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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105492	A. BUILDING ______ B. WING ______	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WEST PALM BEACH	**1626 DAVIS RD WEST PALM BEACH, FL 33406**

(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 An unannounced Recertification survey was conducted on 09/19/2016 through 09/22/2016 at Consulate Healthcare of West Palm Beach. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	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, interview and record review the facility failed to provide activities in accordance with the comprehensive assessment and interest of the residents, for 1 (Resident #217) of 3 residents reviewed for Activities, of a sample of 17 residents interviewed. The findings included: During an interview on 09/20/16 at 9:18 AM Resident #217 was asked, "Does staff provide items so you can do activities on your own, like books or cards?" Resident #217 responded, "No." During this interview Resident #217 explained that she is at the facility because of an ______ to her An device was also noted to her right . The resident explained that it is difficult for her to get out of bed, and that she prefers to be in her room. She stated that she prefers independent activities.	F 248	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law. This plan of correction will serve as the Facility's allegation of substantial compliance. What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #217 Activity of choice was reviewed with	10/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 10/11/2016

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

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F 248	Continued From page 1 On 09/20/16 at 3:14 PM and 09/21/16 at 10:34 AM Resident #217 was noted to be out of her room. As per her roommate, Resident #217 was at physician appointments. During a subsequent interview on 09/21/16 at 12:50 PM Resident #217 stated that she was frustrated as she has had numerous physician appointments, and when she returns she is worn out, again stating that she prefers to be in her room. When asked again if staff have offered her anything to do in her room, she stated they had not. When asked if she had any books or cards she again stated that she did not have either, and volunteered, "I live for cards." Resident #217 explained that she plays cards with a group and enjoys Solitaire. She stated that she bought an electronic Solitaire game, but can't get it to work. When asked if she would like a deck of cards, Resident #217 stated that she would love a deck of cards to play Solitaire. Review of the record revealed Resident #217 was admitted to the facility on with diagnoses to include a . Review of the admission MDS (Minimum Data Set) comprehensive assessment dated documented Resident #217 has a BIMS (Brief Interview for Mental Status) score of out of , indicating she is and . Review of the Activity Preferences section of this assessment documented it is very important for her to have books, newspapers and magazines to read. This comprehensive assessment also documented that it is very important for her to have her favorite activities. Review of the Activities Evaluation, completed on	F 248	resident and a deck of cards was provided. How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken: Current residents were re-interviewed for their preferences in activities, changes were made accordingly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Activity director and staff were in-serviced on providing activity per resident choice and interest. Activity director will review new admission and current residents on their initial and quarterly assessment to ensure resident received activity of their choice. AD/designee will report findings monthly to QA until substantial compliance is maintained.	

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by the Activities Director, documented Resident #217 was and interested in activities, cooperative and motivated. This assessment documented current interests that are very important to the resident as animals/pets, cards, family/friend visits, movies, music, reading and television. Although this assessment documented the card interest as a "small group" activity, Resident #217 stated that she enjoys both small group and independent playing of cards.

Review of the current activities care plan documented Resident #217 prefers to stay in her room and that her interests included card games, coffee hour, food, snacks, in room visits, music, book club, and TV.

During an interview on 09/22/16 at 12:30 PM the Activity Director confirmed she completes the activities initial assessments. When asked about Resident #217, the Activity Director stated that she doesn't like to be in groups and she wants to be in . The Activity Director further stated that Resident #217 is very friendly, likes to watch TV, and likes to read. The Activity Director stated she offered Resident #217 magazines and books when she first got here. Stated that she offers items to read each Friday by going door to door with a cart. When asked if she documents this or documents if any resident accepts anything, the Activity Director stated that she does not. The Activity Director agreed that her assessment for Resident #217 included cards, and stated that she never thought to offer her cards as she "had a Solitaire game on the machine." When told that her machine didn't work the Activity Director stated that she did not know that. When asked if and when she re-assesses her interventions, the

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F 248	Continued From page 3 Activity Director stated that she does it quarterly. The Activity Director stated that she had not re-assessed Resident #217.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. 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 observation, interview and record	F 278	What corrective action(s) will be	10/22/16

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review the facility failed to ensure accurate MDS (Minimum Data Set) assessments for 2 (Resident #103 and #46) of 6 sampled residents reviewed for behaviors and unnecessary medication review, of a total of 19 residents whose MDS assessments were reviewed.

The findings included:

1) An observation on 09/20/16 at 3:03 PM revealed Resident #103 quietly lying in bed with her eyes closed. A (an device used for residents at risk for) was noted to her right . During a subsequent observation on 09/21/16 at 2:25 PM Resident #103 was observed in the common area, sitting next to her . Resident #103 was calm and conversing in with staff.

Review of the record revealed Resident #103 was admitted to the facility on / with diagnoses to include and . Review of the 90 day significant change MDS (Minimum Data Set) assessment dated documented Resident #103 exhibited behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others), 1 to 3 days during the assessment look back period of one week.

Review of the monthly Behavior Symptom Monitoring Flow records for the months of 2016 through 2016 lacked any documented behaviors. Review of the nurse's notes for the month of 2016 lacked any documented behaviors. Review of the Medication Follow-Up visit dated / documented Resident #103 was doing fair, no overt ,

F 278

accomplished for those residents affected by the deficient practice?

Resident #46 and #103 were reassessed to reflect their behavior and their medication administration. Social worker in-serviced on the importance of the accuracy of coding resident behavior.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:

Current resident's MDS with behavior and medication administration were reviewed: those affected by this alleged deficient practice were corrected accordingly.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

MDS/CP teams were in-serviced on MDS accuracy. MDS coordinator or designee will review MDS assessment weekly to ensure accuracy.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.

MDS coordinator or designee will report findings to QA monthly until substantial compliance is maintained.

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patient is with no complaints and no . Review of the Mediation Evaluation dated / documented the only behaviors as refusing to get out of bed and at times, and

During an interview on 09/21/16 at 2:31 PM, Staff N, the CNA (Certified Nursing Assistant) assigned to Resident #103, who has worked at the facility for 3 years, stated Resident #103 does not have any behaviors, and hasn't had any. Staff N stated Resident #103 has always been nice.

During an interview on 09/21/16 at 2:38 PM, Staff G, the RN (Registered Nurse) assigned to Resident #103, who has worked at the facility for about 5 years stated the resident likes to stay in her room or with her roommate. Staff G stated Resident #103 was transferred to this unit on . When asked if the resident has any behaviors, Staff G stated that she sometimes doesn't want to go to the dining room, and that she has a poor appetite. Staff G stated the resident was , thus the was placed. Staff G stated that she had not seen any behaviors for Resident #103 and confirmed that if the resident had had any behaviors, she would document them on the Behavior Symptoms Monitoring Flow Sheet.

On 09/21/16 at 4:28 PM Staff E, an RN and Unit Manager confirmed documentation of behaviors are on the Behavior Symptoms Monitoring Flow Sheet, and stated the resident's behavior for has improved.

During an interview on 09/21/16 at 4:34 PM the SSD (Social Services Director) confirmed she completes the behavior section of the MDS. The

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SSD was asked about the assessment dated , and she referred to her notes. The SSD stated that Resident #103 had behavior symptoms directed toward others. When asked how she determined this, the SSD stated that the staff would have reported it to her and/or it was observed. The SSD did not recall observing any behaviors for Resident #103 and was unable to locate any documented behavior in the record.

During an interview on 09/22/16 at 10:54 AM the DON (Director of Nursing) agreed with the findings and stated that she spoke with each CNA and nurse who usually care for Resident #103, and they all agreed to the lack of behaviors. The DON further explained that she has been doing so well that she has had two medication dose reductions since her admission. The DON acknowledged the MDS inaccuracy.

2) Resident #46 was admitted to the facility in of 2014 with diagnoses that include and .

A physician order was written on for [ ], 75 mg, to be administered once a day at bedtime for ; and a pysician order was written on / / for [ ], 50 mg, to be administered each morning for .

A review of the Annual MDS assessment, dated , and the latest quarterly MDS assessment, dated , shows no medication being administered on any day during the lookback periods for either of these assesessment dates; however, these same MDS assessments completed on and

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F 278	Continued From page 7 do document the administration of an on all 7 days of the lookback periods. A review of the physician order summary for 2016 and 2016 documents the medication was on the Medication Administration Summary for both months and should have been administered each day during these months. No documenation or additional physician orders showing changes in the original order for daily administration of [,] was found within the resident's medical record. A review of the MAR for Resident #46 documents that the medication, [ ], 75 mg, was administered to this resident every evening at bedtime from , 2016 - , 2016 and from 1, 2016 - , 2016.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		10/22/16

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F 280	Continued From page 8 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to update the care plan for 2 of 19 residents reviewed. Resident #161 and Resident #64's care plans were not revised concerning the addition of for resident #161 and bathing preferences for Resident #64. The findings included: 1. A review of the clinical record reveals Resident #161 was admitted to the facility on with diagnoses which included , with features. On the changed her medications to include an medication, 0.5 mg twice a day. A review of the current care plan for the resident did not address the addition of the . The area on the care plan for medications was not checked for the resident. On 9/20/16 at 4:13 PM, the Director of Nursing acknowledged the care plan had omissions. In an interview on 09/21/2016 10:06 AM the MDS consultant stated the addition of the alone would not trigger a significant change on the Minimum Data Set (MDS), but the care plan should have been updated to include the .		What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #161 care plan was reviewed to reflect medication usage. Resident #61 care plan was reviewed to reflect bathing preference. How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken. Current residents with medication their care plan were reviewed none were identified of this alleged deficient practice. Current residents CP were revised to ensure bathing/shower and refusals were addressed accordingly. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: CP team were in-serviced on care plan	

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2) During an interview on 09/19/16 at 2:00 PM Resident #64 was asked, "Do you choose how many times a week you take a bath or shower?" Resident #64 responded "No, I only get bed baths." During a subsequent interview on 09/20/16 at 3:25 PM Resident #64 confirmed that she isn't getting showers. She stated that she did get one a week or so ago and "They decided that they can't do it. It's because my is so " During a third interview on 09/22/16 at 9:41 AM Resident #64 stated that when she tried showering awhile back, it was difficult and "the girls thought I was too " so the resident decided bed baths were ok. Resident #64 stated that she has gotten occasional showers, but would like more. Resident #64 stated that she hasn't told anyone recently about her desire for more showers.

