STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025039	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE SPRINGS OF PALMER	**12130 EAST MAPLE SPRINGS WAY PALMER, AK 99645**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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E 0015 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Address subsistence needs for staff and patients.** . Based on record review and interview the facility failed to ensure a policy and/or procedure was established for provisions of subsistent needs for staff in accordance with CFR 483.73(b)(1). This failed practice placed all residents (based on a census of 5) at risk for loss in continuity of care. Findings: Review on 4/30/20 of the facility's emergency operations plan, dated 12/2019, revealed the Emergency food Plan only addressed meals for residents. During an interview on 4/30/20 the Administrator acknowledged the findings at the time of their discovery. .
E 0024 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish policies and procedures for volunteers.** . Based on record review and interview the facility failed to ensure the emergency plan contained a policy and/or procedure that addressed use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This failed practice placed all residents (based on a census of 5) at risk for loss in continuity. Findings: Review on 4/30/20 of the facility's emergency operations plan, dated 12/2019, revealed the emergency plan did not contain a policy and/or procedure that addressed use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. During an interview on 4/30/20 the Administrator acknowledged the finding at the time of its discovery. .
E 0025 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Create arrangements with other facilities to receive patients.** . Based on record review and interview the facility failed to ensure the emergency plan contained a policy and/or procedure as it relates to the arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. This failed practice placed all residents (based on a census of 5) at risk for loss in continuity and delay in evacuation or transfer. Findings: Review on 4/30/20 of the facility's emergency operations plan, dated 12/2019, revealed the emergency plan did not contain a policy and/or procedure as it relates to the arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. Further review of the plan revealed Evacuate Skilled Nursing Residents to facilities in the area .A complete listing of Receiving Facilities is attached to this plan. (to be determined) . During an interview on 4/30/20 the Administrator acknowledged the finding at the time of its discovery. The Administrator further stated the list of receiving facilities was not attached to the plan. .
E 0033 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish methods for sharing information.** . Based on record review and interview the facility failed to ensure the emergency plan contained a policy and/or procedure that included names and contact information of entities providing services under agreement and other facilities. This failed practice placed all residents (based on a census of 5) at risk for loss in continuity. Findings: Review on 4/30/20 of the facility's emergency operations plan, dated 12/2019, revealed the emergency plan did not contain names and contact information for all entities providing services under agreement and other facilities the facility would use to transfer residents. Further review of the plan revealed Evacuate Skilled Nursing Residents to facilities in the area .A complete listing of Receiving Facilities is attached to this plan. (to be determined) . During an interview on 4/30/20 the Administrator stated that the Disaster Phone List did not contain names and contact information for all entities providing services under arrangement and other like facilities that would be used for the transfer of residents. .
F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review and interview, the facility failed to ensure the Power of Attorney (POA) of 1 resident, out of 5 sampled residents, received full information about the use of a [MEDICAL CONDITION] medication. Specifically, the general consent form used by the facility did not provide documentation to support informed consent of specific medication use, risk, benefits, and alternative options to ensure resident choice in consenting to treatment. This failed practice denied residents and/or their support persons the right to fully understand and consent to treatment. Findings: Record review 4/22-24/20 revealed Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. Review of the Order Summary Report, dated 4/22/20 revealed the Resident was prescribed [MEDICATION NAME] (a [MEDICAL CONDITION] used to treat depression) tablet 10 mg (milligram) to be given by mouth one time a day for depression, with an order date of 3/19/20. Review of the [MEDICAL CONDITION] MEDICATION INFORMED CONSENT & RISK/BENEFIT STATEMENT on 4/23/20 at 11:30 am, revealed Resident #3's POA was contacted for consent for a [MEDICAL CONDITION] medication. Further review of the document revealed no medication name, dosage, or drug specific concerns listed on the consent. During an interview on 4/23/20 at 12:15 pm, the Director of Nursing (DON) confirmed the consent for the [MEDICATION NAME] did not list the medication name, dosage or side effects for this specific medication. .
