the potential for inaccurate information pertaining to each resident's care and services which could result in medication administration errors, reporting of incorrect information to health care providers, and the residents' individual needs going unmet. Findings:	F 514		

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F 514	Continued From page 139	F 514		

1. Resident 6's and 8's MARs, physician orders, and nurses notes were reviewed and verified concurrently with the Nurse Manager on 7/6/15 at 2:30 pm as follows:

a. Resident 6 was admitted to the facility on 6/12/15, with diagnoses of diabetes, high blood pressure (BP), and a pressure ulcer. The physician's orders, dated 6/12/15, page one, indicated, Resident 6 was allergic to three medications, "Allergies: Ativan (antianxiety), Celebrex (anti-inflammatory) and Haldol (antipsychotic).

The bottom of each of the MAR pages contained a space to include a resident's name, room number, physician's name, diagnosis, medical record number, sex, date of birth, allergies, and current month and year. Both the 6/2015 and 7/2015 MARs were blank in the allergy section of the MAR pages. The 7/2015 MAR pages were hand written and indicated the resident name and room number on the first page, and the remaining pages indicated his name and month only, and the remaining sections were blank.

A review of Resident 6's physician's orders, dated 6/18/15, included parameters (instructions when not to give) for BP medications carvedilol and lisinopril, "Hold for systolic BP less than 110" (a measurement of the pressure on the arteries during heart contraction).

Resident 6's 7/2015 MAR indicated incorrect directions to give "Carvedilol twice daily" and to "Hold for systolic BP less than 100." The 7/2015 MAR did not reflect the correct instructions as ordered by the physician on 6/18/15, and this

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resulted in a medication error when Resident 6 continued to receive Carvedilol on 7/1, and 7/3/15, and his systolic BP was less than 110.

The 6/2015 MAR indicated Resident 6 received insulin on a sliding scale (medication amount is based on the blood sugar test). The entries on 6/20, 6/21, 6/25, 6/26, 6/28, 6/29, and 6/30/15 were difficult to read and the amount of insulin, the site of the insulin injection, and the blood sugar test results were difficult to read.

b. A review of Resident 8's record indicated he was admitted to the facility on 3/23/15, with diagnoses which included diabetes, heart failure, post cardiac surgery, and anemia (low iron blood levels). Resident 8 received Coumadin (a blood thinner) based on his blood tests.

On 5/4/15, the physician ordered Coumadin 5 milligrams (mg) daily, and on 5/11/15, the physician changed the mg amount and ordered Coumadin 5.5 mg daily. The 5/2015 MAR indicated from 5/5 to 5/11/15, Resident 8 received an unclear amount of Coumadin, and the record indicated either 5 mg or 5.5 mg of Coumadin was given because staff had drawn a line through the 5 mg amount, changed the dose to 5.5 mg, then recorded, "See new order 5/11/15."

The 6/2015 MAR, page 1, indicated, "Coumadin, give 56 mg," start 5/11/15. There was a hand written 6 next to the pre-printed 5, and the dose read, 56 mg, and the 6/2015 MAR indicated this dose (an extremely excessive, potentially lethal amount) was given from 6/1 to 6/15/15.

The Nurse Manager (NM) verified the above findings and stated the MAR's were incomplete

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and not legible. The NM stated the nurses did not follow the correct procedure to document or make changes to the MAR's and it was difficult to understand the amount of insulin Resident 6 had received and the amount of Coumadin Resident 8 had actually received.

A facility reference, titled, "Clinical Nursing Skills," 8th Edition, Chapter 4, 4-2 Documenting Nurses' Progress Notes, instructed, "Documentation needs to reflect patient care. Nurses record assessment data, changes in a patient's condition, nursing interventions .... Prompt documentation ... increases accuracy and promotes effective communication to all members of the health team."

A policy, dated 7/13, titled, "Charting error Corrections," instructed, specific steps must be taken as careless alterations create the appearance of tampering. Draw a single line through each line of inaccurate material, making certain that it is still legible. Date and Initial.

A policy, dated 2012, titled, "Noting Physician Orders," instructed, "If the order is to change the directions of a current medication. Stop the order on the current MAR and make a new entry."
2. Resident 1 was originally admitted to the facility on 8/9/11, with diagnoses of diabetes, catastrophic stroke and generalized pain.

