STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

(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 Correction Date: 11.29.19 The following deficiencies are the result of investigation of incident #86077-I, #86533-I, #85419-I, #86710-I and complaint #85966-C, completed on October 15 -30 2019. #86077-I, #86533-I, #85419-I, #86710-I and #85966-C were substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		

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

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 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of facility policy and procedure the facility failed to notify the resident's physician of a wrong dose of fentanyl patch administered on 10/6/19 and failed to notify the residents family of a missing fentanyl patch which occurred on 9/15/19 for one resident, (Resident #5). The facility census was 118 residents. Findings include: An Annual Minimum Data Set (MDS) assessment tool, dated 7/14/19, documented Resident #5 had	F 580		

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F 580	Continued From page 2	F 580		

a Brief Interview for Mental Status score of 12, moderately impaired with decision making abilities. The resident required staff assistance for transfers, ambulation, toileting, and personal hygiene. The resident's diagnoses included anemia, hypertension, arthritis, anxiety, depression and chronic pain. The MDS documented the resident was on a scheduled pain medication regimen and received an opiod in the last 7 days of the reference period.

A Progress Notes entry dated 10/6/19 at 11:00 p.m., noted when checking fentanyl patch and narcotic count, the registered nurse (RN), noted 50 mcg patch on Resident #5 instead of the 12.5 mcg as ordered. Fentanyl patch removed, will have am nurse up date family and fax to physician as resident is not having adverse effects. Phoned pharmacy to get in e-kit.

A Medication Error report dated 10/6/19 at 11:00 p.m., documented when checking fentanyl patch and narcotic count, RN noted 50 mcg patch on Resident #5 instead of the 12.5 mcg as ordered. Fentanyl patch removed, on call updated, will have am nurse up date and fax to the physician as resident is not having an adverse effects.

During an interview on 10/29/19 at 11:14 a.m., Staff C (Licensed Practical Nurse) stated she came to work on 10/6/19 to work the 6:00 a.m.-2:00 p.m. shift and also the 2:00 p.m.-10:00 p.m. shift. Staff C confirmed the narcotic count was correct at 6:00 a.m., on the 10/6/19 shift and that she proceeded to do her daily medication administration. When came time to place the fentanyl patch on Resident #5, she verified the label on the patch was the same as the orders on the Medication Administration Record. Staff C

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F 580	Continued From page 3 stated she did not look at the patch itself as she got it out of the box, she went ahead and dated and initialed the patch and proceeded to place on the resident after taking off the old patch. Staff C confirmed and verified that when Staff D came to replace her so she could go work another hall, no narcotic count was completed or checking placements of the fentanyl patches were done. Staff C and Staff D exchanged keys by passing each other in the hall way. During an interview on 10/29/19 at 11:59 a.m., Staff D (Registered Nurse) confirmed and verified that no narcotic count was completed between her and Staff C as they exchanged only the keys to the different medication carts in the hallway and Staff C and herself failed to check placement of the fentanyl patches on the residents when they switched units at 2:30 p.m. on 10/6/19. During an interview on 10/29/19 at 3:34 p.m., Staff E (Certified Medication Aide) confirmed and verified she came to work on 10/6/19 at 3:00 p.m., and that no narcotic count was completed between her and Staff D when they keys were handed over to her for the medication cart and that they failed to check placements of the fentanyl patches on the residents. During an interview on 10/29/19 at 4:15 p.m., Staff F (Registered Nurse) stated when she came to work the 10:00 p.m.- 6:00 a.m., shift on 10/6/19, Staff E and herself did the narcotic count for that unit, they noted the fentanyl patch count was not correct. Both staff then went to check the placement of the patches and noted on Resident #5 the wrong dosage was applied to the resident. Staff F removed the wrong patch and placed the	F 580		

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F 580	Continued From page 4 correct patch on the resident. Staff F confirmed and verified the physician needed to be notified by telephone call of the medication error per the policy and procedure and verified she failed to notify the physician with the phone call. A Progress Notes entry dated 9/15/19 at 9:23 a.m., documented staff unable to locate old fentanyl patch. Primary care provider notified per facility protocol. New one placed and covered with tegaderm. Patient tolerated well. A Progress Notes entry dated 9/18/19 at 4:04 p.m., documented a telephone call was made to Resident #5's daughter regarding the missing Fentanyl patch on 9/15/19. Review of nurses notes indicated that physician had been notified but not the family. Each shift checks placement of patch and initials that it is in the new proper location. It was noted on resident back by the 10:00 p.m., nurse, but when the 6:00 a.m., nurse went to check placement it was not there. A new patch was applied. During an interview on 10/29/19 at 12:42 p.m., Staff A, Registered Nurse (RN), verified she was working on 9/15/19 when the resident's Fentanyl patch was missing. Staff A stated they went to change the Fentanyl patch and discovered it was missing. Staff A checked the resident's clothing, bedding, garbage, tables and drawers, but could not locate the patch. Staff A reported checking all narcotics including patches in the medication cart and they were all correct. Staff A stated she had not filled out an incident report until the facility Director of Nursing explained to her it was a medication error and that she needed to fill out the incident report.	F 580		

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F 580	Continued From page 5 During an interview on 10/29/19 at 11:34 a.m., Staff B, Licensed Practical Nurse, (LPN), stated she thought the patch was on the resident at 10:00 p.m., and confirmed Staff A and Staff B failed to check placement of the patch. Review of the The Medication Error Reporting dated 9/17/19, noted a medication error is an incident where a wrong medication, a wrong dose, the wrong resident, the wrong route, wrong time, medication was omitted, or the wrong reason has occurred when giving the resident a medication. If such an incident occurs it is imperative that you follow the proper steps in informing nurse management, physician, family and obtaining the proper instructions on how to handle the error such as, observation versus a trip the the emergency room depending on the severity: *when a medication error has occurred, the nurse making the error must report to a nurse manager or call the "Management on Call phone". *Physician Notification must occur by telephone to receive any pertinent orders related to care/observation/hospitalization for the resident. *Family Notification must occur and be documented in the nurses notes. *Alert charting must be started and maintained for at least the next 72 hours. During an interview on 10/30/19 at 10:10 a.m., the facility Director Of Nursing confirmed the clinical record lacked any documentation the physician was notified of the resident's wrong dose of the fentanyl patch and the expectation of the nursing staff is to notify the physician of changes in a resident and also that the family needed to be notified of the missing fentanyl patch right away instead of 3 days later.	F 580		