F 0574 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**The resident has the right to receive notices in a format and a language he or she understands.** . Based on record review, observation, interview and policy review, the facility failed to ensure the residents received their required notices. Specifically, information of an external agency was not provided. This failed practice placed all residents (based on census of 5) at risk for violation of rights as a result of not being properly informed of external agency contact information. Findings: Review of the Resident's Admission Packet on 4/21/20 at 2:00 pm revealed no mention of the Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) agency or list of phone numbers or addresses for the Resident's to reference. An observation on 4/21/20 at 2:55pm revealed no posting of the BFCC-QIOs agency or list of phone numbers or addresses for the Resident's to reference. During an interview on 4/23/20 at 12:48 pm, the Director of Nursing (DON) indicated that she was not aware of the required QIO notice. Review on 4/3/20 at 4:00 pm, of the facility's policy Grievance Policy and Procedure, not dated, revealed Residents will be notified of their right to file a grievance verbally, in writing or anonymously and how to contact the grievance official, reasonable time frame for completing the review of the grievance and the contact information of independent entities with whom grievance may be filed

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 0574 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) (ombudsman, State agency, QIO etc.) .
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . F578 Based on record review, interview and policy review, the facility failed to ensure 1 resident's wish not to formulate an Advance Directives (AD) was documented for 1 resident (#5) out of 5 sampled residents. This failed practice had the potential to deny the resident information about their right to establish end of life decisions that may include a medical power of attorney, do not resuscitate order (DNR), and/ or other documents that direct end of life care. Findings: Record review on 4/21-23/20 revealed Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. Further review medical record did not reveal evidence the Resident was offered an AD. During an interview on 4/22/20 at 3:43 pm, the Director of Nursing (DON) stated that the MOST (Medical Orders for Scope of Treatment) was the AD. When told that the MOST form was not an AD, the DON stated the Social Worker (SW) was responsible for assisting the Residents with an AD. During an interview on 4/22/20 at 4:01 pm, with SW #1, the RESIDENT ADMISSION AGREEMENT, dated 2/15/20, was reviewed. SW #1 stated Resident #5 did not have an AD. When asked what the follow up was, SW #1 stated there was no follow up. SW #1 further stated that he/she remembered Resident #5 did not want assistance to formulate an AD, but he/she did not include that documentation in the Resident's medical record. Review of the Facility form RESIDENT RIGHTS, dated 2/20, revealed Each Resident has the right to formulate an advanced directive with the assistance of Maple Springs staff. Review of the Facility's policy Requesting, Refusing and/or Discontinuing Care or Treatment, revised 12/2019, revealed The resident/representative will be informed of his or her rights to .formulate an advance directive. .