Review of the record revealed Resident #64 was admitted to the facility on with a readmission on . Review of the significant change MDS (Minimum Data Set) assessment dated documented Resident #64 has a BIMS (Brief Interview for Mental Status) score of indicating she has problems. This MDS assessment also documented the resident stated it was somewhat important to choose between a tub bath, shower, bed bath or sponge bath.

Review of the physician orders for 2016 documented, "Daily bed bath per patient preference." This order was originally from / . Review of the MDS Kardex for use by the CNA's (Certified Nursing Assistants), it was handwritten in large letters, "Refuses showers."

F 280

accuracy. CP coordinator or designee will audit medication, bathing preference and refusals weekly to ensure accuracy.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.

Care plan coordinator/designee will report findings monthly to QAPI until substantial compliance maintained.

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F 280	Continued From page 10 Review of the current care plans for Resident #64 lacked any documentation of the order for bed baths per resident preference or of the resident's refusal of showers. The current ADL (activities of daily living) care plan simply documented numerous intervention for the provision of bathing. The only intervention related to showers documented, "Provide resident with a sponge bath when a shower cannot be tolerated." This ADL care plan was initiated on / and most recently updated on During an interview on 09/22/16 at 8:52 AM Staff H, a CNA who has worked at the facility for 7 years confirmed that Resident #64 needs to for that she gets both bed baths and showers, but sometimes refuses the showers. During subsequent interviews on 09/22/16 at approximately 10:30 AM both the Unit Manager and DON (Director of Nursing) stated that they have tried showers in the past, and Resident #64 gets very upset with the process. The DON agreed that the care plan lacked the refusal of showers and order for bed baths, and agreed that it had not been revised.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		10/22/16

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This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility failed to provide the necessary care and services for 1 of 1 residents reviewed (Resident # 65), as evidenced by the facility nursing staff failing to assure that medications are administered before and after as ordered by the physician to ensure optimal timing to maximize effectiveness and avoid adverse effects of the medications.

The findings included:

The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included and

The resident was scheduled to receive treatments in a community facility three days a week leaving the facility at 12:30 PM and returning after 5:00 PM on Monday, Wednesday and Friday. The following monthly physician orders were not followed to ensure the resident received the prescribed medications as ordered on days:

1. A physician order prescribed for the resident to receive 50 mg give one tablet by mouth once daily. Hold on days until after on Monday, Wednesday, and Friday. Administration time of 9:00 AM. The Medication Administration Record (MAR) documented the prescription and noted the nurses placed their initials in the appropriate boxes indicating the medication was

What corrective action(s) will be accomplished for those residents affected by the deficient practice?

Resident #65 was reassessed; meds were reviewed to ensure administration before or after per doctor's order.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:

Current residents receiving with medications were reviewed none was identified by this alleged deficient practice.

What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur:

Nursing staff were educated on following doctor's order of residents. Unit Manager will check MAR twice weekly to ensure accuracy.
Findings will be reported to the DCS.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place

DCS/designee will report findings to QAPI monthly until substantial compliance is maintained.

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CONSULATE HEALTH CARE OF WEST PALM BEACH	1626 DAVIS RD WEST PALM BEACH, FL 33406

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administered daily at 9:00 AM with no differentiation on days that the medication was held and given after for 6 of 8 times the resident went to in on and .

2. A physician order prescribed for the resident to receive 0.1 mg by mouth every 8 hours for greater than hold for less than with administration times of 6:00 AM, 2:00 PM and 10:00 PM.
The MAR documented 7 times at the 2:00 PM dose, the nurse circled their initials indicating that the medication was not administered (; which are days the resident was at at 2:00 PM). However the back of the MAR documented 2 of the 7 circled doses on and the " not given because the resident was at ".

An interview was conducted on 09/21/16 at 9:25 AM with Staff C, Registered Nurse, regarding medications for the resident. She stated she gives the 9:00 AM medications to the resident as indicated. She will hold the but she remembers the center asking for them to give the resident the medication because her had been but she needed to follow up on this.

An interview was conducted on 09/21/16 at 10:10 AM with Staff B, Unit Manager and the Assistant Director of Nursing. The surveyor reviewed with the staff regarding the resident's medication administration. Concerns were identified regarding the resident's and administration. The

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F 309	Continued From page 13 prescription prescribes for the medication to be held on , days and given after the resident returns from , . The nurses documented that the medication was administered at 9:00 AM daily and not held on , days as prescribed. The staff confirmed that the documentation indicated that the nurses did not follow the physician order for administration on , days. Furthermore regarding the order, the staff noted the order on the MAR however the nurses did not administer the 2:00 PM dose on , days and the staff did not obtain clarification orders on how the medication was to be administered on these days to ensure the resident did not miss doses of medication to treat her , .	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and clinical record review, the facility failed to offer and provide assistance as needed for personal hygiene as it related to oral care and shaving for 1 of 40 residents observed on Stage One (Resident #16). The findings included: Multiple observations of Resident #16 revealed that the resident was unshaven and his mouth	F 311	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #16 was assisted immediately with his oral care and shaving. How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:	10/22/16

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contained and his teeth were not brushed These observations include: On 09/19/16 at 11:37 AM the resident was observed to be dressed and lying in bed. He was unshaven and had noted and / on his ; on 09/20/16 at 9:44 AM the resident was out of bed in his wheelchair, the resident was dressed but remained unshaven; and on 09/21/16 at 11:45 AM, the resident was observed to be dressed and lying in bed, the resident remained unshaven and his had a large amount of on them.

Interviews were conducted with the resident at the time of the above observations. On 09/19/16 at 11:37 AM, the resident stated he was able to brush his own teeth if set up. He also confirmed he had not been provided the toothbrush or toothpaste and had not been set up to brush his teeth. He further stated the aide had washed him up but did not shave him. During the interview with the resident on 09/21/16 at 11:45 AM, the resident again confirmed he had not brushed his teeth this morning. He stated that the aide did not offer him oral hygiene products or set him up to brush his teeth. The resident also remains unshaven and he confirmed that the staff had not shaved him or offered to shave him.

The clinical record for the resident documented on the Minimum Data Set Assessment (MDS) the resident is of for dressing and personal hygiene. The aide KARDEX also indicated the resident is for activities of daily living.

An interview was conducted on 09/21/16 beginning at 12:22 PM with Staff D, the Certified Nursing Assistant (CNA). She stated she gave

F 311

Current residents who require assistance with oral care and shaving could have been affected: observation was conducted none was identified by this alleged deficient practice.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

Nursing staff were in-serviced on offering and assisting residents with oral care and shaving. Unit Manager/department head will check daily on residents to ensure oral care, shaving is provided and will report findings to morning meeting.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.

DCS/designee will report finding to QAPI monthly until substantial compliance maintained.

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F 311	Continued From page 15 the resident a bed bath this morning but confirmed she did not shave the resident or assist the resident with oral care. She also confirmed she did not ask the resident about shaving and mouth care. The resident can brush his own teeth. She was assigned the resident for the past three days, Monday through Wednesday. She gave the resident a bed bath but she did not shave the resident or set him up for mouth care. She then stated that the resident will sometimes refuse but she admitted she did not ask the resident.	F 311		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to provide the physician ordered diet for one of one resident reviewed for (Resident #65). The findings included: During an observation of the resident room	F 325	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #65 glass of water, OJ, potato chips were removed immediately. Resident was re-educated on her diet and the potential risk if not followed.	10/22/16

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conducted on 9/20/16 at 2:52 PM, a 12 oz glass of ice water was at the bedside. The resident who speaks very little English, could offer no information as to whether she requested it. On the bedside table there was a bag of potato chips, which is very high food.

A review of the clinical record revealed a physician order for , diet, and a of

In an interview at 3:12 PM, the unit manager B acknowledged that the resident should not have been served the 12 ounces of water. She further stated the resident buys the potato chips on her own.

On 9/21/16 at 8:30 AM an observation of the breakfast tray revealed 4 oz of Orange juice was served instead of the Apple Juice marked on the menu slip. When the surveyor questioned whether the resident is allowed to have orange juice (a very high beverage), the nurse removed the orange juice. The resident did not protest.

In an interview at 9:36 AM, the Registered agreed that orange juice is not usually allowed on a diet. Review of the care plan for nutrition and hydration reveals identified focus areas of potential nutrition and fluid imbalances.

Further review of the clinical record reveals laboratory values from the center reflecting a high level of (5.8mg/dl) in the resident's in the month of

A review of the progress notes reveals an entry dated "resident stated she would like to

F 325

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:

Current residents with diet could have been affected by this alleged deficient practice. An audit was conducted to ensure residents with diet do not receive OJ, potato chips and no at bedside, none was identified by this alleged deficient practice.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

Nursing and dietary staff were in-serviced on residents with diet and CDM will monitor resident's tray three times weekly to ensure accuracy.
Nursing manager/department head will monitor resident's room daily to ensure resident with has no at bedside and diet order is followed. Findings will be reported to morning meeting.

How the correction action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place

DCS/designee will report findings to QAPI monthly until substantial compliance is maintained.