On 7/6/15 at 9 am, an interview and concurrent record review was conducted with Licensed Nurse (LN) 1. She confirmed there was inconsistent and/or missing information on Resident 1's MAR for the month of 6/2015, related to the administration of his Fentanyl (powerful narcotic) pain patch. According to the

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F 514	Continued From page 142 MAR, this pain patch was not signed out on 6/2 and 6/14. This medication was signed out as given on the facility's Controlled Substance Record and the placement of this patch was being monitored and checked off each shift on the MAR. The facility's policy titled, "Medication Regulations," dated 6/12, indicated that all medications administered are documented on the MAR for each dose of medication administered, immediately after administration is complete... Administration of all controlled substances must be documented on the patient's MAR. 3. Resident 10 was originally admitted to the facility on 11/1/13, with diagnoses of dementia, skin cancer and partial hemiplegia (paralysis). Resident 10 expired on 5/13/15. Resident 10's record contained an inventory list that was dated 11/1/13, that listed his personal belongings that had been brought into the facility. This form had an area to document the receipt for valuables when they are returned to the family or resident that had not been completed. Resident 10's record contained a nursing note dated, 5/13/15, which indicated that the resident's belongings had been placed in a locked cabinet following his expiration. No further documentation was made in Resident 10's record regarding the disposition of his property. On 7/7/15 at 4:30 pm, an interview and concurrent record review was conducted with the Nurse Manager. She confirmed that there was no documentation regarding the disposition of Resident 10's belongings following his death.	F 514		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOSPITAL	60 EASTER AVENUE WEAVERVILLE, CA 96093

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F 514	Continued From page 143 The facility's policy titled, "Valuables Care of Possessions and Equipment," dated 1/12, indicated that upon discharge, or other disposition of valuables, resident or resident's family is to sign the left portion of the label. This signed label that was attached to the valuables envelope was to be placed permanently in the medical record. 4. a. Resident 10 experienced two witnessed falls on 9/23 and 10/19/14. Resident 10 experienced two unwitnessed falls on 1/3 and 2/23/15. b. Resident 4 was originally admitted to the facility on 3/15/10, with diagnoses of diabetes, weakness and vertigo (dizziness). On 6/27 and 7/3/15, Resident 4 slid out of her bed and was found on the floor without sustaining any injuries. During a concurrent interview and record review, with the Nurse Manager on 7/7/15 at 4:30 pm, she confirmed that the follow-up charting which would include the resident fall flowsheet, neurological check flowsheet and updating the fall care plans were all incomplete following Resident 4 and 10's falls. During an interview with the Director of Staff Development on 7/8/15 at 4:30 pm, he acknowledged that there was inconsistent fall documentation throughout the facility. The facility's policy titled, "Chart Audits- in House on Going Reviews," dated 1/12, indicated the health record would be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient. 5. Resident 2's record was reviewed. Resident 2	F 514		

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F 514	Continued From page 144	F 514		

was admitted on 7/22/14 with diagnoses that included dementia and diabetes that required use of insulin injections.

Resident 2's MARs showed abnormal BS on 7/1/15 at 7 am of 59, 6/29/15 at 7 am of 57, 6/15/15 at 7 am of 32, 6/10/15 at 5 pm of 44, 6/5/15 at 7 am of 52, 5/30/15 at 7 am of 51, 5/23/15 at 7 am of 52, 5/20/15 at 5 pm of 42, 5/17/15 at 7 am of 46, 5/9/15 at 7 am of 52, 5/4/15 of 37 and recheck of 48 at 7 am, 4/29/15 at 7 am of 22 and recheck of 35 did not have any documentation of follow up notification to the physician.

On 7/13/15 at 2:30 pm, MRD acknowledged that follow up notification and documentation was not done for a combined total from 2/27/15 to 7/1/15 of 22 episodes of hypoglycemia (low blood sugar).

6. a. Resident 3's record was reviewed. Resident 3 was admitted to the facility on 11/20/14 with diagnoses that included dementia and diabetes which required treatment with insulin.

A review of her 6/2015 MAR identified six episodes where evening blood sugar exceeded 300 mg/dl.

No physician ongoing instruction for management of low or high blood sugars or parameter notification instructions were found in her physician orders, MAR, or Diabetic care plan since admission on 11/20/14.

A neurological check sheet was incomplete for a fall on 5/11/15.

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F 514	Continued From page 145 Resident 3's MAR for 7/2015 did not contain allergies or birthday on every page. Her 6/2015 MAR had BP omissions on six separate dates. A check for bed alarms was not documented five times in 6/2015. Resident 3's supplement taken 5 times a day was not documented at all for 15 days and for 11 days omitted at least one dose in 6/2015 MAR. b. Resident 5's record was reviewed. Resident 5 was admitted to the facility on 12/14/14 with diagnoses that included a mood disorder and non insulin dependant diabetes. She had an order for daily blood sugar checks initiated on 1/22/15. No physician orders were written for BS physician notification parameters or care for high or low BS. Her diabetes care plan did not identify notification parameters or treatment for high or low BS. Resident 5's fall flow sheet was incomplete for 72 hour post fall documentation for falls on 6/29/15, 4/5/15, 2/22/15, 2/1/15, 1/29/15 and 12/19/14 . c. Resident 9's record was reviewed. Resident 9 was admitted on 7/3/13 with diagnoses that included chronic pain and insulin dependent diabetes. On 4/13/15 at 2:20 am a nurse's note read that Resident 9 was requesting that her BS be checked. Her BS was 45 mg/dl. She accepted a snack, but refused follow up with repeat of BS test. No nurse's notes were made on 4/13/15 to indicate that the physician was notified or what further care was provided.	F 514		

