STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	12/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 11/30/15 and completed on 12/02/15, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident interview, the facility failed to implement an individualized activity program for 1 of 15 sampled residents (Resident #10) dependent on staff for assistance. Failure to implement an individualized activity program to respond to the interests and current capabilities of Resident #10 has the potential to affect her physical, cognitive, and emotional health. Findings include: Review of the facility policy titled "ACTIVITY PROGRAM" occurred on 12/02/15. This policy, reviewed December 2015, stated, ". . . Villa Maria shall have an activity program . . . appropriate to the needs and interests of each resident . . . The program . . . shall promote the . . . psychosocial and intellectual well-being of each resident. . . ."	F 248	1. It is the practice of this facility to provide an activity program that meets the resident□s individual needs and interests. Staff members who work with Resident #10 were educated to keep the music player and talking books within her reach. Education also included turning off roommate'□s music when roommate is not in the room and to assist/encourage roommate to use earphones when both residents are in the room. Case managers were educated to document activities in EHR (electronic health record) for Resident #10. Resident #10 was also offered a room change and declined available room. 2. Residents will be identified through a report from our computer software from MDS Section B1000 who are coded 3 or 4.	1/6/16

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

Electronically Signed | 12/17/2015

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F 248	Continued From page 1 Review of Resident #10's medical record occurred on all days of survey. Diagnoses included cerebral infarction, blindness, and anxiety. The annual Minimal Data Set (MDS), dated 10/23/15, identified intact cognition and requires extensive-to-total assistance for all activities of daily living, except eating and hygiene. The current care plan identified, ". . . My areas of possible preferred activities are: Spiritual services, Music events . . . invite to reading group as accepts, nail care, exercise group. . . . I need assistance/escort to activity functions. . . . Provide me with materials for individual activities as desired. I like the following independent activities: I have audio tapes for listening to novels, guidepost and radio tapes in my room to listen to music and news. . . ." Observations of Resident #10 showed the following: * On 12/01/15 at 8:00 a.m., A certified nurse assistant (CNA) (#2) and an unidentified student nurse provided Resident #10's morning cares. The CNA (#2) and the unidentified student nurse moved Resident #10's tape deck out of her reach prior to repositioning her in the recliner and leaving the room. * On 12/01/15 at 9:25 a.m., The CNA (#2) assisted Resident #10's with her restorative therapy exercises. During the session, an activity staff member (#3) knocked, entered Resident #10's room, and invited her to the group exercise program that was in progress in the resident lounge. (This was the only invitation to an activity observed throughout the survey.) * Throughout the survey, staff and/or Resident	F 248	3. Staff will be educated to document activities done with the residents identified above. An Activities Tool will be developed so any staff member can record an activity with a resident. The case managers will utilize this tool for documentation purposes. Activity documentation may be added as tasks in the POC (Point of Care) so the RAs are able to document on activities. The activities policy has been updated to reflect that activity documentation will be included in POC and/or progress notes. Case managers will continue to individualize activities for residents that are visually impaired. 4. A quality audit will be conducted for residents who are coded 3 or 4 as above. The audit will be conducted monthly for the first quarter and quarterly as needed. This audit will be completed by case managers. 5. The facility will have corrective actions implemented and be in substantial compliance by January 6, 2016.	

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F 248	Continued From page 2 #10's non-English speaking roommate left her foreign music playing loudly (the music could be heard in the resident lounge area) whether she was in their room or not. A psychiatric report, dated 04/23/15, identified, ". . . Reports occasional increases in anxiety . . . Talked about her roommate; states she would like a roommate she can talk to. . . ." The resident activity record identified the following: * October 01-31, 2015, The activity staff recorded "cognitive activity, creative activity, physical activity, spiritual activity, and staff 1:1's" as the activities of the day on 9/31 days. * November 01-30, 2015, The activity staff recorded "creative activity, physical activity, and special activity" as the activities of the day on 9/30 days. * December 01-2, 2015, The activity staff recorded "physical activity and staff 1:1's" as the activities of the day on 2/2 days. (Observation showed Resident #10 was invited to one activity throughout the survey; which she did not attend.) During a resident interview on the afternoon of 12/02/15, when asked if she is invited to/attends facility activities, Resident #10 stated, "Not to many." The facility failed to implement an individualized activity program and/or make environmental allowances for Resident #10's visual deficits and social needs.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		1/6/16