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F 325	Continued From page 17 drink orange juice, was notified of dietary restrictions. Will honor preferences. Will care plan change." This note was signed by the Certified Manager ( ). In an interview conducted on 9/21/16 at 12:00 PM, the was not aware of the resident's very high level in the and did not verbalize risks of high foods to the resident. Further review of the progress notes revealed dietary education as to risks, such as , from ingestion of high foods for a resident was not documented.	F 325		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the medication rate was 10.7 percent. Three medication errors were identified while observing a total of 28 opportunities, affecting Resident # 124 and # 155. The findings included: 1) An observation of the medication administration for Resident # 124 was conducted on 09/18/16 beginning at 9:44 AM with Staff A, Licensed Practical Nurse. The nurse prepared 11 tablets (5 mg one tablet; 325 mg one tablet; 500 mg 2 capsules; 100 mg one tablet; MN ER 60 mg one tablet;	F 332	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #124 and #155 were assessed by nursing no negative outcome was identified. Medication error was done for the , family and MD were notified. Medications reviewed by MD New order obtained. How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:	10/22/16

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F 332	Continued From page 18 0.5 mg one tablet; 400 mg one tablet; 1 GM one tablet; MCR 50 mg one cap; 25 mg one tablet). Upon verifying the number of tablets in the cup, the surveyor inquired about one tablet noted in the cup as being a half tablet. The nurse stated he did not have any half tablets. Upon further investigation it was noted that the other half of the tablet was on the floor in front of the medication cart. Closer inspection of the resident's pills yielded that the broken tablet was the 100 mg. The nurse also prepared 2 (- (blue top); (white cap), and one (prop 50 mcg). The following errors were also noted regarding the medication administration: a. The nurse failed to use the proper technique when administering the At 10:11 AM, the nurse shook the bottle of multiple times and inserted the into the resident's and one The nurse performed the same administration procedure when administering the in the resident's . The nurse did not have the resident her to clear the before administering the have the resident her did not occlude the alternate ; did not have the resident the to insure penetration of the medication before administering the into the other The facility's policy and procedure regarding administration of medications included the following procedure for):	F 332	Current resident receiving medications including were reviewed none was identified by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nurses were in-serviced on procedure for medication administration via and ADCS/designee will do med pass with the nurses two times weekly to ensure compliance. Findings will be reported to DCS. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. DCS/designee will report findings to QAPI monthly until substantial compliance is maintained.	

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"Instruct resident to .
Resident should be sitting upright with tilted back slightly.
Occlude one with . Insert tip into open .
Instruct resident to and squeeze once, quickly and firmly. Repeat if ordered. Then repeat on other side.
Instruct the resident to keep tilted back for several minutes and slowly through "

b. The nurse failed to administer the correct medication and the number of prescribed. At 10:13 AM, the nurse administered one in each

Upon reconciliation of the above medication administration with the current physician orders signed by the physician, the above medications were confirmed and noted a physician prescription for
instill in both twice daily. The nurse administered one of .

On 09/22/16 at 9:08 AM an interview was conducted with Staff A. The surveyor reviewed with the nurse the medication administration. The nurse confirmed that he was unaware the pill broke in half until the surveyor brought it to his attention. He further confirmed that he did not follow the proper procedure for the administration and did not administer two of . He used the and administered one in each .

2) A medication pass observation for Resident #155 was made on 09/19/16 beginning at 9:11

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F 332	Continued From page 20 AM with two surveyors. Staff C, an RN (Registered Nurse) obtained the resident's medications to include the Review of the label on the plastic bag that contained the was a sticker that documented, "Medication has boxed warning: Wait 1 minute between ; shake well before using." Staff C entered the room of Resident #155 to administer the medications. Staff C instructed the resident on how to i the medication. Staff C administered the first dose of the , waited just 5 to 10 seconds and administered the second dose. During an interview on 09/19/16 at 10:55 AM Staff C was asked about the time frame for administering the two of the . The RN agreed that she should wait a minute between the doses, but did not agree that she failed to wait. Review of the facility policy Medications" documented, "Wait approximately 1 minute between OR as ordered by physician OR according to manufacturer's recommendations." The record lacked any specific physician order related to the time frame for administration of the doses.	F 332		
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:	F 333		10/22/16

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Based on clinical record review and staff interview, the facility staff failed to follow the physician orders for , medication administration on multiple doses and medications prescribed to treat the resident's for 1 of 1 , resident reviewed (Resident #65). This is evidenced by the nurses failing to follow the physician orders for established parameters to administer or hold routine and/or as needed medications; failed to administer medication prescribed three times daily for 4 days; failed to follow physician orders regarding , medication on treatment days and failed to obtain clarification of prescribed , medication to ensure the resident did not miss routine doses of , medication while at treatments.

The findings included:

The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included and . The resident was scheduled to receive treatments in a community facility three days a week leaving the facility at 12:30 PM and returning after 5:00 PM on Monday, Wednesday and Friday. The following monthly physician orders were not followed to ensure the resident received and/or held the prescribed medications to treat her when indicated:

1. On , the physician prescribed for the resident to receive 0.1 mg by mouth every 8 hours for greater

F 333

What corrective action(s) will be accomplished for those residents affected by the deficient practice?

Resident #65 medication were reviewed by MD change was made per physician order. Resident received meds per , schedule.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken.

Current residents receiving and with order for parameters were audited to ensure compliance none was identified by this alleged deficient practice.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

Licensed staff was in-serviced on med error, following MD order with residents and parameters.
Unit Managers will review MAR twice weekly to ensure compliance. Findings will be reported to DCS.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:

DCS/designee will report findings to QAPI monthly until substantial compliance maintained.

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than Hold for less than . The Medication Administration Record (MAR) documented the above order and noted administration times of 9:00 AM, 6:00 PM and 10:00 PM. There is also a notation on the medication entry to "see below re-written." The notation below documented a physician prescription prescribing for the resident to receive 0.1 mg every 8 hours as needed for greater than . Hold for less than . However further review of the physician orders did not document corresponding physician prescriptions discontinuing the routine and prescribing the as needed . The MAR also did not document nurses initials in the appropriate boxes to indicate that the nurses administered the prescribed medication from through /.

The MAR documented an entry for the prescribed 0.1 every 8 hours and noted administration times of 6:00 AM, 2:00 PM and 10:00 PM. Despite the medication having parameters associated with the administration of the , there are no specific documented for the administration of the medication. The facility noted for the three shifts however, there are multiple doses of the that were administered when the corresponding did not meet the prescribed parameters but the nurses placed their initials in the appropriate boxes to indicate the medication was administered.

On the 11-7 shift, the nurses documented that they administered the 28 times at 6:00 AM however there were 27 legible

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documented for this time period and 26 documented failed to meet the prescribed parameters of greater than for administration of the . The 26 documented for 11-7 shift noted the resident's ranged from to .

On the 3-11 shift, there were 28 legible documented and 16 times the documented did not meet the prescribed parameters yet the nurses placed their initials in the appropriate boxes to indicate the resident received the 28 times at 10:00 PM.

On the 7-3 shift, there were 27 legible documented, 24 did not meet the prescribed parameters for the administration however the nurses documented that they administered the medication 22 times at 2:00 PM, 6 of those 22 times the resident was documented as being at at 2:00 PM.

Furthermore, the physician prescribed on 0.1 mg to be administered as needed every 8 hours with the stated parameters of administering the medication when the resident's is greater than

The Medication MAR documented the monitoring of the resident's each shift. The nurses documented that the resident's were greater than 20 times, ranging from to . However the nurses failed to indicate the as needed was administered when the resident's exceeded the prescribed parameters 10

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times, on , 3-11 ; , 7-3, , 11-7, , 7-3, ; , 3-11 ; 7-3, ; , 7-3 , 3-11, , 11-7 ; 3-11,

2. A / / physician order prescribed for the resident to receive 50 mg give one tablet by mouth once daily. Hold on days until after on MWF. Administration time of 9:00 AM. The Medication Administration Record (MAR) documented the Metroprolol prescription and noted the nurses placed their initials in the appropriate boxes indicating the medication was administered daily at 9:00 AM with no differentiation on days that the medication was held and given after for 6 of 8 times the resident went to in on / , / , / , / , / and / / .

Additionally, the MAR documented the medication was administered daily. The nurses placed their initials in the appropriate boxes indicating they administered the medication at 9:00 AM including days. There is no indication the medication was held before and administered when the resident returned as prescribed.

An interview was conducted on 09/21/16 at 9:25 AM with Staff C, Registered Nurse, regarding medications for the resident. She stated she gives the 9:00 AM medications to the resident as indicated. She will hold the but she remembers the center asking for them to give the resident the medication because her had been but she needed to follow up on this.