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F 514	Continued From page 146 The 7/3/15 nurse's progress notes did not reflect that the MD was notified of a low BS and Resident 9's refusal of juice or snacks at 12 noon as per her care plan and physician orders written 7/1/15 to contact physician if BS was below 60 mg/dl. The 7/3/15 note did not reflect how her BS went from 48 mg/dl to greater than 500 mg/dl in five hours. On 7/8/15 at 3:10 pm, the facility Director of Staff Development (DSD) stated that he was aware of a breakdown in communication between physicians and nurses. DSD stated he gave training to licensed staff related to medication pass and documentation of insulin refusals during the month of 5/2015. He stated that his concern with the documentation in Resident 9's record was what prompted the in-service training. d. Resident 11's record was reviewed. Resident 11 was admitted to the facility on 4/5/14 with diagnoses that included diabetes that required insulin. Resident 11 did not have parameters for BS directed by the physician for notification and care on her orders or MAR since admit. The above documentation errors were acknowledged during a interview and record review with MRD on 7/13/15 at 2:30 pm.	F 514		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520		9/3/15

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F 520	Continued From page 147 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's quality assessment and assurance committee (QAA) failed to identify, develop, and implement appropriate plans of action to ensure deficient areas in the delivery of services and resident outcomes were corrected or improved when the facility failed to: 1. Identify the diabetic care process was not safe and appropriate. 2. Ensure the policy and procedures were followed to potentially reduce avoidable falls/accidents and other adverse clinical outcomes. 3. Ensure the residents' records accurately	F 520		

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F 520	Continued From page 148 reflected resident care. 4. Maintain clinical records to current standards (legible, complete and accurate). These failures resulted in the facility's inability to identify quality deficiencies and develop action plans and contributed to an Immediate Jeopardy situation, substandard quality of care, and the potential to adversely affect the safety and well-being of all residents. Refer to F157, F226, F271, F279, F281, F309, F314, F323, F329, F333, F353, F354, F371, F425, F428, F465, F505, F514, and F520. Findings: On 7/8/15 at 9, the CNO (Chief Nursing Officer) stated the previous Nurse Manager had been responsible for the QI program at the facility. She stated the facility's QI program had previously been a part of the hospital wide QI program and in December 2014, the Nurse Manager had decided to have a separate QI program for the facility. The CNO stated the previous Nurse Manager left in March 2015, and that she was not aware of the facility's current QI program, or action plans for improvement at the facility. The CNO stated that on 6/29/15, the facility had planned to train the facility staff and the new facility Nurse Manager in the new process. She stated the QI program for the facility would be managed by the hospital's current Continuous Quality Improvement (CQI) Nurse. The CNO stated other departments had always continued to include the facility in the QI process and identify the needs of the facility within their departments (infection control, housekeeping,	F 520		

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F 520	Continued From page 149	F 520		

maintenance, and dietary). The CNO stated the facility's Nursing Department had not identified or followed-up with specific QI projects in 2015.

On 7/8/15 at 11:40 am, Licensed Nurse A stated she was not aware of any QI projects, and was not aware if there was a QI committee for the facility.

On 7/8/15 at 11:30 am, the Unit Secretary stated that she had been informed she would gather information for the QI committee, and that she had not been trained how she would gather the information.

On 7/8/15 at 1 pm, the Medical Director stated he was not aware if the facility had a QI program, and it had been months since he had been informed of any improvement projects for the facility.

On 7/13/15 at 9:30 am, the CQI Nurse stated she had been recently informed the facility's QI program would also become a part of the hospital wide program. She stated some of the facility's information was currently part of the hospital's CQI program, such as falls and infection control, but she was not aware of any specific actions plans for the facility or their specific issues. The CQI Nurse stated each department of the facility would be represented at the CQI meeting, and would include the facility's Nurse Manager.

A document titled, Mountain Communities Healthcare District, dated 1/29/12, Section 8.3, "Quality Assurance ..." included, "The board shall also require mechanisms to assure the provision of one level of care ..., and to assure that patients with the same health problem are receiving a

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F 520	Continued From page 150 consistent level of care."	F 520		