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F 278	Continued From page 3 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 1 of 1 sampled resident (Resident #19) coded incorrectly for	F 278	1. It is the practice of this facility to complete the MDS accurately following the RAI user'□s manual guidelines. The MDS for resident #19 was corrected and resubmitted to the State and CMS. 2. The facility acknowledges that the coding of E0100A, hallucinations, did not	

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F 278	Continued From page 4 hallucinations. Failure to accurately complete the MDS does not allow each resident's assessment to guide the creation of an effective care plan. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, page E-1, stated, "Hallucination The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch." Page E-2 stated, "Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis . . ." Review of Resident #19's medical record occurred on December 1-2. 2015. Diagnoses included history of anxiety. The MDSs, dated 08/18/15 and 11/18/15, identified Resident #19 exhibited hallucinations during the seven day assessment period. Review of the medical record failed to identify any hallucinations exhibited by Resident #19 during the MDS assessment period. During an interview on the afternoon of 12/02/15, an administrative nurse (#1) failed to locate documentation of any hallucinations observed during the seven day assessment period.	F 278	meet the intent of the RAI user'□s manual. A report was generated from the facility MDS software to identify current residents who had question E0100A answered as "Yes." The documentation during reference periods was reviewed to ensure coding was correct. There were no other coding errors of Section E0100A found. 3. All case managers and MDS nurses were educated on ensuring documentation is present prior to coding "Yes" in Section E0100A, hallucinations, on the MDS. 4. A report will be completed through the MDS software for any "yes" answers to MDS question E0100A. An audit will be completed to ensure the documentation supports coding "yes" to E0100A. This audit will be done monthly for one quarter and then quarterly as needed. The first audit was completed and there were no errors found in E0100A. The quality audit will be conducted by an MDS nurse. 5. The facility will have corrective actions implemented and be in substantial compliance by January 6, 2016.	
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	F 314		1/6/16

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F 314	Continued From page 5 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, record review, and staff interview, the facility failed to provide necessary treatment and services to promote healing of pressure ulcers for 1 of 2 sampled residents (Resident #8) with a current pressure ulcer. Failure to implement pressure-relieving interventions as care planned may result in delayed healing or the development of new pressure ulcers. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, peripheral vascular disease, and a left heel pressure ulcer. The current MDS, dated 09/09/15, identified extensive assistance from two or more people for bed mobility, and a stage 3 pressure ulcer present on admission. Resident #8's current care plan stated, ". . . I have an alteration or potential for an alteration in my skin integrity related to: . . . pressure area to left heel present on admission . . . Interventions . . . I have Pressure Relieving strategies of Pressure relieving W/C [wheelchair] cushion and pressure relief boots while in bed but I refuse at times. Float heels at all times with pillows. . . ." The following observations showed showed staff	F 314	1. It is the practice of our facility to provide pressure relieving interventions that promote healing and avoid worsening or development of new pressure ulcers. For Resident #8, attempts were made to correctly float heels, both by using a thicker pillow and by using two pillows. These attempts were unsuccessful as they caused discomfort to Resident #8's legs. Also, Resident #8 continued to refuse the pressure relieving boots, so a new brand was obtained and offered to Resident #8. Education was provided on the new boots and Resident #8 wears them in bed according to personal preference. Resident #8 is on a level 2 mattress (RestQ Comfortex). Per manufacturer, "A 6-chamber Suspension System floats heels while keeping the lower legs level..." With this mattress in place, Resident #8's heels are floated regardless of refusals of pillow and/or pressure relieving boots. As of December 15, 2015, the heel ulcer on Resident #8 is resolved. 2. A report was generated from the EHR to identify all residents with heel ulcers and all residents who are care planned to have their heels floated.	