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F 333	Continued From page 25 An interview was conducted on 09/21/16 at 10:10 AM with Staff B, Unit Manager and the Assistant Director of Nursing. The surveyor reviewed with the staff regarding the resident's medication administration. Concerns were identified regarding the resident's and administration. The and prescription prescribes for the medication to be held on days and given after the resident returns from . The nurses documented that the medication was administered at 9:00 AM daily and not held on days as prescribed. The staff confirmed that the documentation indicated that the nurses did not follow the physician order for administration on days. Furthermore regarding the order, the staff noted the order on the MAR however the nurses did not administer the 2:00 PM dose on days and the staff did not obtain clarification orders on how the medication was to be administered on these days to ensure the resident did not miss doses of medication to treat her . Additionally on , the was made as needed the resident's reading met the parameters on multiple occasions and the medication was not administered. Also the routine dose of was administered multiple times when based on the resident's reading should have been held.	F 333		
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	F 371		10/22/16

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F 371	Continued From page 26 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure: equipment and utensils surfaces were clean and air dried, walls and floors were intact, smooth and cleanable, dumpster was free of holes, and staff washed hands during food preparation activities and during tray pass. This has the potential to affect all the residents who eat orally, 102 of 115 residents. The findings included: During the initial tour of the kitchen conducted on 09/19/16 beginning at 8:55 AM and subsequent visits during the survey, accompanied by the Certified Dietary Managers (CDM) the following concerns were identified: 1) On 9/19/16 the surveyor observed small cracks, holding water and dirt in the surface of the floor in the dish room. There were also other cracks in the floor where the wall joins the floor in areas around the kitchen. The floor drain in front of the walk in refrigerator was obstructed with debris and uncovered. 2) There was a section of the wall missing in the back of the kitchen adjacent to the storeroom entrance door. It was partially covered with a black colored board.	F 371	What corrective actions will be accomplished for those residents affected by the deficient practice: A) Cracks were sealed with silicone at time of survey, floor drain cleared of debris and covered at time of survey. B) Board was removed and ceramic tile installed at time of survey. C) The three ceramic tiles in the Janitor closet were replaced at time of survey, wet mop stored correctly at time of survey. D) Wall vent in the back of the kitchen was cleaned at the time of survey. E) Cutting boards were stacked correctly at the time of survey, new cutting boards ordered at the time of survey and was received. F) Knife rack was cleaned at time of survey. G) Slotted spoons and spatula were ordered at the time of survey and received. H) Dietary staff in-serviced on the importance of proper hand washing per policy with return demonstration. I) Waste Company notified of the need for new dumpster at the time of survey. J) Nursing staff in-serviced on the	

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F 371 Continued From page 27

3) In the Janitor Closet there were three tiles missing on the wall and wet mop was stored directly on the floor.
4) The wall vent in the back of the kitchen was heavily coated with dust and debris.
5) The heavily worn cutting boards were placed in the clean utensil area stacked so that moisture was trapped between them and not allowed to air dry.
6) The knife rack had a film on dust on the top of the magnetic strip.
7) In the clean utensil rack, several slotted spoons, and a spatula had melted handles that form areas to hold food debris.
8) During the observation of the luncheon meal service conducted from 11:00 AM to 12:00 PM on 09/21/16, the AM cook performed many tasks preparing food, assembling utensils, and setting up the trayline. During that time, she did not wash her hands and change her gloves before starting the trayline.
9) On 9/19/16 at 9:15 AM the surveyor observed the dumpster area accompanied by the CDMs. One of the two dumpsters, both of which were full of debris, had a line of holes along the lower edge on each side where the metal had rusted through. The CDM acknowledged the poor condition of the dumpster.
10) An observation of the passing of the lunch trays was made on 09/19/16 at 12:11 PM on the Friar Unit. On 09/19/16 at 12:15 PM Staff K, a CNA (Certified Nursing Assistant) was in _ _ and washed her hands for a total of just 10 seconds. Staff K went directly to the common area to get a resident and wheel her to B, moved her bed table in front of her, and washed her hands again for a total of 10 to 15 seconds. Staff K obtained the tray for the resident and assisted the resident in setting up the meal.

F 371

importance of proper hand washing during meal delivery per policy with return demonstration.

What corrective actions will be accomplished for those residents affected by the deficient practice?

Current residents have the potential to be affected by the alleged deficient practice. Dietary rounds to be conducted three times per week to ensure compliance.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?
A) Dietary rounds to be conducted three times per week for any non-sealed cracks in the floor and broken or missing tiles or blocked drains.
B) Dietary staff in-serviced on proper storage of mops, cutting boards and melted handles on utensils as well as cleanliness of vents and knife rack.
C) Observation of dumpster for holes three times per week.
D) Observation of dietary staff and nursing staff for proper hand washing by Dietary Manager/ADCS two times per week.

Dietary Manager/designee will bring findings to the QAPI meeting until substantial compliance maintained.

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F 371	Continued From page 28 Staff K failed to properly hand wash or sanitize between care for two different residents. Review of the policy "Hand Washing Technique" dated 11/30/14 documented, "Rub hands together vigorously for 15 - 20 seconds, generating friction on all surfaces of the hands and fingers."	F 371		
F 428 SS=D	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 clinical record reviews and staff interview, the facility physician failed to document the risk versus benefits when declining the pharmacy recommendations for 1 of 5 residents reviewed for pharmacy services (Resident #136). The findings included: The monthly pharmacy reviews for Resident # 136 revealed that the consultant pharmacist on the ...... Medication Regimen Review Report noted that "the resident is noted to be experiencing defined on a change of condition medication regimen review request	F 428	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #136 drug regimen was reviewed by MD, risk versus benefits was documented. How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken: Current residents pharmacy	10/22/16

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F 428	Continued From page 29 completed by the facility. and 's use has been associated with . The Consultant recommended that the physician evaluate the , and as contributing to this change in status, perhaps discontinuing its use. If this is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that the medication is not believed to be contributing to the resident's change in condition; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences (e. g. /). The Physician's Response noted "I decline the recommendation and do not wish to implement any changes due to the following reasons." However the physician did not document the rational or risk versus benefit. Review of the clinical record for Resident # 136 did not provide evidence of this risk versus benefit being addressed in the record. An interview was conducted on 09/22/16 at approximately 1:30 PM with the Director of Nursing, who confirmed the physician did not document the risk versus benefit for the continuation of the medications.	F 428	recommendations have been reviewed for appropriate response risk versus benefits documentation. What measures will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: Attending physician will be in-serviced on proper documentation of the pharmacy recommendation. DCS will audit pharmacy recommendations for compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: DCS/designee will report findings to QAPI monthly until substantial compliance is maintained.	
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		10/22/16

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F 431	Continued From page 30 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, record review and policy review the facility failed to store medications in 1 of 5 medication carts (the medication cart on the odd side of the Friar Unit). The nurse's practice and technique of closing the medication cart resulted in the possibility for any resident or visitor to obtain access to the medications for 13 residents, during her worked evening shifts. The facility failed to maintain an accurate accounting of controlled substances for	F 431	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Med cart was locked immediately. 1:1 in-service was done with the nurse at the time of survey. Resident #125 and #167 has an accurate account of controlled substance, behavior monitoring sheets in place.	

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2 of 5 random residents (Resident #125 and #167). The facility failed to ensure medications were not left unattended for 1 of 4 residents (Resident #124) observed during the medication pass observations.

The findings included:

1) During the medication pass observation on 09/20/16 at 5:12 PM Staff L, an RN (Registered Nurse) drew up for administration to the resident in . Upon returning to the medication cart, the RN carefully pulled out the locking mechanism with her fingers and proceeded to open the cart. The RN did not use any key; this medication cart had a locking mechanism to push in to lock, and to use a key to unlock. Staff L poured three additional pills for administration to the resident, and carefully and methodically, as if this was her practice, pushed in the locking mechanism part way. In doing this, the drawers were locked, but the locking mechanism could be pulled out by hand, not using a key, thus unlocking the medication cart and leaving medications for 13 residents available to anyone passing by. During the four-day survey, numerous family member were observed coming and going from this unit, as well as numerous residents independently moving throughout the building. One resident was observed wheeling himself independently through the unit, inspecting and playing with/moving all the door handles and locking mechanisms on the doors.

During an interview immediately after the medication pass, Staff L would not admit that she purposely did not lock the cart, nor would she admit that it was her practice.

F 431

Resident #124 medications are not left unattended.

How we will identify others having the potential to be affected by the same deficient practice and what correction action will be taken:

Current residents have the potential to be affected by the alleged deficient practice. Audit of the controlled substance, behavior and flow sheet was conducted, none was identified by this alleged deficient practice.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:

Licensed nurses were in-serviced on not leaving medication unattended. Med cart to be completely locked at all times and documentation of controlled substances and flow sheet to be done properly. Unit manager will monitor behavior monitoring and flow sheet twice weekly and randomly check the med cart to ensure compliance. Will also monitor nurses during med pass to ensure meds are not left unattended; check the controlled substance sheet to ensure nurses sign the mars, flow sheet and accordingly. findings will be reported to DCS weekly.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance

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F 431	Continued From page 32 During an interview on 09/20/16 at 5:50 PM the DON (Director of Nursing) and Regional Consultant were made aware of the findings and agreed with the failure to lock the medication cart. Review of the policy "5.3 Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles" dated 12/01/07 documented, "The facility should ensure that all drugs and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room, inaccessible by residents and visitors. 2) An observation of the medication cart for the Unit 09/22/16 at 1:43 PM was made with Staff J, an LPN (Licensed Practical Nurse). A random check of the controlled substance record for Resident #125 documented the medication (a medication for) 15 mg (milligrams) to be given at bedtime, as needed. Further review of this record documented the was removed from the box in the medication cart on / and at 10 PM both nights. Review of both the Behavior Symptom Monitoring Flow Record and MAR (Medication Administration Record) for 2016 lacked the documented administration of the medication on those dates. A second controlled substance record for Resident #167 documented the medication (a for) 5-325 mg, to give 1 or 2 tablets every 6 hours, as needed for This record documented one tablet was removed from the box in the medication cart on / at 9 AM. Review of both the Flow Sheet and the MAR for 2016 lacked	F 431	program will be put into place DCS/designee will report finding to QAPI monthly until substantial compliance maintained.	

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the documented administration of the medication on that date.

During this side by side review of the controlled substance records and the clinical records for Resident #125 and #167, Staff J agreed with the findings.

3) An observation of the medication administration for Resident # 124 was conducted on 09/18/16 beginning at 9:44 AM with Staff A, Licensed Practical Nurse . The nurse prepared 11 tablets, 2 and one . At 10:03 AM, the nurse walked into the resident's room, the nurse placed all the medications on the resident's table and the nurse left the medications on the table while he walked into the bathroom on the other side of the room, to obtain gloves. The medications were left on the overbed table out of the direct vision of the nurse. The nurse also walked out of the room to his medication cart in the hallway twice and retrieved a pair of gloves. While the nurse left the medications at the bedside, the resident picked up the plastic bag containing the . When the nurse returned, he took the bag containing the from the resident. After administering one of the and the pills, the nurse placed the administered bottle back on the table and again went into the bathroom to wash his hands. Again the nurse left the 2 bottles of and the on the table. He also walked out of the room again twice to obtain gloves from the medication cart.