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and staff interviews, the facility failed to report potential abuse to the state agency, Iowa Department of Inspection and Appeals. Resident #5 had a missing Fentanyl (a topical opioid pain medication) patch. The facility reported a census of 118 residents.	F 609		

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F 609	Continued From page 7 Findings included: An Annual Minimum Data Set (MDS) assessment tool, dated 7/14/19, documented Resident #5 with a Brief Interview for Mental Status score of 12, moderately impaired with decision making abilities. The resident required staff assistance for transfers, ambulation, toileting, and personal hygiene. The resident's diagnoses included anemia, hypertension, arthritis, anxiety, depression and chronic pain. The MDS documented the resident was on a scheduled pain medication regimen and received an opiod in the last 7 days of the reference period. A Progress Notes entry dated 9/15/19 at 9:23 a.m., documented staff unable to locate old fentanyl patch. Primary care provider notified per facility protocol. New one placed and covered with tegaderm. Patient tolerated well. The Medication Error report dated 9/18/19 at 2:26 p.m., documented staff went to apply new pain patch. This nurse looked all over residents upper front and back area and was unable to locate the old patch. Applied new patch with clear film dressing and fax sent to primary care provider per facility protocol. On the form, under Other Info, noted agitation and anxiety related to medication administration. During an interview on 10/29/19 at 12:42 p.m., Staff A, Registered Nurse (RN), verified she was working on 9/15/19 when the resident's Fentanyl patch was missing. Staff A stated they went to change the Fentanyl patch and discovered it was missing. Staff A checked the resident's clothing, bedding, garbage, tables and drawers, but could	F 609		

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F 609	Continued From page 8	F 609		

not locate the patch. Staff A reported checking all narcotics including patches in the medication cart and they were all correct. Staff A stated she had not filled out an incident report until the facility Director of Nursing explained to her that it was a medication error and she needed to fill out the incident report.

During an interview on 10/29/19 at 11:34 a.m., Staff B, Licensed Practical Nurse, (LPN), stated she thought the patch was on the resident at 10:00 p.m., and confirmed Staff A and Staff B failed to check placement of the patch.

During an interview on 10/29/19 at 1:54 p.m., the facility Director of Nursing stated the facility found out about the missing fentanyl patch by reading the Progress Notes for the resident on 9/18/19, and that is when the investigation started and the facility failed to call the missing patch into the office due to feeling it was an isolated incident.

The Abuse Policy and Procedure, dated 6/2019, identified the policy statement as all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident medical symptoms. The policy directed staff to report all allegations Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the supervisor on duty and management on-call. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later

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F 609	Continued From page 9 than two (2) hours after the allegation is made. All allegations of Resident neglect, exploitation mistreatment injures of unknown origin and misappropriation shall be reported to the Iowa Department of Inspection and Appeals, not later then two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or note later than twenty-four (24) hours if events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation but do not result in serious bodily injury. The facility's undated, Abuse Investigation policy, directed staff to notify the Department of Inspection and Appeals after completion of the investigation, but no more than 2 hours after the incident. During an interview 10/29/19 at 1:54 p.m., the facility Director of Nursing verified she expected all staff to report any allegation of potential abuse and staff needed to follow up with investigating and reporting to the proper authorities per the facility Abuse policy and procedure.	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy and procedures the facility failed to ensure that physician's orders were followed and	F 658		

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F 658	Continued From page 10	F 658		

medications were prepared and administered according to professional standards for one resident, (Resident #5). The facility reported a census of 118 residents.

Findings include:

An Annual Minimum Data Set (MDS) assessment tool, dated 7/14/19, documented Resident #5 with a Brief Interview for Mental Status score of 12, moderately impaired with decision making abilities. The resident required staff assistance for transfers, ambulation, toileting, and personal hygiene. The resident's diagnoses included anemia, hypertension, arthritis, anxiety, depression and chronic pain. The MDS documented the resident on a scheduled pain medication regimen and received an opiod in the last 7 days of the reference period.

A Progress Notes entry dated 10/6/19 at 11:00 p.m., noted when checking fentanyl patch and narcotic count, the Registered Nurse noted 50 mcg patch on Resident #5 instead of the 12.5 mcg as ordered. The Fentanyl patch was removed, will have am nurse up date family and fax to physician as resident is not having adverse effects. Phoned pharmacy to get in e-kit.

A Medication Error report dated 10/6/19 at 11:00 p.m., documented when checking fentanyl patch and narcotic count the Registered Nurse noted a 50 mcg patch on Resident #5 instead of the 12.5 mcg as ordered. The Fentanyl patch removed, on call updated, will have am nurse up date and fax to the physician as resident is not having an adverse effects.