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F 314	Continued From page 6 failed to float Resident #8's heels and/or offer pressure relieving boots as care planned: *11/30/15 at 1:27 p.m.: A certified nursing assistant (CNA) (#10) transferred Resident #8 to bed and placed a pillow under her lower legs/feet. Observation showed the resident's heels rested on the pillow. *12/01/15 at 7:53 a.m.: Resident #8 resting in bed with a pillow under her lower legs. Observation showed her heels rested directly on the mattress. *12/01/15 at 11:20 a.m.: A CNA (#11) transferred Resident #8 to bed and placed a pillow under her lower legs. Observation showed the resident's heels rested directly on the mattress. *12/01/15 at 3:06 p.m.: A CNA (#12) transferred Resident #8 to bed and placed a pillow under her lower legs. Observation showed the resident's heels rested on the pillow. *12/01/15 at 5:35 p.m.: A CNA (#9) transferred Resident #8 to bed and placed a pillow under her lower legs/feet. Observation showed the resident's heels rested on the pillow. During an interview on 12/02/15 at 3:05 p.m., a supervisory nurse (#13) agreed staff should ensure Resident #8's heels do not rest directly on the pillow/mattress while in bed.	F 314	3. Direct care staff will be educated to ensure care planned interventions for those residents with heel ulcers are in place and on how to float heels properly. The staff will also be educated to report any difficulty or noncompliance with strategies to float heels. 4. A quality audit will be conducted for residents who are care planned to have heels floated to make sure heels are floated properly. A second quality audit will be conducted for residents that have heel ulcers to make sure appropriate interventions are in place. These audits will be completed weekly for four weeks, then monthly for the rest of the quarter and quarterly as needed. This audit will be completed by the RN Unit Managers. 5. The facility will have corrective actions implemented and be in substantial compliance by January 6, 2016	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care;	F 328		1/6/16

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F 328	Continued From page 7 Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 2 of 5 sampled residents (Resident #2 and #7) with orders for oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications and/or hospitalization related to oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like many medication, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, congestive heart failure, dyspnea, and mild cognitive impairment. The physician orders stated, ". . . Oxygen at 2-5	F 328	1. It is the practice of our facility that residents receive proper treatments, including respiratory care. For resident #7, Just In Time training was provided to direct caregivers on the lane that Resident #7 resides. This education included having the portable oxygen filled and turned on each morning prior to Resident #7 getting up. The portable oxygen is then refilled at the end of the day shift (one oxygen canister lasts eight hours) and remains on per nasal cannula. With HS cares for resident #7, the portable oxygen is shut off and the oxygen concentrator is turned on and oxygen administered via nasal cannula. The concentrator is only used at night. Resident #2 no longer resides in facility. 2. Residents that utilize oxygen have the potential to be affected. These residents are able to be identified through a report from our computer software. 3. Direct care staff will be educated on proper use of oxygen concentrators and portable oxygen units. This will include setting oxygen rates, turning devices on/off, and filling portable canisters. In addition to the Physician□'s Orders, the information on resident oxygen use can be found on the RA (resident assistant)	