On 09/22/16 at 9:08 AM an interview was conducted with Staff A. The nurse confirmed he left the medications unattended and recalls the resident picking up the container for one of the

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F 431	Continued From page 34 when the medications were left on the table. The facility's policy regarding Medication Administration documented "Facility staff should not leave medications or chemicals unattended."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		10/22/16

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F 441

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and policy review the facility failed to ensure 3 of 4 nurses (Staff A, C, H), observed during the medication pass observations properly hand washed or sanitized, to help prevent the development and transmission of and . This practice affected 3 of 4 residents observed (Residents #155, #87 and #124) .

The findings included:

1) A medication pass observation was made on 09/19/16 at 9:13 AM for Resident #155. Staff C, an RN (Registered Nurse) prepared 3 pills and for administration. After giving the pills and the , Staff C went into the bathroom of Resident #155 and washed her hands for a total of 5 to 10 seconds.

2) A medication pass observation was made on 09/20/16 at 4:22 PM for Resident #87. Staff H, an RN, gathered supplies on a disposable tray to obtain an ( ). Staff H washed her hands in the resident's bathroom, by applying soap and rubbing her hands together for 6 seconds. Staff H gloved, obtained the , and washed her hands again by soaping and rubbing her hands together for 4 to 5 seconds. Staff H gloved, cleaned the

What corrective action(s) will be accomplished for those residents affected by the deficient practice?

Resident #155, #87 and #124 were assess no adverse outcome identified.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:

Current resident have the potential to be affected by the alleged deficient practice.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:

Staff was in-service on proper hand washing per facility policy with return demonstration. control nurse/Unit Managers will observe hand washing during med pass twice weekly.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance

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(machine used to obtain and the) with a bleach wipe, removed her gloves and washed her hands by applying soap and immediately rinsing. At 4:40 PM after the administration of to Resident #87, Staff H did a final hand washing by applying friction for just 5 seconds.

During an interview on 09/22/16 at 10:45 AM the DON (Director of Nursing) was made aware of the hand washing issues, and agreed the nurses are to wash their hands for more than 5 - 10 seconds. The DON was asked to provide the hand hygiene policy.

Review of the policy "Hand Washing Technique" dated 11/30/14 documented, "Rub hands together vigorously for 15 - 20 seconds, generating friction on all surfaces of the hands and fingers."

3) An observation of the medication administration for Resident # 124 was conducted on 09/18/16 beginning at 9:44 AM with Staff A, Licensed Practical Nurse. The nurse failed to follow accepted standards of practice for handwashing by failing to perform hand hygiene between glove changes; failed to wash hands appropriately by turning off the water with his just washed hands and turning on the water after he had applied the soap and scrubbed his hands.

At 10:04 AM, after the nurse administered into the resident's the nurse removed his gloves and administered the pills/medications in the medication cup. He then went into the bathroom to wash his hands. The nurse washed his hands and turned off the water with his just washed hands. Upon retrieving another pair of gloves the nurse donned the gloves and

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program will be put into place

DCS/designee will report findings to QAPI monthly until substantial compliance is maintained.

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F 441	Continued From page 37 administered the to the resident. After administering the , the nurse removed his gloves, the nurse retrieved another pair of gloves and donned the new pair of gloves. The nurse did not perform hand hygiene between glove changes. He then donned another pair of gloves and administered the second After removing his gloves, the nurse applied soap to his hands. However the nurse did not turn on the water at this time. He then rubbed his hands together with the soap on his hands and used his soaped up left hand and turned on the water faucet to rinse his hands. He then obtained paper towels to dry his hands and to turn off the water. On 09/22/16 at 9:08 AM an interview was conducted with Staff A. The surveyor reviewed with the nurse the hand hygiene observation during the medication administration.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 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.	F 514		10/22/16

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This REQUIREMENT is not met as evidenced by:

Based on clinical record review and staff interview, the facility staff failed to ensure the accuracy and completeness of the medical records for 3 of 19 residents whose records were reviewed (Resident # 65, # 127 and # 217). This is evidenced by the staff amending documentation contained on the medication administration record and not appropriately dating the added documentation; failed to ensure as needed medications were documented when administered and exceptions (meds not administered) were appropriately circled and the reason the medication was not administered was documented on the medication administration record. The facility failed to ensure the orders were not contradictory but accurately reflected the current physician orders (Resident # 127); and failed to ensure the care and services related to the resident's were accurately documented (Resident #217).

The findings included:

1) Review of the clinical record for Resident # 65 on 09/20/16 at approximately 2:30 PM the Medication Administration Record (MAR) documented two doses of as needed 0.1 mg doses were noted as administered on the back of the MAR. However upon receipt of the copied MAR on 09/20/16, the back of the MAR documented 4 additional doses of as needed dated , and . Furthermore review of the same MAR on 09/21/16 at 3:00 PM again revealed 4 additional doses of as needed documented on the back of the MAR which were not previously documented. The entries were

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What corrective action(s) will be accomplished for those residents affected by the deficient practice?

Resident #67 has no negative outcome. 1:1 in-service provided to nurse identified regarding amending documentation. Resident #127 clarification order was obtained regarding Resident #217 location and type of were clarified in the medical record.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken

Current residents with order and medication with parameters have the potential to be affected by this alleged deficient practice. Current resident's medical records were reviewed to ensure compliance; none was found to be affected.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:

Nurses were in-serviced on proper documentation and amending. Unit Manager will randomly check documentation twice weekly to ensure accuracy and compliance. Findings will

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dated , , and
and did not indicate a late entry notation on the MAR.

A physician order prescribed for the resident to receive 0.1 mg by mouth every 8 hours for greater than hold for less than with administration times of 6:00 AM, 2:00 PM and 10:00 PM.
The MAR documented 7 times at the 2:00 PM dose, the nurse circled their initials indicating that the medication was not administered (, , , , , , ; which are days the resident was at at 2:00 PM). However the back of the MAR documented 2 of the 7 circled doses on and indicating the reason the medication was circled as the " not given because the resident was at ". There was no further documentation indicating the reason the other 5 doses of circled medications were not administered.

2) An observation on 09/20/16 at 3:09 PM revealed Resident #127 lying in bed on his right side, well propped with pillows, and his head elevated. An RN (Registered Nurse) was at the bedside, and the of was noted to be running. An additional observation on / at 9:18 AM revealed Resident #127 in bed with the . The resident was on his back with the head of the bed elevated.

Review of the record revealed Resident #127 was admitted to the facility on with a re-admission on . Review of the current physician order sheet for , 2016

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be reported immediately to DCS.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place

DCS/designee to report findings monthly to QAPI until substantial compliance is maintained.

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documented the order dated for the of (off at 10 AM - on at 2 PM). Review of this same physician order sheet for , 2016 documented the order for at "off at 10 A - on 8 ?". The A or P for AM or PM was not legible.

Review of the nutritional assessment dated , and the follow-up notes on and all documented the as at for , on at 2 PM and off at 10 AM.

During an interview on 09/21/16 at 9:32 AM, Staff B, an RN and the Unit Manager was shown the conflicting orders, stated the current physician's order for the was the off at 10 AM and on at 8 PM. The Unit Manager agreed that the 8 PM could not be correct. When asked about the order on the 2016 physician order sheet, the Unit Manager did not answer.

The was present during the interview with the Unit Manager, confirmed that the current order was for for , off at 10 AM and on at 2 PM, and that the order was not taken off the 2016 POS (physician order sheet). The agreed the record documented conflicting orders.

3) Review of the record on 09/20/16 at 10:24 AM revealed Resident #217 had an to the left that was present upon admission, as documented on the care physician's progress note dated . The resident had been admitted on Friday

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

PRINTED: 10/12/2016
FORM APPROVED
OMB NO. 0938-0391

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During an interview on 09/21/16 at 12:50 PM Resident #217 stated that her left was from a , as she had on her . Resident #217 further stated the to the of her right started last , from a new of ordered by her . The resident stated that she has had treatments to that since that time. She stated that she had to her right to improve to that .

Review of the record revealed Resident #217 was admitted to the facility on with a diagnosis of a . The record lacked documentation as to which was . Review of the initial nursing assessment dated documented a "large " at the left and a and device to the right .

Review of the admission orders dated documented the order to apply a ; (a device that applies to enhance) to the left on Tuesdays, Thursdays and Saturdays. Review of the TAR (Treatment Administration Record) for 2016 revealed the was not applied to the left on Saturday , as evidenced by the blank box where the nurse's initials for completion should be. Review of the Daily Skilled Nurse's Note for lacked any documented care.

During an interview on 09/21/16 at 10:32 AM, Staff P, the RN who normally cares for Resident #217 confirmed the has always been for the right not the left .

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During an interview on 09/21/16 at 11:45 AM the DON was asked about the initial order for the to the left , and where that order came from. The DON was unable to locate any documentation, and stated it sometimes comes from report from the hospital. The DON stated that admissions made sure the was here prior to the resident arriving. The DON also found documentation in the record that the to the right was a .

During an interview on 09/22/16 at 11:49 AM, Staff I, the LPN (Licensed Practical Nurse) who cared for Resident #217 during the day on , when the was due to be applied to the , stated the wasn't at the facility, so their protocol is to do a wet to dry . She further stated that the supervisor was going to do the Staff I was asked to locate and provide any documented care to the on , and she was unable to find any.