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** . Based on record review, observation, interview and policy review, the facility failed ensure 1) the name of the Grievance Officer (GO) was posted; 2) information on the residents right to file an anonymous grievance was posted or provided to the residents; and 3) the grievance policy was implemented. These failed practices had the potential affect all residents, based on a census of 5, to deny the residents the right to voice grievances. Review of the Resident's Admission Packet on 4/21/20 at 2:00 pm revealed a CONCERNS AND COMPLAINTS document. The facility's Grievance Officer (GO) was not listed on the document. Further review revealed no information about the Resident's right to file a grievance anonymously, or instructions on how they could. An observation on 4/21/20 at 2:55pm revealed the same CONCERNS AND COMPLAINTS document posted on the wall near the front entrance. The facility's Grievance Officer (GO) was not listed on the document, and no information was mentioned about the Resident's right to file grievance anonymously, or instructions on how they could. Further observation revealed no place in the facility to deposit anonymous grievances. During an interview on 4/21/20 at 3:04 pm, Certified Nursing Assistant (CNA) #1 stated that if a Resident had a complaint, he/she would report the complaint to the Director of Nursing (DON). When asked if the Resident had a complaint about the DON, CNA #1 stated he/she would report that complaint to the Facility Administrator. When asked if the Resident wanted to file a grievance anonymously, CNA #1 stated he/she did not know what to do. CNA #1 further stated the grievance forms for the Residents were kept in a filing cabinet behind the Nurse's station. During an interview on 4/22/20 at 9:10 am, Social Worker (SW) #1 stated he/she was also the GO. When asked about the process for the Residents to file a grievance, SW #1 stated the Resident had to ask a staff member to provide him or her with a grievance form. When asked how the Resident could file a grievance anonymously, SW #1 stated there was no place for the Residents to deposit an anonymous grievance form. During an interview on 4/22/20 at 11:35 am, Resident #5 stated he/she did not know who the grievance officer was. Resident #5 further stated that if he/she had a complaint, he/she would let the Facility Administrator know. Review of the facility policy Grievance Policy and Procedure, not dated, revealed Grievances/complaints may be presented .Anonymously, may use red drop boxes located throughout Maple Springs Wasilla . Further review revealed Residents will be notified of their right to file a grievance verbally, in writing or anonymously and how to contact the grievance official . .
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review, interview and policy review, the facility failed to ensure the resident's care plans were individualized to meet medical and psychosocial needs for 2 residents (#3 and 5) out of 5 sampled residents. Specifically, anticoagulants (blood thinners) and [MEDICAL TREATMENT] (a clinical purification of the blood, as a substitute for the normal function of the kidney) specific interventions were missing from the care plans. This failed practice placed the residents at risk for not receiving necessary services to address their individual needs. Findings: Resident #3 Record review 4/22-24/20 revealed Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. Review of the Order Summary Report, dated 4/22/20, revealed Resident #3 was taking Apixaban (a blood thinner used to treat and prevent stoke in people with [MEDICAL CONDITION]) 5 mg (milligram) by mouth two times a day [MEDICAL CONDITION](cardiovascular accident) related to [MEDICAL CONDITION]. Review of Resident #3's Care Plan, initiated on 2/19/20, revealed no documentation of the Resident being on a blood thinner, or potential precautions or complications to observe for with the medication. During an interview on 4/23/20 at 12:15 pm, the Director of Nursing (DON) stated the anticoagulant medication was not on the Resident's Care Plan. The DON further stated that the medication use and complications should have been included in the care plan. Resident #5 Anticoagulant: Record review on 4/21-25/20 revealed Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. Review of Order Summary Report, dated 4/24/20, revealed an order for [REDACTED]. Review of Resident #5's Care Plan, revised 3/17/20, revealed no documented use of an anticoagulant or adverse medication precautions related to bleeding risks. [MEDICAL TREATMENT]: AV (arteriovenous) Fistula (A surgical procedure where an artery and vein are joined together under the skin of the arm to provide the access for [MEDICAL TREATMENT]): During an interview on 4/23/20 at 2:49 pm, Resident #5 stated