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F 328	Continued From page 8 liter via nasal cannula every shift . . ." The resident's current care plan stated, ". . . I have, altered respiratory status/Difficulty Breathing related to: COPD [chronic obstructive pulmonary disease]/Emphysema, Hx [history] of Respiratory Failure, Impaired breathing mechanics, hx aspiration pneumonia, Increased secretions, CHF [congestive heart failure]. . . Give me oxygen as ordered by the physician . . ." Observations showed the following: * 11/30/15 at 2:21 p.m.: Resident #7 seated in the lounge wearing a nasal cannula connected to a portable oxygen tank set at zero. The certified nursing assistant (CNA) (#15) assisted the resident to her room and into the bathroom. The CNA (#15) assisted the resident back to the lounge and the portable oxygen tank remained at zero. * 11/30/15 at 2:33 p.m.: The CNA (#16) checked on Resident #7 seated in the lounge. The CNA (#16) noted the portable oxygen tank set at zero, and that the oxygen tank was empty. The CNA (#16) assisted the resident back into her room and connected the resident's nasal cannula/tubing to the room oxygen concentrator set at 2 liters. * 11/30/15 at 2:40 p.m.: The CNA (#16) returned to Resident #7's room with a filled portable oxygen tank. The CNA (#16) unattached the resident's oxygen tubing from the room oxygen concentrator and attached it to the portable oxygen tank. The portable oxygen tank remained at zero. * 11/30/15 at 4:30 p.m.: Resident #7 seated in her recliner with the resident's nasal cannula/tubing attached to the room oxygen	F 328	lane sheet tool and also on the eTAR (electronic treatment administration record). 4. A quality audit will be completed to ensure that residents using oxygen have their oxygen turned on at the ordered rate and that the portable oxygen units are not empty. This audit will be completed weekly for two weeks, monthly for the remainder of the quarter, and then quarterly as needed. This audit will be completed by the RN Unit Managers. 5. The facility will have corrective actions implemented and be in substantial compliance by January 6, 2016.	

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F 328	Continued From page 9	F 328		

concentrator set on zero. The portable oxygen tank was observed hanging from the resident's walker, unattached from the resident's oxygen tubing and set at 2 liters.
* 12/01/15 at 7:54 a.m.: Resident #7 in the restorative therapy room utilizing the Nu Step. The resident had on her nasal cannula which was attached to the portable oxygen tank and set on zero.
* 12/02/15 at 8:01 a.m.: Resident #7's oxygen tubing and nasal cannula laying on the floor of the resident's room.
* 12/02/15 at 8:04 a.m.: Resident #7 observed in the restorative therapy room exercising her upper extremities using the arm bike. The resident was wearing the oxygen nasal cannula attached to the portable oxygen tank. The portable oxygen tank remained at zero.

During an interview on 12/02/15 at 2:46 p.m., a supervisory nurse (#14) stated it is the responsibility of the CNAs and the nurses to make sure portable oxygen tanks are on and set as ordered. She stated nurses should be checking the oxygen tank settings if a resident ambulates from one room to another. The supervisory nurse stated the oxygen tubing and the nasal cannula should not be on the floor.

The facility staff failed to ensure Resident #7's received oxygen via an oxygen tank and an oxygen concentrator as ordered by the physician, failed to ensure the oxygen tanks contained oxygen, and ensure the tanks and concentrators were set at the appropriate rate.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses

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F 328	Continued From page 10 included dementia and cerebrovascular disease. The resident's current care plan stated, ". . . I am receiving end of life comfort care due to end stage dementia with weakness, poor intake, and weight loss . . . Interventions . . . Oxygen as ordered for comfort. . . ." Current physician's orders stated, ". . . O2 [oxygen] per nasal cannula for comfort 0-4 liters every shift for comfort. . . ." Observation on 11/30/15 at 4:13 p.m. showed Resident #2 resting in bed with oxygen via nasal cannula at two liters. Two CNAs (#7 and #8) transferred Resident #2 to her wheelchair using a sit-to-stand mechanical lift. One CNA (#8) changed Resident #2's oxygen source from the concentrator to a portable oxygen tank on the back of the resident's wheelchair. The CNA failed to turn the oxygen tank on and transported the resident to the lounge area.	F 328		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide food or fluids in a form designed to meet the resident's needs for 1 of 8 sample residents (Resident #13) with altered texture diets. Failure to provide a mechanical soft diet with nectar thickened liquids to the resident as ordered increases the risk of aspiration, pneumonia, and dehydration.	F 365	1. It is the practice of our facility to provide food prepared in a form designed to meet the individual needs of residents. For Resident #13, RN Unit Manager spoke with resident regarding her current diet texture orders and her preference to eat mixed nuts. A conference call with the son, case manager, dietician, and RN	1/6/16