During an interview on 09/22/16 at 1:12 PM the DON provided documentation that the supplies had not arrived at the facility on , and agreed that the sequence of events at the time of admission to the facility, and during the first weekend at the facility, was not thoroughly documented in the record for Resident #217.

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N 000	INITIAL COMMENTS An unannounced Relicensure survey was conducted on 09/19/2016 through 09/22/2016 at Consulate Healthcare of West Palm Beach, License #15950961. The facility had deficiencies found at the time of the visit.	N 000		
N 054 SS=E	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident ' s medical record during that shift. This Statute or Rule is not met as evidenced by: Based on administrative and clinical record review and staff interview, the facility staff failed to follow the physician orders for medication administration on multiple doses and medications prescribed to treat the resident's for 1 of 1 patient reviewed (Resident #65). This is evidenced by the nurses failing to follow the physician orders for established parameters to administer or hold routine and/or as needed medications; failed to administer medication prescribed three times daily for 4 days; failed to follow physician orders regarding medication on treatment days and failed to obtain clarification of prescribed medication to ensure the resident did not miss routine doses of medication while at treatments. The facility also failed to followed the physician orders for 2 of 4 residents observed	N 054	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under State and Federal law. This plan of correction will serve as the Facility's allegation of substantial compliance. What corrective actions will be accomplished for those residents affected by the deficient practice? Resident #65 was reassessed; meds	10/22/16

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during medication administration (Residents # 124 and # 155).

The findings included:

1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included and
The resident was scheduled to receive treatments in a community facility three days a week leaving the facility at 12:30 PM and returning after 5:00 PM on Monday, Wednesday and Friday. The following monthly physician orders were not followed to ensure the resident received and/or held the prescribed medications to treat her pressure when indicated:

A. On , the physician prescribed for the resident to receive 0.1 mg by mouth every 8 hours for greater than . Hold for less than . The Medication Administration Record (MAR) documented the above order and noted administration times of 9:00 AM, 6:00 PM and 10:00 PM. There is also a notation on the medication entry to "see below re-written." The notation below documented a physician prescription prescribing for the resident to receive 0.1 mg every 8 hours as needed for , greater than . Hold for less than ... However further review of the physician orders did not document corresponding physician prescriptions discontinuing the routine and prescribing the as needed . The MAR also did not document nurses ' initials in the appropriate boxes to indicate that the nurses administered the prescribed medication from

N 054

were reviewed to ensure administration before or after , per doctor's order. Resident #124 and #155 were assessed by nursing, no negative outcome was identified. Medication error was done for the , family and MD were notified. Medications reviewed by MD, new order obtained.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:

Current residents receiving with medications were reviewed, none was identified by this alleged deficient practice. Current resident receiving medication including were reviewed, none was identified for this alleged deficient practice.

What measures will be put into place or what system changes will be made to ensure that the alleged deficient practice does not recur:

Nursing staff were educated on following doctor's order of , residents. Unit manager will check MAR twice weekly to ensure accuracy.
Nurses were in-serviced on procedure for medication administration via and
ADCS/designee will do med pass with the nurses two times weekly to ensure compliance.
Findings will be reported to DCS.

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N 054	Continued From page 2 through / The MAR documented an entry for the prescribed 0.1 every 8 hours and noted administration times of 6:00 AM, 2:00 PM and 10:00 PM. Despite the medication having parameters associated with the administration of the , there are no specific documented for the administration of the medication. The facility noted for the three shifts however, there are multiple doses of the that were administered when the corresponding did not meet the prescribed parameters but the nurses placed their initials in the appropriate boxes to indicate the medication was administered. On the 11-7 shift, the nurses documented that they administered the 28 times at 6:00 AM however there were 27 legible documented for this time period and 26 documented failed to meet the prescribed parameters of greater than for administration of the . The 26 , documented for 11-7 shift noted the resident's ranged from to . On the 3-11 shift, there were 28 legible documented and 16 times the documented did not meet the prescribed parameters yet the nurses placed their initials in the appropriate boxes to indicate the resident received the 28 times at 10:00 PM. On the 7-3 shift, there were 27 legible documented, 24 did not meet the prescribed parameters for the	N 054	How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. DCS/designee will report findings to QAPI monthly until substantial compliance is maintained.	

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N 054	Continued From page 3 administration however the nurses documented that they administered the medication 22 times at 2:00 PM, 6 of those 22 times the resident was documented as being at at 2:00 PM. Furthermore, the physician prescribed on 0.1 mg to be administered as needed every 8 hours with the stated parameters of administering the medication when the resident's , is greater than The Medication MAR documented the monitoring of the resident's each shift. The nurses documented that the resident's were greater than 20 times, ranging from to . However the nurses failed to indicate the as needed was administered when the resident's exceeded the prescribed parameters 10 times, on , 3-11 , 7-3, , 11-7, , 7-3, , 3-11 7-3, , 7-3 , 3-11, , 11-7 3-11, . B. A physician order prescribed for the resident to receive 50 mg give one tablet by mouth once daily. Hold on days until after on MWF. Administration time of 9:00 AM. The Medication Administration Record (MAR) documented the Metroprolol prescription and noted the nurses placed their initials in the appropriate boxes indicating the medication was administered daily at 9:00 AM with no differentiation on days that the medication was held and given after for 6 of 8 times the resident went to in , on , , , and .	N 054		

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N 054	Continued From page 4 Additionally, the MAR documented the medication was administered daily. The nurses placed their initials in the appropriate boxes indicating they administered the medication at 9:00 AM including days. There is no indication the medication was held before , and administered when the resident returned as prescribed. An interview was conducted on 09/21/16 at 9:25 AM with Staff C, Registered Nurse, regarding medications for the resident. She stated she gives the 9:00 AM medications to the resident as indicated. She will hold the but she remembers the center asking for them to give the resident the , medication because her , had been but she needed to follow up on this. An interview was conducted on 09/21/16 at 10:10 AM with Staff B, Unit Manager and the Assistant Director of Nursing. The surveyor reviewed with the staff regarding the resident's medication administration. Concerns were identified regarding the resident's and administration. The and prescription prescribes for the medication to be held on , days and given after the resident returns from , . The nurses documented that the medication was administered at 9:00 AM daily and not held on , days as prescribed. The staff confirmed that the documentation indicated that the nurses did not follow the physician order for administration on , days. Furthermore, regarding the order, the staff noted the order on the MAR however the nurses did not administer the 2:00 PM dose on , days and the staff did not obtain	N 054		

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clarification orders on how the medication was to be administered on these days to ensure the resident did not miss doses of medication to treat her . Additionally, on , the was made as needed the resident's reading met the parameters on multiple occasions and the medication was not administered. Also the routine dose of was administered multiple times when based on the resident's reading should have been held.

2. An observation of the medication administration for Resident # 124 was conducted on beginning at 9:44 AM with Staff A, Licensed Practical Nurse. The nurse prepared 11 tablets (5 mg one tablet; 325 mg one tablet; 500 mg 2 capsules; 100 mg one tablet; MN ER 60 mg one tablet; 0.5 mg one tablet; 400 mg one tablet; 1 GM one tablet; MCR 50 mg one cap; 25 mg one tablet). Upon verifying the number of tablets in the cup, the surveyor inquired about one tablet noted in the cup as being a half tablet. The nurse stated he did not have any half tablets. Upon further investigation it was noted that the other half of the tablet was on the floor in front of the medication cart. Closer inspection of the resident's pills yielded that the broken tablet was the 100 mg. The nurse also prepared 2 (- (blue top); (white cap), and one (prop 50 mcg).

The following errors were also noted regarding the medication administration:

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a. The nurse failed to use the proper technique when administering the .
At 10:11 AM, the nurse shook the bottle of multiple times and inserted the into the resident's and one . The nurse performed the same administration procedure when administering the in the resident's The nurse did not have the resident her to clear the before administering the have the resident tilt her ; did not occlude the alternate did not have the resident the to insure penetration of the medication before administering the into the other

The facility's policy and procedure regarding administration of medications included the following procedure for (,):
"Instruct resident to .
Resident should be sitting upright with head tilted back slightly.
Occlude one with . Insert tip into open .
Instruct resident to and squeeze once, quickly and firmly. Repeat if ordered. Then repeat on other side.
Instruct the resident to keep tilted back for several minutes and slowly through "

b. The nurse failed to administer the correct medication and the number of prescribed.
At 10:13 AM, the nurse administered one in each

Upon reconciliation of the above medication administration with the current physician orders signed by the physician, the above medications

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were confirmed and noted a physician prescription for instill 2 in both twice daily. The nurse administered one of .

On 09/22/16 at 9:08 AM an interview was conducted with Staff A. The surveyor reviewed with the nurse the medication administration. The nurse confirmed that he was unaware the pill broke in half until the surveyor brought it to his attention. He further confirmed that he did not follow the proper procedure for the administration and did not administer two of . He used the and administered one in each .

3. A medication pass observation for Resident #155 was made on 09/19/16 beginning at 9:11 AM with two surveyors. Staff C, an RN (Registered Nurse) obtained the resident's medications to include the . Review of the label on the plastic bag that contained the was a sticker that documented, "Medication has boxed warning: Wait 1 minute between shake well before using."

Staff C entered the room of Resident #155 to administer the medications. Staff C instructed the resident on how to the medication. Staff C administered the first dose of the waited just 5 to 10 seconds and administered the second dose.

During an interview on 09/19/16 at 10:55 AM Staff C was asked about the time frame for administering the two of the . The RN agreed that she should wait a minute between the doses, but did not agree that she failed to wait.