During an interview on 10/29/19 at 11:14 a.m.,

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F 658	Continued From page 11 Staff C, Licensed Practical Nurse stated she came to work on 10/6/19 to work the 6:00 a.m.-2:00 p.m. shift and also the 2:00 p.m.-10:00 p.m. shift. Staff C confirmed the narcotic count was correct at 6:00 a.m., on the 10/6/19 shift and she proceeded to do her daily medication administration. When came time to place the fentanyl patch on the resident, she verified the label on the patch was the same as the orders on the Medication Administration Record. Staff C stated she did not look at the patch itself as she got it out of the box, she went ahead and dated and initialed the patch and proceeded to place it on the resident after taking off the old patch. Staff C stated when Staff D came to replace her so that she could go work another hall, no narcotic count was completed or checking placements of the patches were done. Staff C and Staff D exchanged keys by passing each other in the hall way. During an interview on 10/29/19 at 11:59 a.m., Staff D, Registered Nurse confirmed no narcotic count was completed between her and Staff C as they exchanged only the keys to the different medication carts in the hallway, and Staff C and herself failed to check placement of the Fentanyl patches on the residents when they switched units at 2:30 p.m. on 10/6/19. During an interview on 10/29/19 at 3:34 p.m., Staff E, Certified Medication Aide confirmed she came to work on 10/6/19 at 3:00 p.m., and no narcotic count was completed between her and Staff D when they keys were handed over to her for the medication cart and they failed to check placements of the Fentanyl patches on the residents.	F 658		

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F 658	Continued From page 12 During an interview on 10/29/19 at 4:15 p.m., Staff F, Registered Nurse stated when she came to work the 10:00 p.m.- 6:00 a.m., shift on 10/6/19, Staff E and herself did the narcotic count for that unit, they noted the Fentanyl patch count was not correct. Both staff then went to check the placement of the patches and noted on Resident #5 the wrong dosage was applied to the resident. Staff F removed the wrong patch and placed the correct patch on the resident. Staff F confirmed and verified the physician needed to be notified by telephone call of the medication error per the policy and procedure and verified she failed to notify the physician with the phone call. A Progress Notes entry dated 9/15/19 at 9:23 a.m., documented staff unable to locate old fentanyl patch. Primary care provider notified per facility protocol. New one placed and covered with tegaderm. Patient tolerated well. A Progress Notes entry dated 9/18/19 at 4:04 p.m., documented a telephone call made to Resident #5's daughter regarding the missing Fentanyl patch on 9/15/19. Review of Nurses Notes indicated physician had been notified but not the family. Each shift checks placement of patch and initials that it is in the new proper location. It was noted on Resident #5's back by the 10:00 p.m., nurse, but when the 6:00 a.m., nurse went to check placement it was not there. A new patch was applied. During an interview on 10/29/19 at 12:42 p.m., Staff A, Registered Nurse, verified she was working on 9/15/19 when the resident's Fentanyl patch was missing. Staff A stated they went to change the Fentanyl patch and discovered it was missing. Staff A checked the resident's clothing,	F 658		

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F 658	Continued From page 13 bedding, garbage, tables and drawers, but could not locate the patch. Staff A reported checking all narcotics including patches in the medication cart and they were all correct. Staff A stated she had not filled out an incident report until the facility Director of Nursing explained to her that it was a medication error and she needed to fill out the Incident Report. During an interview on 10/29/19 at 11:34 a.m., Staff B, Licensed Practical Nurse, stated she thought the patch was on the resident at 10:00 p.m., and confirmed Staff A and Staff B failed to check placement of the patch. Review of the Narcotic Policy and Procedure dated 6/2019, stated it is the policy of this facility to maintain records of all narcotics including narcotic pain patches at the time of receiving in the facility until destruction. Procedure: *Only residents with physician orders will receive narcotics/narcotic pain patches as directed. *Narcotic and narcotic pain patches will be kept in the controlled substance lock box and reconciled at the end of each shift between the charge nurse responsible and the charge nurse taking responsibility of the medications. *Both nurses will sign the shift change log verifying the Narcotic count is accurate at the time of reconciliation. *Narcotic medications/Narcotic pain patches will be maintained as resident specific. *At the ordered time of administration, the nurse that signs the narcotic count sheet will also sign the medication administration record verifying he/she administered that medication. *The nurse will initial and date the narcotic/narcotic pain patch at time of administration.	F 658		

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F 658	Continued From page 14 *The nurse will administer narcotic per physician order, such as to apply a narcotic pain patch and document where the narcotic patch was placed on the resident on the medication administration record. *At shift change, the charge nurse and the relieving charge nurse will verify placement of all narcotic pain patches and document as such on the medications administration record. *Upon placement of the new patch, the patch that was removed will be discard via Drug buster and secure method and verified as such by the nurse removing and the nurse verifying discard of patch. Any time narcotics are disposed of 2 nurses must be present and sign documentation for proper disposal. *Any discrepancies in this policy may lead to disciplinary action up to termination. During an interview on 10/30/19 at 10:15 a.m., Staff G, Licensed Practical Nurse stated the nurses are expected to follow the policy and procedure for counting the narcotics and also to check placement of any narcotic patches.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		

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F 684	Continued From page 15 Based on record review, staff interview, and review of facility policy and procedure the facility failed to provide adequate assessment and timely intervention for a resident that had a wrong dose of a narcotic patch (Resident #5) and also two resident's that had an altercation (Resident #3 and #4). The facility reported a census of 118 residents. Findings include: 1. An Annual Minimum Data Set (MDS) assessment tool, dated 7/14/19, documented Resident #5 with a Brief Interview for Mental Status score of 12, moderately impaired with decision making abilities. The resident required staff assistance for transfers, ambulation, toileting, and personal hygiene. The resident's diagnoses included anemia, hypertension, arthritis, anxiety, depression and chronic pain. The MDS documented the resident on a scheduled pain medication regimen and received an opiod in the last 7 days of the reference period. A Progress Notes entry dated 10/6/19 at 11:00 p.m., noted when checking Fentanyl patch and narcotic count a Registered Nurse noted a 50 mcg patch on Resident #5 instead of the 12.5 mcg as ordered. The Fentanyl patch was removed, will have am nurse up date family and fax to physician as resident is not having adverse effects. Phoned pharmacy to get in e-kit. A Medication Error report dated 10/6/19 at 11:00 p.m., documented when checking Fentanyl patch and narcotic count a Registered Nurse noted a 50 mcg patch on Resident #5 instead of the 12.5 mcg as ordered. The Fentanyl patch was	F 684		