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F 365	Continued From page 11 Findings include: - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included dementia, schizophrenia, gastro-esophageal reflux disease, constipation, dyspepsia, dysphagia, and dry mouth. The current care plan stated, ". . . Focus . . . I have ADL [activity of daily living] self care performance deficits . . . Interventions . . . Eating: I require set up, prompting, and cueing assistance to eat. . . . . Focus . . . I have nutritional problems or potential for nutritional problems related to: Schizophrenia, hyponatremia, HTN [hypertension], lactose intol. [intolerance] and depression. . . . I am at risk for dysphagia and need altered tx [texture]. . . . Interventions . . . . Provide and serve mechanical soft diet with low lactose and Dysph [dysphagia] mech [mechanical] soft food tx. and nectar thick liquids as ordered. . . . I require staff assist with set up, cues, enc. [encouragement], and supervision . . . Staff will offer me adequate nutrition . . . Focus . . . I am at risk for, dehydration or potential for unstable fluid status related to : Dx [diagnosis] schizophrenia, HTN, need for thickened liquids . . . Interventions . . . Offer and encourage me to drink 1600 cc [cubic centimeters] of nectar thickened fluids of choice in 24 hrs [hours]. Ensure I have access to nectar thickened liquids of choice whenever possible. I need set up, cues, encouragement and supervision with fluid intake in order to meet daily requirements. . . ." - Observation on 11/30/15 at 1:34 p.m. showed a CNA (certified nurse aide) (#15) assist Resident #13 from the recliner chair to the dining room	F 365	Unit Manager was also held. Food textures were discussed along with resident□'s desire to have foods of choice. Son aware of risks and requested that resident be given textures as tolerated per resident preference. An order was obtained for diet textures as tolerated. 2. Residents that receive mechanical soft diet textures have the potential to be affected. A report was generated from our EHR to identify residents with mechanical soft diets. 3. Education will be provided to dietary staff and direct care staff to report any non-compliance or requests for foods that are not part of the recommended diet textures. The location of information regarding altered texture diets will also be reviewed. 4. A quality audit will be completed to ensure that residents who have a mechanical soft diet ordered are receiving the correct food texture and any non-compliance or request for any other food textures will be reported. This audit will be completed weekly for two weeks, monthly for the remainder of the quarter, and then quarterly as needed. The audit will be completed by the RN Unit Manager. 5. The facility will have corrective actions implemented and be in substantial compliance by January 6, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	12/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 365	Continued From page 12 table in the Eastlyn unit lounge. The CNA (#17) obtained the resident a roast beef sandwich and a lunch bag containing mixed nuts as per the resident's request, and placed them in front of the resident. Observation showed no nectar thickened liquid provided to Resident #13 during this snack. The CNA (#17) sat with Resident #13 to supervise her snack time, the CNA (#17) switched off with the CNA (#18) to continue supervising Resident #13 during her snack and watched the resident consume the mixed nuts. Both the CNAs (#17 & #18) failed to provide a nectar thickened liquid during her snack time and failed to notify the nurse of Resident #13's request to eat mixed nuts. During an interview on 12/01/15 at 4:14 p.m., a licensed dietician (#19) stated mixed nuts and peanuts are not considered an appropriate texture for a mechanical soft diet. During an interview on 12/02/15 at 2:46 p.m., a supervisory nurse (#14) stated she expected the CNAs to notify the nurse and ask if giving the mixed nuts/peanuts was appropriate for Resident #13's dietary restriction of a mechanical soft diet. The facility failed to ensure Resident #13 consumed a snack meal consisting of a mechanical soft texture with nectar thickened liquids.	F 365		
F 431 SS=D	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	F 431		1/6/16

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F 431	Continued From page 13 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically 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, record review, review of facility policy, professional literature review, and staff interview, the facility failed to ensure proper labeling of medications during 1 of 7 observations of medication pass. Failure to ensure the insulin pen label matched the	F 431	1. It is the practice of our facility that medications are properly labeled. Pharmacy was notified for a new label on for Resident #17□'s insulin pen. The label was delivered and the insulin pen was relabeled by pharmacy.	