that he/she would have to tell the staff which arm to use to obtain his/her blood pressure, so that the staff didn't use the arm containing the fistula by mistake. Review of Resident #5's Care Plan, revised 3/17/20, revealed Do not draw blood or take B/P (blood pressure) in arm with graft. Further review did not specify which arm contained the Resident's fistula. During an interview on 4/23/20 at 3:14 pm, the DON agreed that specifying which arm contained the fistula would have been important to add to the Resident's care plan. During an interview on 4/23/20 at 2:49 pm, Resident #5 stated that his/her fistula was currently blocked and the [MEDICAL TREATMENT] facility was sending him/her to an appointment to have his/her fistula evaluated. Further review of the Resident's care plan revealed no intervention of assessing the Resident's fistula for bruit (a sound made by the high pressure flow of blood through the fistula that indicates how well the [MEDICAL TREATMENT] fistula is functioning) or thrill (blood flow through the fistula felt on the overlying skin as a vibration). [MEDICAL TREATMENT] (HD) catheter (a 2 pronged tube placed in the chest used for exchanging blood to and from the [MEDICAL TREATMENT] machine and the patient): Review of Resident #5's Care Plan, revised 3/17/20, revealed Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of infection to access site . During an interview on 4/23/20 at 2:49 pm, Resident #5 stated that the staff had assessed his/her [MEDICAL TREATMENT] catheter every once in a while. The Resident further stated that he/she had plastic wrap in his/her room and would use the plastic wrap to cover his/her [MEDICAL TREATMENT] catheter prior to taking a shower. Further review of the Resident's care plan did not mention the process for covering the [MEDICAL TREATMENT] catheter before the Resident showers, or the prevention of the [MEDICAL TREATMENT] catheter from becoming wet to prevent infection. During an interview on 4/23/20 at 1:31 pm, Licensed Nurse (LN) #1 stated that covering the [MEDICAL TREATMENT] catheter would have been important to add to the Resident's care plan. Review of the facility's policy, [MEDICAL TREATMENT] Access Care, revised 12/2019, revealed The central catheter site must be kept clean and dry at all times. Bathing and showering are not permitted with this device. Review of NATIONAL

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) KIDNEY FOUNDATION, [MEDICAL TREATMENT] Access, at https://www.kidney.org/atoz/content/hemoaccess, accessed on 4/25/20, revealed that patients must keep their catheter dressing clean and dry. Further review regarding the [MEDICAL TREATMENT] fistula revealed to check the blood flow several times each day by feeling for a vibration, also called a pulse or thrill. If you do not feel this, or if there is a change, call your doctor or your [MEDICAL TREATMENT] center. Weights: During an interview on 4/21/20 at 10:27 am, Resident #5 stated he/she was nauseated after [MEDICAL TREATMENT] last week because he/she had a lot of fluid removed from his/her body at [MEDICAL TREATMENT]. Review of the Residents weights in the Electronic Health Record (EHR) from 2/17/20 at 12:01pm, through 4/22/20 at 12:40 pm, revealed no documentation related to the monitoring of the Resident's weigh in-between [MEDICAL TREATMENT] treatments. During an interview on 4/23/20 at 1:31 pm, LN #1 confirmed that the Resident had his/her weights done at the [MEDICAL TREATMENT] clinic on Mondays, Wednesdays and Fridays, and the facility had not done weights on the Resident. During a follow up interview on 4/23/20 at 2:49 pm, Resident #5 stated he/she got sick after [MEDICAL TREATMENT] yesterday, because they took off 3.5kg of water weight. The Resident further stated that he/she was gaining weight. Review of the Resident's Care Plan initiated 2/19/20 revealed Goal (Resident) will have no s/sx (signs/symptoms) of complications from [MEDICAL TREATMENT] through the review date. Further review revealed no interventions regarding monitoring of the Residents weight. Review of https://www.kidney.org/atoz/content/dry-weight, How do I maintain dry weight (normal weight without any extra fluid in your body) after [MEDICAL TREATMENT]? reviewed on 5/6/20, revealed Keep track of your daily weight. Keeping track of your weight is important between [MEDICAL TREATMENT] sessions. If you see sudden weight gain between sessions, you should tell your healthcare provider immediately. Review of the facility's policy [MEDICAL CONDITION], Care of a Resident with, revised 12/19, revealed Education and training of staff included, specifically .the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis .The care of grafts and fistulas .the resident's comprehensive care plan will reflect the resident's needs related to [MEDICAL CONDITION]/[MEDICAL TREATMENT] care. .