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F 684	Continued From page 16 removed, on call updated, will have am nurse up date and fax to the physician as resident is not having an adverse effects. Review of, Changes in Condition dated 5/20/19, stated a change in condition is any thing out of normal. It can be: Abnormal vital signs, behaviors, pain, Mental status changes, not getting out of bed, not eating etc. Steps to follow whenever there is a change in condition: *Obtain vital signs. This should be the first initial assessment. *Complete head to toe assessment. *If abnormal vital signs, notify physician and family immediately. *Request for start labs depending on the situation. *Put the patient on alert charting and complete progressive assessments during your shift. *Update the family of the resident condition progressively. *If the doctor gives orders for labs/medications, obtain the labs immediately and document the reasons for not obtaining. Call pharmacy to first dose medication if not in the facility. *Call the lab to pick up labs and remember to call for the results. *Offer interventions you are able to: example pain management. TAKE NOTE *Do not fax physician orders for changes in condition. Obtain orders, edit the orders in the Point Click Care as telephone, submit and print the telephone orders. Fax the telephone orders to the physician for signature. We are no longer going to fax for physician orders that need immediate intervention. *Initiate 72 hour hot charting.	F 684		

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F 684	Continued From page 17 During an interview on 10/30/19 at 10:15 a.m., Staff G, Licensed Practical Nurse confirmed the clinical record lacked any assessments for Resident #5 after receiving the wrong dose of the Fentanyl patch and it is expected the nurses follow the change of condition policy and procedure. 2. A reentry MDS with an assessment date 9/24/19, documented Resident #3 with moderately impaired cognition for decision making abilities, inattention and disorganized thinking, hallucinations, delusion, physical behavioral symptoms directed toward others, and other behaviors directed toward others and wandering 1-3 days during the reference period. The MDS documented the resident required supervision in how resident walks between locations, in his/her room, and how resident walks in corridor on unit. The resident had diagnosis of anxiety, psychotic disorder, dementia without behavioral disturbance, major depression and paranoid personality disorder. Resident #3's Plan of Care with a revision dated 9/10/19, identified the resident had a behavior problem due to dementia, wandering, anxiety and delusional disorder, aggressive behaviors to family members and other residents. Interventions include: *Anticipate and meet needs. *Assure resident is safe. *Be mindful of location when resident is up and ambulatory and attempt to keep at arms length from other residents. *Provide 1-1 activities with resident if anxious. *Provide divisional activities like snack and encourage fluids. *Provide 1-1 with staff due to recent behaviors	F 684		

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F 684	Continued From page 18 and aggressive altercation with another resident with a date of 9/21/19. *Red Rose program, high risk for resident to resident behavior. *Redirect or distract resident is being over affectionate toward other residents. Staff to redirect resident from getting into other resident rooms. The Physical Incident Report dated 9/21/19 at 10:04 p.m., documented resident allegedly put their hand on the right side of another resident's face. The Progress Notes dated 9/21/19 at 1:06 p.m., documented Resident #3 before lunch and after lunch started to show signs and symptoms of anxiousness, pacing the halls and inability to redirect at times, several episodes of tear-fullness. Nurse and staff have redirected resident with activities of daily living, communication, snacks, currently resident is watching television in main area with stuffed animal. The Progress Notes dated 9/21/19 at 9:53 p.m., noted alleged resident to resident altercation. Investigation on going, no injuries observed. Resident had multiple tearful episodes this shift along with getting irritated and upset and yelling multiple times. Resting quietly in bed. 3. A Significant Change in Status (MDS) assessment dated 8/20/19, documented Resident #4 with a Brief Interview for Mental Status score of 4, indicated severe decision impairment. The resident had verbal behavior symptoms directed towards others, other behaviors directed towards others and wandering 4 to 6 days occurred.The	F 684		

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F 684	Continued From page 19 MDS documented change in behaviors had gotten worse. The resident required limited assistance with how walks between locations in his/her room and walks in the corridor. The resident's diagnoses included Non-Alzheimer Dementia, depression and weakness. Resident #4's Plan of Care with a initiated date 7/12/19, identified the resident had potential to be physically aggressive related to history of altercation, dementia, poor impulse control. Interventions include: *Provide emotional support to the resident. *When agitated: intervene before agitation escalates, guide away form source of distress, engage calmly in conversation, if response is aggressive, staff to walk away calmly and approach later. A Physical Incident Report dated 9/21/19 at 10:14 p.m., noted no physical contact was seen by this author. No injuries observed at time of incident. The Progress Notes dated 9/21/19 at 10:22 p.m., documented Resident #4 reported to CNA "I was hit by that lady". When resident asked to point out the lady that did this resident was not able to recall and then stated, "oh hell I don't know". No redness regarding injury noted to resident's face at this time. Son was notified and reassured that this matter would be investigated and get back to him as soon as we knew something. Review of the facility footage on 10/16/19 at 1:01 p.m., for the incident on 9/21/19, revealed the following: *5:27 p.m., no resident or staff in the Birch hallway, then Resident #3 started to ambulate down the hall way towards the double doors into	F 684		

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F 684	Continued From page 20 the unit *5:29:14 p.m., Resident #3 started to ambulate with the merry walker into Resident #4's doorway of the residents room, able to see the right rear of the merry walker as ambulated through the door way *5:29:35 p.m., Resident #3 sits down in the merry walker in the door way of Resident #4 room *5:29:55 p.m., Resident #4 started to push Resident #3 out of the door way while Resident #3 was still sitting in the merry walker, Resident #4 had a walker in front of him, both residents start to punch each other back and forth. Resident #4 pushed Resident #3 out into the middle of the hall way and attempted to go around the merry walker, and Resident #3 hit Resident #4, Resident #4 hit Resident #3 back. Resident #4 finally was able to move around Resident #3 and started to ambulate down the hallway to the common area. Resident #3 immediately turned the merry walker around and chased Resident #4 to the common area, Resident #3 caught the other resident and they both turned towards each other and started throwing punches back and forth with both hands to the face, arms and shoulders, Resident #4 started to loose balance and grabbed onto Resident #3's arm for stability, while Resident #3 continued to punch the other resident in the face, neck, arm and shoulders. *5:32:09 p.m., Staff J, Certified Nursing Assistant came into view of the camera and took Resident #4 away from Resident #3 and proceeded to assist out of view of the camera. Resident #3 sat down in the merry walker and began to cry. *5:32:32 p.m., Staff K, Certified Nursing Assistant was seen coming down the hallway to the common area and looked at Resident #3 sitting in the merry walker crying and continued to walk on	F 684		