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F 431	Continued From page 14 physician's order and the medication administration record (MAR) may result in a medication error. Findings include: Review of the facility policy and procedure titled "Pharmacy: Nursing Protocols" occurred on 12/02/15. This policy, dated November 2015, stated, ". . . 6) When a new order requires an updated label, the pharmacy will be notified to send out a new label consistent with the new order. . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 9th Edition, dated 2012, page 863 stated, ". . . Compare the label of the medication against the MAR." Observation during medication pass on 12/01/15 at 10:17 a.m. showed Resident #17 received NovoLog insulin. The label on the NovoLog vial stated to inject 20 units at breakfast. Resident #17's MAR and physician's orders stated to inject 24 units at breakfast. Review of Resident #17's physician's order identified the order changed from 20 to 24 units of NovoLog insulin on 11/16/15, and the facility initiated the change on 11/17/15. During an interview on 12/01/15 at 10:20 a.m. a licensed nurse (#4) confirmed Resident #17's NovoLog order changed 15 days earlier.	F 431	2. Residents that receive insulin have the potential to be affected. All insulin pens in facility were checked to ensure that the label matched the eMAR (electronic medication administration record) and Physician'□s Order. All insulin pens were found to be correctly labeled according to the eMAR and Physician'□s Order. 3. The Director of Nursing contacted the pharmacist and developed the following process for delivering insulin labels. With any insulin order change the pharmacy will call to identify how many pens the facility currently has for that particular resident. Pharmacy will bring the corresponding number of updated labels and affix them to each insulin pen. Nursing staff will be educated on the change in process and the importance of ensuring the correct label is on the pen. 4. A quality audit will be completed on residents who receive insulin to ensure label, eMAR, and Physician□'s Order match. This audit will be completed weekly for four weeks, then monthly for the remainder of the quarter, then quarterly as needed. These audits will be completed by the RN Unit Manager. 5. The facility will have corrective actions implemented and be in substantial compliance by January 6, 2016.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential	F 456		1/6/16

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F 456	Continued From page 15 mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure 1 of 3 microwaves observed in dietary areas of the facility remained in safe working order. Failure to maintain a microwave in safe working order has the potential to become a fire hazard. Findings include: During the dietary tour on 11/30/15 at 3:00 p.m. with an administrative dietary member (#6), observation of the microwave in the North nourishment center, near the resident lounge, showed an area of the door melted and a damaged area, triangular in shape approximately 2 inches long and 1.5 inches at the widest point with exposed wires, at the left lower back corner. At the time of the observation, the dietary member (#6) stated she did know of the damage to the microwave and agreed it was not safe. The dietary member placed an out-of-order sign on the microwave and directed staff to call maintenance. The environmental tour occurred on 12/01/15 at 2:00 p.m. with an administrative maintenance member (#5). When asked about the microwave, this staff member stated the microwaves go out about every three months and they are replaced. The maintenance member (#5) identified staff did not report the damaged microwave until the	F 456	1. It is the practice of the facility to maintain equipment in a safe operating condition. The microwave in the North nourishment center was replaced with a new microwave. 2. The remaining two microwaves were inspected for any damaged areas and none were found. 3. Staff will be educated to report and log any damaged or malfunctioning microwaves. Maintenance will replace any damaged or malfunctioning microwaves. 4. A quality audit will be completed to ensure microwaves are in safe working order. This audit will be completed monthly for the first quarter, then quarterly as needed. This audit will be completed by the Environmental Director. 5. The facility will have corrective actions implemented and be in substantial compliance by January 6, 2016.	

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F 456	Continued From page 16 dietary tour on 11/30/15.	F 456		