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . F698 Based on record review, interview, and policy review, the facility failed to ensure 1 Resident (#5) out of 1 Resident sampled for [MEDICAL TREATMENT], received the services consistent with professional standards of practice. Specifically, 1) no documentation existed regarding monitoring of the resident's [MEDICAL TREATMENT] sites; 2) infection risk during resident own dressing change; and 3) no documentation of weights being done on non-[MEDICAL TREATMENT] days. These failed practices placed the resident at risk for infection, fluid overload and receiving less than optimal care. Findings: Record review on 4/21-23/20 revealed Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. [MEDICAL TREATMENT] (HD) catheter (a 2 pronged tube placed in the chest used for exchanging blood to and from the [MEDICAL TREATMENT] machine and the patient): During an interview on 4/23/20 at 1:31 pm, Licensed Nurse (LN) #1 stated that he/she had not assessed the Resident's [MEDICAL TREATMENT] catheter during his/her shift. LN #1 further stated there would have been a note written by the evening shift LN who would have assessed the catheter when the Resident returned from [MEDICAL TREATMENT]. During an interview on 4/23/20 at 2:49 pm, Resident #5 stated that he/she goes to [MEDICAL TREATMENT] every Monday, Wednesday and Friday. The Resident further stated that the staff had assessed his/her [MEDICAL TREATMENT] catheter every once in a while. Review of the Nurse's Note(s), dated from 2/14/20 at 4:00 pm, through 4/24/20 at 2:49 am, revealed no documentation related to the monitoring of the Resident's [MEDICAL TREATMENT] catheter site upon return from the [MEDICAL TREATMENT] treatment. Review of Resident #5's Care Plan, revised 3/17/20, revealed Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of infection to access site: Redness, Swelling, warmth or drainage. Review of the facility's policy, [MEDICAL TREATMENT] Access Care, revised 12/2019, revealed The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (interventions if needed). 3. If [MEDICAL TREATMENT] was done during shift. 4. Any part of report from [MEDICAL TREATMENT] nurse post-[MEDICAL TREATMENT] being given. 5. Observations post-[MEDICAL TREATMENT]. Review of https://www.cdc.gov/infectioncontrol/guidelines/bsi/index.html#rec6, Guidelines for the Prevention of Intravascular Catheter-Related Infections (2011) revealed Monitor the catheter sites . by palpation through an intact dressing on a regular basis, depending on the clinical situation of the individual patient. HD catheter dressing change: Review of physician's orders [REDACTED]. Res (Resident) may perform own wound care PRN (as needed). Review of Resident #5's Care Plan, revised 3/17/20, revealed (Resident) shall perform port care at [MEDICAL TREATMENT] site PRN. During an interview on 4/23/20 at 3:14 pm, the Director of Nursing (DON) stated she had obtained an order from the doctor to allow the Resident to change his/her own HD catheter dressing. When asked what supplies the Resident would have needed to do the dressing change, the DON stated she was not aware of the required supplies. Review of the facility's policy, [MEDICAL TREATMENT] Access Care, revised 12/2019, revealed If the dressing becomes wet, dirty or not intact, the dressing shall be changed by a licensed nurse trained in this procedure .Those caring for the catheter site must wear a mask and gloves when doing so. Dressing changes, if ordered, should be done using sterile technique. Review of https://www.cdc.gov/[MEDICAL TREATMENT]/patient/index.html , Patient Information, accessed on 5/6/20, revealed Among [MEDICAL TREATMENT] patients, infections are the second leading cause of death .Keep your catheter bandage clean and dry. If your bandage gets wet, notify your healthcare professional. AV (arteriovenous) Fistula (a surgical procedure where an artery and vein are joined together under the skin of the arm to provide access for [MEDICAL TREATMENT]): During an interview on 4/23/20 at 2:49 pm, Resident #5 stated his/her AV Fistula was blocked and the [MEDICAL TREATMENT] facility was sending him/her on an appointment to have