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F 684	Continued From page 21 by. *5:33:56 p.m., Staff L, Licensed Practical Nurse comes into view of the camera and walked by Resident #3 who was still in the merry walker and continued to walk out of the unit through the double doors. *5:37:49 p.m., Staff L came back through the double doors onto Birch unit and stopped at Resident #3 still in the merry walker and does a quick look over the residents arms, face and neck, then walked out of view of the camera into the common area. During an interview on 10/15/19 at 4:20 p.m., Staff G and Staff M (Registered Nurse) both stated the facility Director of Nursing spoke to the staff on the Birch unit and explained to them Resident #3 had just been readmitted back to the facility on 9/20/19 for behaviors and that staff needed to keep a close eye on her at all times to make sure there is no altercation between any of the residents on the Birch unit. During an interview on 10/16/19 at 12:36 p.m., Staff K stated the facility Director of Nursing brought each of the staff into the office and explained the staff needed to keep a close eye on the resident at all times, for which is different from 1-1 supervision. Keeping a close eye on the resident means that they are in your vision at all times, 1-1 supervision means you are with in an arms length away from the resident at all times. During an interview on 10/14/19 at 4:01 p.m., Staff J confirmed and verified that the facility Director of Nursing brought each of the staff into the office and explained the staff needed to keep a close eye on the resident at all times, for which is different from 1-1 supervision. Keeping a close	F 684		

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F 684	Continued From page 22	F 684		

eye on the resident means they are in your vision at all times, 1-1 supervision means that you are with in an arms length away from the resident at all times. Staff J stated it was their responsibility to make sure Resident #3 was in their line of vision at all times and that Staff J got distracted from that due to being called over by the charge nurse whom was passing medications to assist in identifying who the resident's were. Staff J confirmed that when there was a commotion in the Birch hallway the resident was not in the line of vision as requested by the facility Director of Nursing. Staff J stated the last time Resident #3 was in their line of vision was around 4:30 p.m., and could not recall where the resident was after that time.

During an interview on 10/16/19 at 12:38 p.m., Staff L confirmed and verified the facility Director of Nursing brought each of the staff into the office and explained the staff needed to keep a close eye on the resident at all times, for which is different from 1-1 supervision. Keeping a close eye on the resident means that they are in your vision at all times, 1-1 supervision means that you are with in an arms length away from the resident at all times.
Staff L stated no assessments were completed on Resident #3 or Resident #4 as no red marks were seen as they did a quick eye over the residents.

During an interview on 10/21/19 at 12:40 p.m., the facility Director of Nursing stated all the staff were brought into the office and explained that Resident #3 needs to have an eye on them at all times due to just being readmitted to the facility on 9/20/19 and that it is different from being a 1-1 supervision. Keeping an eye on a resident is the

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F 684	Continued From page 23 expectation that the resident is always in your line of vision and 1-1 supervision is the expectation that staff are at a arms length away from the resident. Review of Changes in Condition dated 5/20/19, stated a change in condition is any thing out of normal. It can be: Abnormal vital signs, behaviors, pain, Mental status changes, not getting out of bed, not eating etc. Steps to follow whenever there is a change in condition: *Obtain vital signs. This should be the first initial assessment. *Complete head to toe assessment. *If abnormal vital signs, notify physician and family immediately. *Request for start labs depending on the situation. *Put the patient on alert charting and complete progressive assessments during your shift. *Update the family of the resident condition progressively. *If the doctor gives orders for labs/medications, obtain the labs immediately and document the reasons for not obtaining. Call pharmacy to first dose medication if not in the facility. *Call the lab to pick up labs and remember to call for the results. *Offer interventions you are able to: example pain management. TAKE NOTE *Do not fax physician orders for changes in condition. Obtain orders, edit the orders in the Point Click Care as telephone, submit and print the telephone orders. Fax the telephone orders to the physician for signature. We are no longer going to fax for physician orders that need immediate intervention.	F 684		

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F 684	Continued From page 24 The Allegation for Abuse/Resident to Resident checklist dated 8/24/16, instructed staff to: *Ensure Residents are safe/separate the residents and keep them separated the remainder of the shift. *If staff is suspected remove staff from the floor immediately *Resident to Resident: Complete head to toe assessment and complete progress note on both residents. *Obtain witness statements from all staff on the hallway including house keeping, maintenance, activities and dietary. *Notify Director of Nursing once you have obtained all statements. *Notify DIA hotline. Document the time you called DIA. *Notify physician for both residents. *Notify both residents Family/POA. *Complete incident report for both aggressor and victim. *Place both residents on alert charting times 72 hours. During an interview on 10/16/19 at 2:30 p.m., Staff G and Staff M both confirmed and verified the clinical record lacked any documentation of Resident #3 and Resident #4 as being assessed per the policy and procedure for the change of condition, and it is expected to follow the procedure and policy for the Allegation of Abuse policy and procedure.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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F 689	Continued From page 25 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of facility policy and procedure the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for for residents, (Resident #6, #5, #3 and #4). The facility census was 118 residents. Findings include: 1. A reentry Minimum Data Set (MDS) assessment tool, dated 9/24/19, documented Resident #6 with impaired short term memory and moderately impaired decision making abilities. The resident required extensive assistance with all aspects of daily living. The MDS documented the resident with diagnoses of anxiety, dementia without behavioral disturbance, personal history of other mental and behaviors and major depression. The resident had a fall with no injuries. Resident #6's Plan of Care with a initiated dated 2/10/19 and a revision date 8/14/19, had a focus area for high risk for falls related to confusion, history of falls, incontinence, psychoactive drug use, unaware of safety needs, and attempts to self transfer at times. Interventions include: *Uses pressure pad alarm in chairs and wheelchair. has floor mat alarm by bed. Ensure the devices are in place as needed.	F 689		