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N 054	Continued From page 8 Review of the facility policy " Medications" documented, "Wait approximately 1 minute between OR as ordered by physician OR according to manufacturer's recommendations." The record lacked any specific physician order related to the time frame for administration of the doses. Class III	N 054		
N 093 SS=E	59A-4.112(4), FAC Controlled Drug - Accounting The pharmacist shall determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain an accurate accounting of controlled substances for 2 (Resident #125 and #167) of 5 random residents. The findings included: An observation of the medication cart for the Unit 09/22/16 at 1:43 PM was made with Staff J, an LPN (Licensed Practical Nurse). A random check of the controlled substance record for Resident #125 documented the medication (a medication for) 15 mg (milligrams) to be given at bedtime, as needed. Further review of this record documented the was removed from the box in the medication cart on / and at 10 PM both nights. Review of both the Behavior Symptom Monitoring Flow Record and MAR (Medication Administration Record) for 2016 lacked the documented	N 093	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #125 and #167 has an accurate account of controlled substance, behavior monitoring sheets in place. How we will identify others having the potential to be affected by the alleged deficient practice. Audit of the controlled substance, behavior and flow sheet was conducted, none wad identified by this alleged deficient practice. What corrective action will be taken to correct the alleged deficient practice: Licensed nurses were in-service on	10/22/16

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N 093	Continued From page 9 administration of the medication on those dates. A second controlled substance record for Resident #167 documented the medication (a for) 5-325 mg, to give 1 or 2 tablets every 6 hours, as needed for . This record documented one tablet was removed from the box in the medication cart on / at 9 AM. Review of both the Flow Sheet and the MAR for , 2016 lacked the documented administration of the medication on that date. During this side by side review of the controlled substance records and the clinical records for Resident #125 and #167, Staff J agreed with the findings. Class III	N 093	documentation of controlled substance and flow sheet to be done properly. Unit manager will monitor behavior monitoring and flow sheet twice weekly to ensure compliance. Will also monitor nurses during med pass to ensure nurses sign the mar, , flow sheet and BMS accordingly. Findings will be reported to DCS weekly. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place. DCS/designee will report finding to QAPI monthly until substantial compliance maintained.	
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized.	N 101		10/22/16

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N 101	Continued From page 10 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results This Statute or Rule is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure the accuracy and completeness of the medical records for 3 of 19 residents whose records were reviewed (Resident # 65, # 127 and # 217). This is evidenced by the staff amending documentation contained on the medication administration record and not appropriately dating the added documentation; failed to ensure as needed medications were documented when administered and exceptions (meds not administered) were appropriately circled and the reason the medication was not administered was documented on the medication administration record. The facility failed to ensure the orders were not contradictory but accurately reflected the current physician orders (Resident # 127); and failed to ensure the care and services related to the resident's were accurately documented (Resident #217). The findings included: 1) Review of the clinical record for Resident # 65 on 09/20/16 at approximately 2:30 PM the Medication Administration Record (MAR) documented two doses of as needed 0.1 mg doses were noted as administered on the back of the MAR. However, upon receipt of the copied MAR on 09/20/16, the back of the MAR documented 4 additional doses of as needed dated , and . Furthermore, review of the same	N 101	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #65 has no negative outcome. 1:1 in-service provided to nurse identified regarding amending documentation. Resident #127 clarification order was obtained regarding Resident # 217 location and type of were clarified in the medical record. How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken. Current residents with order and medication with parameters have the potential to be affected by this alleged deficient practice. Current resident's medical records were reviewed to ensure compliance; none was found to be affected. How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken: Nurses were in-serviced on proper	

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N 101	Continued From page 11 MAR on 09/21/16 at 3:00 PM again revealed 4 additional doses of as needed documented on the back of the MAR which were not previously documented. The entries were dated , , and and did not indicate a late entry notation on the MAR. A physician order prescribed for the resident to receive 0.1 mg by mouth every 8 hours for greater than hold for less than with administration times of 6:00 AM, 2:00 PM and 10:00 PM. The MAR documented 7 times at the 2:00 PM dose, the nurse circled their initials indicating that the medication was not administered (, , , , , , ; which are days the resident was at at 2:00 PM). However the back of the MAR documented 2 of the 7 circled doses on and indicating the reason the medication was circled as the " not given because the resident was at ". There was no further documentation indicating the reason the other 5 doses of circled medications were not administered. 2) An observation on 09/20/16 at 3:09 PM revealed Resident #127 lying in bed on his right side, well propped with pillows, and his head elevated. An RN (Registered Nurse) was at the bedside, and the of was noted to be running. An additional observation on 09/21/16 at 9:18 AM revealed Resident #127 in bed with the at . The resident was on his back with the head of the bed elevated. Review of the record revealed Resident #127 was	N 101	documentation and amending. Unit Manager will randomly check documentation twice weekly to ensure accuracy and compliance. Findings will be reported immediately to DCS. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. DCS/designee to report findings monthly to QAPI until substantial compliance is maintained.	

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N 101	Continued From page 12 admitted to the facility on with a re-admission on . Review of the current physician order sheet for , 2016 documented the order dated for the of (off at 10 AM - on at 2 PM). Review of this same physician order sheet for , 2016 documented the order for at "off at 10 A - on 8 ?". The A or P for AM or PM was not legible. Review of the nutritional assessment dated , and the follow-up notes on and all documented the as at for 20 hours, on at 2 PM and off at 10 AM. During an interview on 09/21/16 at 9:32 AM, Staff B, an RN and the Unit Manager was shown the conflicting orders, stated the current physician's order for the was the , off at 10 AM and on at 8 PM. The Unit Manager agreed that the 8 PM could not be correct. When asked about the order on the 2016 physician order sheet, the Unit Manager did not answer. The was present during the interview with the Unit Manager, confirmed that the current order was for for 20 hours, off at 10 AM and on at 2 PM, and that the order was not taken off the 2016 POS (physician order sheet). The agreed the record documented conflicting orders. 3) Review of the record on 09/20/16 at 10:24 AM revealed Resident #217 had an , to the left that was present upon admission, as documented on the	N 101		

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care physician's progress note dated .
The resident had been admitted on Friday

During an interview on 09/21/16 at 12:50 PM Resident #217 stated that her left was from a , as she had on her . Resident #217 further stated the to the of her right started last , from a new of ordered by her . The resident stated that she has had treatments to that since that time. She stated that she had to her right to improve to that .

Review of the record revealed Resident #217 was admitted to the facility on with a diagnosis of a . The record lacked documentation as to which was . Review of the initial nursing assessment dated documented a "large " at the left , and a and device to the right

Review of the admission orders dated documented the order to apply a (a device that applies to enhance) to the left on Tuesdays, Thursdays and Saturdays. Review of the TAR (Treatment Administration Record) for 2016 revealed the was not applied to the left on Saturday , as evidenced by the blank box where the nurse's initials for completion should be. Review of the Daily Skilled Nurse's Note for lacked any documented care.

During an interview on 09/21/16 at 10:32 AM, Staff P, the RN who normally cares for Resident #217 confirmed the has always been

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N 101	Continued From page 14 for the right not the left During an interview on 09/21/16 at 11:45 AM the DON was asked about the initial order for the to the left and where that order came from. The DON was unable to locate any documentation, and stated it sometimes comes from report from the hospital. The DON stated that admissions made sure the was here prior to the resident arriving. The DON also found documentation in the record that the to the right was a . During an interview on 09/22/16 at 11:49 AM, Staff I, the LPN (Licensed Practical Nurse) who cared for Resident #217 during the day on , when the was due to be applied to the , stated the wasn't at the facility, so their protocol is to do a wet to dry . She further stated that the supervisor was going to do the . Staff I was asked to locate and provide any documented care to the on , and she was unable to find any. During an interview on 09/22/16 at 1:12 PM the DON provided documentation that the supplies had not arrived at the facility on , and agreed that the sequence of events at the time of admission to the facility, and during the first weekend at the facility, was not thoroughly documented in the record for Resident #217. Class III	N 101		
N 201 SS=E	400.022(1)(l), FS Right to Adequate and Appropriate Health Care	N 201		10/22/16

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N 201	Continued From page 15 The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide activities in accordance with the comprehensive assessment and interest of the residents, for 1 (Resident #217) of 3 residents reviewed, of a sample of 17 residents who were able to be interviewed. The faciliy failed to ensure medications were administered before and after for optimal effectiveness for 1 (Residnet #65) of 1 resident reviewed for treatments. The facility failed to provide assistance for personal hygiene related to oral care and shaving for 1 (Resident #16) of 40 residents observed. The facility also failed to provide a diet related to high foods and for Resident #65. The findings included: 1. During an interview on 09/20/16 at 9:18 AM Resident #217 was asked, "Does staff provide items so you can do activities on your own, like books or cards?" Resident #217 responded, "No." During this interview Resident #217 explained that she is at the facility because of an to her An device was also noted to her right . The resident explained that it is difficult for her to get out of bed, and that she prefers to be in her room. She stated that she prefers independent activities.	N 201	What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident #217 Activity of choice was reviewed with resident and a deck of cards was provided. Resident #65 medication were reviewed by MD, change was made per physician order. Resident received meds per schedule. Resident #16 was assisted immediately with his oral care and shaving. Resident #65 glass of water, OJ, potato chips were removed immediately. Resident was re-educated on her diet and the potential risk if not followed. How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken. Current residents were re-interviewed for their preferences in activities, changes were made accordingly. Current residents receiving and with order for parameters were audited to ensure compliance, none was identified	

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On 09/20/16 at 3:14 PM and 09/21/16 at 10:34 AM Resident #217 was noted to be out of her room. As per her roommate, Resident #217 was at physician appointments.