his/her fistula evaluated. Review of the Nurse's Note(s), dated from 2/14/20 at 4:00 pm, through 4/24/20 at 2:49 am, revealed no documentation related to the Resident's fistula for bruit (a sound made by the high pressure flow of blood through the fistula, that indicates how well the [MEDICAL TREATMENT] fistula is functioning) or thrill (blood flow through the fistula felt on the overlying skin as a vibration). Review of the facility's policy, [MEDICAL TREATMENT] Access Care, revised 12/2019, revealed Check patency of the site at regular intervals. Palpate (feel) the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access. Peritoneal [MEDICAL TREATMENT] (PD) catheter (a plastic tube surgically placed through the abdominal wall, into the abdominal cavity for PD) site: Review of the Nurse's Note(s), dated from 2/14/20 at 4:00 pm, through 4/24/20 at 2:49 am, revealed no documentation related to the monitoring of the peritoneal [MEDICAL TREATMENT] catheter site. Review of the Nurse's Note(s), dated 3/13/20 at 4:25 pm, revealed the Resident was ordered an antibiotic while at [MEDICAL TREATMENT] for infection prevention of [MEDICAL TREATMENT] port. Further review revealed no documented follow up monitoring of the [MEDICAL TREATMENT] catheters. Review of the facility's policy Peritoneal [MEDICAL TREATMENT] (Continuous Ambulatory), revised 12/2019, revealed The following information should be recorded in the resident's medical record .The condition of the catheter, insertions site and surrounding skin. Review of Resident #5's Care Plan, revised 3/17/20, revealed Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of infection to access site: Redness, Swelling, warmth or drainage. Weights: During an interview on 4/21/20 at 10:27 am, Resident #5 stated he/she was nauseated after [MEDICAL TREATMENT] last week because he/she had a lot of fluid removed from his/her body by the [MEDICAL TREATMENT]. Review of the Residents weights in the Electronic Health Record (EHR) from 2/17/20 at 12:01pm, through 4/22/20 at 12:40 pm, revealed no documentation related to the monitoring of the Resident's weigh in-between [MEDICAL TREATMENT] treatments. During an interview on 4/23/20 at 1:31 pm, LN #1 confirmed that the Resident had his/her weights done at the [MEDICAL TREATMENT] clinic on Mondays, Wednesdays and Fridays, and the facility had not done weights on the Resident in-between [MEDICAL TREATMENT] treatments. During a follow up interview on 4/23/20 at 2:49 pm, Resident #5 stated he/she got sick after [MEDICAL TREATMENT] yesterday, because they took off 3.5kg of water weight. The Resident further stated that he/she was gaining weight. Review of the Resident's Care Plan initiated 2/19/20 revealed Goal (Resident) will have no s/sx (signs/symptoms) of complications from [MEDICAL TREATMENT] through the review date. Further review revealed no interventions regarding monitoring of the Residents weight. Review of https://www.kidney.org/atoz/content/dry-weight, How do I maintain dry weight (normal weight without any extra fluid in your body) after [MEDICAL TREATMENT]? accessed on 5/6/20, revealed Keep track of your daily weight. Keeping track of your weight is important between [MEDICAL TREATMENT] sessions. If you see sudden weight gain between sessions, you should tell your healthcare provider immediately. Review of the facility's policy [MEDICAL CONDITION], Care of a Resident with, revised 12/2019, revealed Education and training of staff included, specifically .the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis .The care of grafts and fistulas .the resident's comprehensive care plan will reflect the resident's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) needs related to [MEDICAL CONDITION]/[MEDICAL TREATMENT] care. Review of http://currentnursing.com/nursing_management/nursing_standards.html, ANA Standards of practice, accessed on 5/2020, revealed Standard l. Assessment The nurse collects comprehensive data pertinent to the patients health or situation (;) Measurement criteria 1. Collects data in a systematic and ongoing process .4. Collects pertinent data using appropriate assessment techniques 5. Document relevant data in a retrievable form.