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F 689	Continued From page 26 A Fall Incident Report dated 9/24/19 at 1:38 a.m., documented Registered Nurse with another resident when Certified Nursing Assistant reported the fall. Upon entering the hall, Resident #6 was laying in front of the wheelchair, head towards wall and feet towards wheelchair. Vital signs taken, went to assess range of motion but pain with movement of left hip. When asked if hurt, resident put hand on left hip and said "right here". When lightly touching left leg or foot resident would jerk/jump. No other injuries noted at this time. Phoned Power of Attorney, and physician, orders received to send to Emergency room. The Post Fall Evaluation dated 9/24/19 at 1:54 a.m., documented Resident #6 had a fall which resulted in an Emergency room visit/hospitalization, with pain in the left leg/foot, with prior history of falls in the facility. The Emergency Department Notes dated 9/24/19 at 2:07 a.m., documented Resident #6 had a witnessed fall while walking, fell onto left side, no injury to the head or neck, complaints of low back and left hip pain with a diagnosis of intertrochanteric fracture of left hip, closed, initial encounter. The X-ray Report dated 9/24/19 at 4:14 a.m., documented acute proximal left femur fracture due to a fall with left hip pain, findings include: an acute proximal left femur fracture noted involving the trochanters and base of the femoral neck. A Major Injury Determination Form, signed and dated by the physician on 9/27/19 at 1:34 p.m., stated after reviewing the circumstances of the incident causing the injury the previous functional	F 689		

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F 689	Continued From page 27 ability of the patient, and the patients prognosis, I believe the injury sustained is a major injury. During an interview on 10/17/19 at 12:25 p.m., Staff H, Certified Nursing Assistant stated there was no pad alarm on the wheelchair, and didn't know one had to be on the wheelchair as care planned. During an interview on 10/17/19 at 11:40 a.m., Staff F, RN confirmed and verified there was no alarm sounding when came out of another resident room to assist with the resident that fell. During an interview on 10/17/19 at 4:30 p.m., Staff G, LPN stated the expectation of the staff is to follow the residents plan of care and to have had the pad alarm while the resident was in the wheelchair. During an interview on 10/21/19 at 1:08 p.m., Staff I, CNA confirmed and verified there was no alarm sounding as staff came out of another resident room. 2. An Annual MDS assessment tool, dated 7/14/19, documented Resident #5 had a Brief Interview for Mental Status score of 12, moderately impaired cognition for decision making skills. The resident required staff assistance for transfers, ambulation, toileting, and personal hygiene and had no falls since the latest admission. The resident's diagnoses included anemia, hypertension, arthritis, anxiety, depression and chronic pain. The MDS documented the resident was on a scheduled pain medication regimen and received an opiod in the last 7 days of the reference period.	F 689		

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F 689	Continued From page 28 The Care Area Assessment dated 7/14/19, documented the resident had potential for falls with difficulty maintaining sitting balance, impaired balance during transitions, anti-depressants, anti-anxiety medications, diagnoses of anemia, arthritis, cognitive impairment, dementia, anxiety and depression. Resident was at risk for falling due to taking anti-depressant, anti-anxiety and opiod and will proceed with the plan of care. Resident #5's Plan of Care had a focus area, with a initiated date of 2/20/19, stated resident is at risk for falls related to confusion, psychoactive drug use, unaware of safety needs. Interventions include: *Uses a FMA (floor mat alarm) and motion sensor alarm. Ensure the devices are in place. Motion sensor alarm alerts staff in the hallway. The Progress Notes dated 8/17/19 at 12:40 p.m., documented Resident #5 on floor, upon arrival in room, this nurse found resident on the floor next to recliner. Lying horizontally on left side, head against the wall. Alert and conscious, stating " I fell, can I get up". Noted moderate amount of blood on floor, from deep cut on the left shin. Applied pressure, asked house keeper to call supervisor, who came right away, called family right away and family gave OK to send to hospital. Order received per phone from the Doctor. 911 called and they arrived shortly thereafter. Left with the resident on the stretcher. Prior to the fall, the Certified Nursing Assistant had assisted resident to the recliner and covered with blanket as normally does, per the Certified Nursing Assistant the FMA was not in use due to the refusal by the resident which does at times. The Progress Notes dated 8/17/19 at 4:30 p.m.,	F 689		

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F 689	Continued From page 29 documented Resident #5 arrived back to facility in daughters car. This nurse and supervisor assisted with getting resident into wheelchair. Resident appeared tired and weak, family informed by this nurse and supervisor the trauma and movement may be contributing factors. Resident appears in good mood. Laceration is covered with dressing upon arrival. No drainage noted. Per daughters, Resident #5 received 35 staples and the Emergency Room physician told them to remove the staples in 14 days. Review of the Post Fall Evaluation completed on 8/17/19 at 12:40 p.m., documented resident had injury related to this fall with an Emergency Room visit due to a laceration on the left shin. Resident with prior history of falls in the facility with similarities between current and post falls, attempting to get out of the recliner. 3. A reentry MDS with an assessment date 9/24/19, documented Resident #3 with moderately impaired for decision making abilities, inattention and disorganized thinking, hallucinations, delusion, physical behavioral symptoms directed toward others, and other behaviors directed toward others and wandering 1-3 days during the reference period. The resident required supervision in how resident walks between locations in his/her room, and how resident walks in corridor on unit. The resident's diagnosis included anxiety, psychotic disorder, dementia without behavioral disturbance, major depression and paranoid personality disorder. The Resident #3's Plan of Care with a revision dated 9/10/19, identified resident had a behavior problem due to dementia, wandering, anxiety and delusional disorder, aggressive behaviors to	F 689		