During a subsequent interview on 09/21/16 at 12:50 PM Resident #217 stated that she was frustrated as she has had numerous physician appointments, and when she returns she is worn out, again stating that she prefers to be in her room. When asked again if staff have offered her anything to do in her room, she stated they had not. When asked if she had any books or cards she again stated that she did not have either, and volunteered, "I live for cards." Resident #217 explained that she plays cards with a group and enjoys Solitaire. She stated that she bought an electronic Solitaire game, but can't get it to work. When asked if she would like a deck of cards, Resident #217 stated that she would love a deck of cards to play Solitaire.

Review of the record revealed Resident #217 was admitted to the facility on with diagnoses to include a . Review of the admission MDS (Minimum Data Set) comprehensive assessment dated documented Resident #217 has a BIMS (Brief Interview for Mental Status) score of out of , indicating she is and . Review of the Activity Preferences section of this assessment documented it is very important for her to have books, newspapers and magazines to read. This comprehensive assessment also documented that it is very important for her to have her favorite activities.

Review of the Activities Evaluation, completed on by the Activities Director, documented

N 201

by this alleged deficient practice.
Current residents who require assistance with oral care and shaving could have been affected: observation was conducted none was identified by this alleged deficient practice.
Current residents with diet could have been affected by this alleged deficient practice. An audit was conducted to ensure residents with diet do not receive OJ, potato chips and no at bedside; none was identified by this alleged deficient practice.

What measures will be put into place or what system changes will be made to ensure that the deficient practices does not recur:

Activity Director and staff were in-serviced on providing activity per resident choice and interest. Activity Director will review new admission and current residents on their initial and quarterly assessment to ensure resident received activity of their choice.
Licensed staff was in-serviced on med error, following MD order with residents and parameters.
Unit Managers will review MAR twice weekly to ensure compliance. Findings will be reported to DCS.
Nursing staff were in-serviced on offering and assisting residents with oral care and shaving. Unit Manager/department head will check daily on residents to ensure oral care, shaving is provided and will report findings to morning meeting.
Nursing and dietary staff were in-serviced on residents with diet and

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Resident #217 was ' and interested in activities, cooperative and motivated. This assessment documented current interests that are very important to the resident as animals/pets, cards, family/friend visits, movies, music, reading and television. Although this assessment documented the card interest as a "small group" activity, Resident #217 stated that she enjoys both small group and independent playing of cards.

Review of the current activities care plan documented Resident #217 prefers to stay in her room and that her interests included card games, coffee hour, food, snacks, in room visits, music, book club, and TV.

During an interview on 09/22/16 at 12:30 PM the Activity Director confirmed she completes the activities initial assessments. When asked about Resident #217, the Activity Director stated that she doesn't like to be in groups and she wants to be in The Activity Director further stated that Resident #217 is very friendly, likes to watch TV, and likes to read. The Activity Director stated she offered Resident #217 magazines and books when she first got here. Stated that she offers items to read each Friday by going door to door with a cart. When asked if she documents this or documents if any resident accepts anything, the Activity Director stated that she does not. The Activity Director agreed that her assessment for Resident #217 included cards, and stated that she never thought to offer her cards as she "had a Solitaire game on the machine." When told that her machine didn't work the Activity Director stated that she did not know that. When asked if and when she re-assesses her interventions, the Activity Director stated that she does it quarterly. The Activity Director stated that she had not

. CDM will monitor residents tray three times per week to ensure accuracy.
Nursing manager/department head will monitor resident's room daily to ensure resident with has no ..._.. at bedside and diet order is followed.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.

DCS/designee will report findings to QAPI monthly until substantial compliance is maintained.

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re-assessed Resident #217.

2. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included and . The resident was scheduled to receive treatments in a community facility three days a week leaving the facility at 12:30 PM and returning after 5:00 PM on Monday, Wednesday and Friday. The following monthly physician orders were not followed to ensure the resident received the prescribed medications as ordered on days:

A. A physician order prescribed for the resident to receive 50 mg give one tablet by mouth once daily. Hold on days until after on Monday, Wednesday, and Friday. Administration time of 9:00 AM. The Medication Administration Record (MAR) documented the prescription and noted the nurses placed their initials in the appropriate boxes indicating the medication was administered daily at 9:00 AM with no differentiation on days that the medication was held and given after for 6 of 8 times the resident went to in on , , , , and .

B. A physician order prescribed for the resident to receive 0.1 mg by mouth every 8 hours for greater than , hold for less than with administration times of 6:00 AM, 2:00 PM and 10:00 PM.
The MAR documented 7 times at the 2:00 PM dose, the nurse circled their initials indicating that the medication was not administered (,

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; which are days the resident was at at 2:00 PM). However the back of the MAR documented 2 of the 7 circled doses on and the " not given because the resident was at ".

An interview was conducted on 09/21/16 at 9:25 AM with Staff C, Registered Nurse, regarding medications for the resident. She stated she gives the 9:00 AM medications to the resident as indicated. She will hold the but she remembers the center asking for them to give the resident the medication because her had been but she needed to follow up on this.

An interview was conducted on 09/21/16 at 10:10 AM with Staff B, Unit Manager and the Assistant Director of Nursing. The surveyor reviewed with the staff regarding the resident's medication administration. Concerns were identified regarding the resident's and administration. The prescription prescribes for the medication to be held on days and given after the resident returns from . The nurses documented that the medication was administered at 9:00 AM daily and not held on days as prescribed. The staff confirmed that the documentation indicated that the nurses did not follow the physician order for administration on days. Furthermore regarding the order, the staff noted the order on the MAR however the nurses did not administer the 2:00 PM dose on days and the staff did not obtain clarification orders on how the medication was to be administered on these days to ensure the resident did not miss doses of medication to treat

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3. Multiple observations of Resident #16 revealed that the resident was unshaven and his mouth contained and his teeth were not brushed These observations include: On 09/19/16 at 11:37 AM the resident was observed to be dressed and lying in bed. He was unshaven and had noted and on his teeth; on 09/20/16 at 9:44 AM the resident was out of bed in his wheelchair, the resident was dressed but remained unshaven; and on 09/21/16 at 11:45 AM, the resident was observed to be dressed and lying in bed, the resident remained unshaven and his had a large amount of on them.

Interviews were conducted with the resident at the time of the above observations. On 09/19/16 at 11:37 AM, the resident stated he was able to brush his own teeth if set up. He also confirmed he had not been provided the toothbrush or toothpaste and had not been set up to brush his teeth. He further stated the aide had washed him up but did not shave him. During the interview with the resident on 09/21/16 at 11:45 AM, the resident again confirmed he had not brushed his teeth this morning. He stated that the aide did not offer him oral hygiene products or set him up to brush his teeth. The resident also remains unshaven and he confirmed that the staff had not shaved him or offered to shave him.

The clinical record for the resident documented on the Minimum Data Set Assessment (MDS) the resident is of for dressing and personal hygiene. The aide KARDEX also indicated the resident is for activities of daily living.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95032	A. BUILDING: ______ B. WING ______	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WEST PALM E	1626 DAVIS RD WEST PALM BEACH, FL 33406

(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) COMPLETE DATE
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An interview was conducted on 09/21/16 beginning at 12:22 PM with Staff D, the Certified Nursing Assistant (CNA). She stated she gave the resident a bed bath this morning but confirmed she did not shave the resident or assist the resident with oral care. She also confirmed she did not ask the resident about shaving and mouth care. The resident can brush his own teeth. She was assigned the resident for the past three days, Monday through Wednesday. She gave the resident a bed bath but she did not shave the resident or set him up for mouth care. She then stated that the resident will sometimes refuse but she admitted she did not ask the resident.

4. During an observation of the resident room conducted on 9/20/16 at 2:52 PM, a 12 oz glass of ice water was at the bedside. The resident who speaks very little English, could offer no information as to whether she requested it. On the bedside table there was a bag of potato chips, which is very high food.

A review of the clinical record revealed a physician order for diet, and a of .

In an interview at 3:12 PM, the unit manager B acknowledged that the resident should not have been served the 12 ounces of water. She further stated the resident buys the potato chips on her own.

On 9/21/16 at 8:30 AM an observation of the breakfast tray revealed 4 oz of Orange juice was served instead of the Apple Juice marked on the menu slip. When the surveyor questioned whether the resident is allowed to have orange juice (a very high beverage), the nurse

Agency for Health Care Administration

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	95032	A. BUILDING: ______ B. WING ______	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WEST PALM E	1626 DAVIS RD WEST PALM BEACH, FL 33406

(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) COMPLETE DATE
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removed the orange juice. The resident did not protest.

In an interview at 9:36 AM, the agreed that orange juice is not usually allowed on a diet. Review of the care plan for nutrition and hydration reveals identified focus areas of potential nutrition and fluid imbalances.

Further review of the clinical record reveals laboratory values from the center reflecting a high level of (5.8mg/dl) in the resident's in the month of

A review of the progress notes reveals an entry dated "resident stated she would like to drink orange juice, was notified of dietary restrictions. Will honor preferences. Will care plan change." This note was signed by the). In an interview conducted on / at 12:00 PM, the was not aware of the resident's very high level in the and did not verbalize risks of high foods to the resident. Further review of the progress notes revealed dietary education as to risks, such as , from ingestion of high foods for a resident was not documented.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 30, 2016

Administrator
Consulate Health Care Of West Palm Beach
1626 Davis Rd
West Palm Beach, FL 33406

RE: Recertification surveys

Dear Administrator:

On September 19, 2016-September 22, 2016, Recertification, Licensure and Life Safety Code surveys were conducted in your facility by representatives of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit.

You will not receive a copy of this letter and attachments in the mail; you will only receive this electronic report.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than October 22, 2016.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not

recur, i.e., what quality assurance program will be put into place.

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed December 22, 2016 if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on March 22, 2017 if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based

interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). If you have questions, please contact the Delray Beach Field Office at (561) 381-5840.

Sincerely,

Maryanne Salerni for

Arlene Mayo-Davis
Field Office Manager

AMD/ms
Enclosure

R6WB