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** . Based on record review and interview the facility failed to ensure a policy was maintained for monthly drug regimen reviews that included time frames for different steps in the process and steps taken by pharmacist when an urgent action was identified. This failed practice placed all residents (based on a census of 5) at risk for receiving unnecessary medication and delay or impediment of reviews of their monthly medication regime. Findings: Review of the facility policy Medication Utilization and Prescribing- Clinical Protocol, revised 12/2019, revealed The consultant pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medication, including medication regimens that are not supported based on clinical signs or symptoms. Further review revealed the policy made no mention of time frames or the steps the pharmacist must take when he/she identifies an irregularity or urgent action to protect the resident. During an interview on 4/23/20 at 1:04 pm, the Director of Nursing (DON) stated the policy did not include timelines for the various steps of the monthly medication regiment review. The DON further stated the policy did not include steps to be taken by a pharmacist in the event that he/she identified an irregularity that required urgent action to protect the resident. .
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review, interview and policy review, the facility failed to ensure two residents (#2 and #5) out of 5 sampled residents, had complete and/or accurate medical records. This failed practiced placed the residents at risk for receiving the incorrect interventions or interventions not cohesive to the residents' wishes and an incomplete medical record which did not facilitate communication among the interdisciplinary team. Findings: Resident #5 Record review on 4/21-23/20 revealed Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. Record review on 4/23/20 at 11:13 am, revealed a scanned document in Resident #5's electronic health record (EHR), stamped MRR (medication regimen review) PLEASE PLACE IN CHART, dated 2/16/20, was illegible. During an interview on 4/23/20 at 1:23 pm, the Director of Nursing (DON) agreed the MRR document scanned into Resident #5's EHR was illegible, and stated that the original document had been shredded. Resident #2 Record review on 4/21-23/20 revealed Resident #2 was admitted to the facility with [DIAGNOSES REDACTED]. Record review on 4/23/20 at 1:00 pm revealed Resident #5's Medical Orders for Scope of Treatment, was found in Resident #2's EHR. Review of the facility' policy Charting and Documentation, revised 12/2019, revealed All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** . Based on observation, interview and policy review, the facility failed to ensure the proper cleaning of a blood glucose monitor. Specifically, 1) the blood glucose monitor was not cleaned prior to being placed in the case, and 2) the blood glucose monitor was not cleaned per manufacturers' instructions. This failed practice had the potential to affect all Resident's requiring a blood sugar check, based on a census of 5, and increased the risk for the development and transmission of disease and infection in a vulnerable population. Findings: An observation on 4/22/20 at 12:15 pm revealed CNA #2 had performed a blood glucose check on Resident #3, using the Medline Evencare Proview blood glucose monitor. After the procedure, CNA #2 placed the uncleaned blood glucose monitor back into the fabric carrying case. CNA #2 then walked to the Nurse's station, removed the uncleaned blood glucose monitor from the case, and wiped down the monitor with an alcohol prep pad. CNA #2 then placed the blood glucose monitor back into the dirty case for storage. After the procedure, when asked about the cleaning process, CNA #2 stated he/she did not want to clean the device in the Resident's room because the device would have been contaminated. During an interview on 4/23/20 at 3:38 pm, the Director of Nursing (DON) stated the blood glucose monitor should have been cleaned outside the room, but should not have been placed into the case prior to the device being cleaned. Review on 4/24/20 at 4:07 pm of the Medline Evencare Proview blood glucose monitoring system user's guide, not dated, revealed The EVENCARE ProView Meter should be cleaned and disinfected between each patient. Cleaning Instructions: Cleaning is the removal of visible dirt and debris. Whenever your glucose meter is dirty, clean the outside of the meter with a new CaviWipes towelette or an EPA-registered disinfecting wipe. The cleaning process does not reduce the risk for transmission of infectious diseases. Disinfection Instructions: The meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. The Disinfection process reduces the risk of transmitting infectious diseases if it is performed properly. Review on 4/24/20 at 5:00 pm of the facility's policy Cleaning and disinfection of Resident-Care items and Equipment, revised 12/2019, revealed Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions. .