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F 689	Continued From page 30 family members and other residents. Interventions include: *Anticipate and meet needs. *Assure resident is safe. *Be mindful of location when resident is up and ambulatory and attempt to keep at arms length from other residents. *Provide 1-1 activities with resident if anxious. *Provide divisional activities like snack and encourage fluids. *Provide 1-1 with staff due to recent behaviors and aggressive altercation with another resident with a date of 9/21/19. *Red Rose program, high risk for resident to resident behavior. *Redirect or distract resident is being over affectionate toward other residents. Staff to redirect resident from getting into other resident rooms. The Physical Incident Report dated 9/21/19 at 10:04 p.m., documented Resident #3 allegedly put their hand on the right side of another resident face. The Progress Notes dated 9/21/19 at 1:06 p.m., noted Resident #3 before lunch and after lunch started to show signs and symptoms of anxiousness, pacing the halls and inability to redirect at times and several episodes of tear-fullness. Nurse and staff have redirected resident with activities of daily living, communication, snacks. Currently resident is watching television in main area with stuffed animal. The Progress Notes dated 9/21/19 at 9:53 p.m., documented alleged resident to resident altercation. Investigation on going, no injuries	F 689		

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F 689	Continued From page 31 observed. Resident had multiple tearful episodes this shift along with getting irritated and upset and yelling multiple times. Resting quietly in bed. A Significant Change in Status (MDS) assessment with a reference dated 8/20/19, documented Resident #4 with a Brief Interview for Mental Status score of 4, indicated severe decision impairment. The resident had verbal behavior symptoms directed towards others, and other behaviors directed towards others and wandering 4 to 6 days occurred and change in behaviors had gotten worse. The resident required limited assistance with how walks between locations in his/her room and walks in the corridor. The residents diagnoses included Non-Alzheimer Dementia, depression and weakness. Resident #4's Plan of Care with a initiated date 7/12/19, identified the resident as potential to be physically aggressive related to history of altercation, dementia, poor impulse control. Interventions include: *Provide emotional support to the resident. *When agitated: intervene before agitation escalates, guide away form source of distress, engage calmly in conversation, if response is aggressive, staff to walk away calmly and approach later. A Physical Incident Report dated 9/21/19 at 10:14 p.m., documented no physical contact was seen by this author. No injuries observed at time of incident. The Progress Notes dated 9/21/19 at 10:22 p.m., documented the resident reported to Certified Nursing Assistant "I was hit by that lady" when	F 689		

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F 689	Continued From page 32	F 689		

resident asked to point out the lady that did this resident was able to recall and then stated, "oh hell I don't know". No redness regarding injury noted to resident face at this time. Son was notified and reassured this matter would be investigated and would get back to him as soon as we knew something.

Review of the facility footage on 10/16/19 at 1:01 p.m., for the incident on 9/21/19, revealed the following:
*5:27 p.m., no resident or staff in the Birch hallway, then Resident #3 started to ambulate down the hall way towards the double doors into the unit.
*5:29:14 p.m., Resident #3 started to ambulate with the merry walker into Resident #4's doorway of the residents room, able to see the right rear of the merry walker as ambulated through the door way.
*5:29:35 p.m., Resident #3 sat down in the merry walker in the door way of Resident #4's room.
*5:29:55 p.m., Resident #4 started to push Resident #3 out of the door way while Resident #3 was still sitting in the merry walker, Resident #4 had a walker in front of him, both residents started to punch each other back and forth. Resident #4 pushed Resident #3 out into the middle of the hall way and attempted to go around the merry walker, and Resident #3 hit Resident #4, Resident #4 hit Resident #3 back. Resident #4 finally was able to move around Resident #3 and started to ambulate down the hallway to the common area. Resident #3 immediately turned the merry walker around and chased Resident #4 to the common area, Resident #3 caught the other resident and they both turned towards each other and started throwing punches back and forth with both hands

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F 689	Continued From page 33 to the face, arms and shoulders, Resident #4 started to loose balance and grabbed onto Resident #3's arm for stability, while Resident #3 continued to punch the other resident in the face, neck, arm and shoulders. *5:32:09 p.m., Staff J, Certified Nursing Assistant came into view of the camera and took Resident #4 away from Resident #3 and proceeded to assist out of view of the camera. Resident #3 sat down in the merry walker and began to cry. *5:32:32 p.m., Staff K, Certified Nursing Assistant was seen coming down the hallway to the common area and looked at Resident #3 sitting in the merry walker crying and continued to walk on by. *5:33:56 p.m., Staff L, Llicensed Practical Nurse came into view of the camera and walked by Resident #3 who was still in the merry walker, and continued to walk out of the unit through the double doors. *5:37:49 p.m., Staff L came back through the double doors onto Birch unit and stopped at Resident #3 still in the merry walker, and did a quick look over the residents arms, face and neck, then walked out of view of the camera into the common area. During an interview on 10/15/19 at 4:20 p.m., Staff G and Staff M (Registered Nurse) both stated the facility Director of Nursing spoke to the staff on the Birch unit and explained to them Resident #3 had just been readmitted back to the facility on 9/20/19 for behaviors and staff needed to keep a close eye on her at all times to make sure there is no altercation between any of the residents on the Birch unit. During an interview on 10/16/19 at 12:36 p.m., Staff K confirmed and verified the facility Director	F 689		

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F 689	Continued From page 34 of Nursing brought each of the staff into the office and explained the staff needed to keep a close eye on the resident at all times, which is different from 1-1 supervision. Keeping a close eye on the resident means they are in your vision at all times, 1-1 supervision means that you are with in an arms length away from the resident at all times. During an interview on 10/14/19 at 4:01 p.m., Staff J confirmed and verified the facility Director of Nursing brought each of the staff into the office and explained the staff needed to keep a close eye on the resident at all times, which is different from 1-1 supervision. Keeping a close eye on the resident means they are in your vision at all times, 1-1 supervision means that you are with in an arms length away from the resident at all times. Staff J stated it was their responsibility to make sure Resident #3 was in their line of vision at all times and Staff J got distracted from that due to being called over by the charge nurse whom was passing medications to assist in identifying who the residents were. Staff J confirmed that not until there was a commotion in the Birch hallway the resident was not in the line of vision as requested by the facility Director of Nursing. Staff J stated the last time Resident #3 was in their line of vision was around 4:30 p.m., and could not recall where the resident was after that time. During an interview on 10/16/19 at 12:38 p.m., Staff L confirmed and verified the facility Director of Nursing brought each of the staff into the office and explained the staff needed to keep a close eye on the resident at all times, which is different from 1-1 supervision. Keeping a close eye on the resident means they are in your vision at all	F 689		

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F 689	Continued From page 35 times, 1-1 supervision means that you are with in an arms length away from the resident at all times. Staff L stated no assessments were completed on Resident #3 or Resident #4 as no red marks were seen as they did a quick eye over the residents. During an interview on 10/21/19 at 12:40 p.m., the facility Director of Nursing stated all the staff were brought into the office and explained that Resident #3 needs to have an eye on them at all times due to just being readmitted to the facility on 9/20/19 and that it is different from being a 1-1 supervision. Keeping an eye on a resident is the expectation the resident is always in your line of vision and 1-1 supervision is the expectation that staff are at a arms length away from the resident. The Allegation for Abuse/Resident to Resident checklist dated 8/24/16, instructed staff to: *Ensure Residents are safe/separate the residents and keep them separated the remainder of the shift. *If staff is suspected remove staff from the floor immediately. *Resident to Resident: Complete head to toe assessment and complete progress note on both residents. *Obtain witness statements from all staff on the hallway including house keeping, maintenance, activities and dietary. *Notify Director of Nursing once you have obtained all statements. *Notify DIA hotline. Document the time you called DIA. *Notify physician for both residents. *Notify both residents Family/POA. *Complete incident report for both aggressor and victim.	F 689		

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F 689	Continued From page 36 *Place both residents on alert charting times 72 hours.	F 689		

F580: Notify of changes (Injury/Decline/Room)

It is the practice of the facility to ensure proper notification to: Resident/DPOA/Physician of medication errors, missing fentanyl patch, or Narcotics.

Corrective action taken to the resident found to have been affected by the deficient practice.

Resident #5 DPOA was notified on 9/18/19 @ 16:04, Dr. Danielson was notified on 10/7/19. Resident was assessed for adverse effects related to medication error; no adverse effects observed.

How will the center identify other residents having the potential to be affected by the same deficient practice?

All residents who reside in the facility and have physician orders for Fentanyl patches.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Licensed nurses were re-educated on the requirements of notification to the resident's responsible party and physician when there is a medication error, or missing Fentanyl patch/narcotics.
- DON or designee will randomly audit 5 residents per week x 4 weeks, and integrate into QA audits. All physician orders will be put on carbon copy sheets, and double checked by the A.D.O.N.s to ensure the physician orders have been followed.
- A medication error checklist has been created, in the event that a medication error occurs.

Quality Assurance Plan to Monitor performance to make sure corrections are achieved and are permanent.

- Identified concerns shall be reviewed by the facility QAA committee.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when the corrective action will be completed 11/29/19.

F609: Reporting of alleged Violation

- It is the practice of the facility to ensure DIA is notified of a potential allegation of abuse.

Corrective action taken to the resident found to have been affected by the deficient practice

- Investigation was conducted for the missing fentanyl patch. Physician and family notified. New Fentanyl patch was re-applied per physician orders. Resident assessed no adverse effects noted.

How will the center identify other residents having the potential to be affected by the same deficient practice?

- All residents who reside in the facility and have fentanyl patches.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- The narcotics policy will be reviewed and updated.
- Licensed staff and DON will be educated on the new Narcotics Policy.
- DON or designee will conduct random audits weekly on patients who have fentanyl patches, to ensure proper steps have been completed and appropriate notification is complete.

Quality Assurance Plan to Monitor performance to make sure corrections are achieved and are permanent.

- Identified concerns shall be reviewed by the facility QAA committee.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when the corrective action will be completed 11/29/19

F658: Services provided meet professional standards

It is the policy of the facility to ensure physician orders are followed and executed in a professional manner, and facility policies and procedures are followed including family and/or physician notifications.

Corrective action taken to the resident found to have been affected by the deficient practice

- Resident # 5 was assessed for adverse effects related to Fentanyl patch medication error. Family was notified of the missing fentanyl patch for resident #5 on 9/18/19.

How will the center identify other residents having the potential to be affected by the same deficient practice?

- All residents who have experienced a medication error.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Staff will be Re-educated on maintaining professional standards, which include following facility policies and procedures and notifications. A medication error check list has been introduced to guide nurses when a medication error has occurred.
- DON/Designee will audit patients with a fentanyl patch, for compliance with checking placement for 4 weeks and then incorporated into facility QA auditing process.

Quality Assurance Plan to Monitor performance to make sure corrections are achieved and are permanent.

- Identified concerns shall be reviewed by the facilities QAA committee.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when the corrective action will be completed 11/29/19

F684: Quality of care

- The facility strives to ensure each resident receives treatment and care in accordance with profession standards of care including assessments and provision of interventions.

Corrective action taken for resident to have been affected by the deficient practice.

- Resident #5 was assessed for adverse effects related to wrong dose of narcotic.
- Resident #3 was transferred to VA Hospital and placed in an appropriate facility.
- Resident #4 was assessed for injury and psychosocial effects related to the incident.

How will the center identify other residents having the potential to be affected by the same deficient practice?

- All residents who reside in the facility and experience a medication error or have a physical altercation with another resident.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Staff will be re-educated on how to complete assessments with any changes in condition.
- Random audits will be conducted on residents who have a resident to resident altercation to ensure compliance with appropriate interventions are complete and in place for 4 weeks.
- Random audits will be done on residents with medication errors for 4 weeks to ensure compliance then during daily QA meeting.

Quality Assurance Plan to Monitor performance to make sure corrections are achieved and are permanent.

- Identified concerns shall be reviewed by the facilities QAA committee.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when the corrective action will be completed 11/29/19