STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/21/2017 through 03/23/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two (2) complaints were investigated. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 109 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #19 and Residents #23 and #24) and three (3) closed record reviews (Residents #20 through #22).	F 000		
F 157 SS=E	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (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	F 157		4/25/17

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

Electronically Signed | 04/07/2017

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F 157	Continued From page 1 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) 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). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the physician of a change of condition for one of 24 residents in the survey sample, Resident # 3. The facility staff failed to notify Resident # 3's physician for multiple high blood sugars over a 4 day period. Findings include:	F 157	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this plan of correction. In addition, the following plan constitutes the center's	

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F 157	Continued From page 2 Resident # 3 was admitted to the facility on 10/24/12. Diagnoses for Resident # 3 included, but were not limited to: HTN (high blood pressure), obesity, renal insufficiency, PVD (peripheral vascular disease) and DM (diabetes mellitus). The most current MDS (minimum data set) was a quarterly assessment dated 02/14/17, which assessed the resident as having a cognitive score of 14 indicating the resident was cognitively intact for daily decision making skills. This assessment additionally assessed the resident as requiring extensive assistance from staff for most all ADL's (activities of daily living). During clinical record review, Resident # 3's physician's orders were reviewed. An order dated 01/06/17 documented, "...accucheck TID [three times daily] X [times] 5 days and show me..." Resident # 3's January 2017 MARs (medication administration records) were reviewed and documented the following blood sugar levels: 01/06/17-4:00 p.m.=518 01/07/17-8:00 a.m.=504 01/07/17-11:30 a.m.=HI 01/07/17-4:00 p.m.=549 01/08/17-8:00 a.m.=402 01/08/17-11:30 a.m.=HI 01/08/17-4:00 p.m.=518 01/09/17-8:00 a.m.=495 01/09/17-11:30 a.m.=401 01/09/17-4:00 p.m.=518 01/10/17-8:00 a.m.=496 01/10/17-11:30 a.m.=525	F 157	allegation of compliance. All alleged deficiencies have been ore will be corrected by the dates indicated. 1. For resident #3 the physician was informed of the hyperglycemic episodes and orders were followed. 2. A review has been conducted by the Director of Clinical Services/designee to ensure that the physician was notified if the resident had a hyperglycemic episode for the past thirty (30) days. 3. In-servicing has been provided to the licensed nurses on reporting hyperglycemic episodes to the physician timely. A random weekly review will be conducted by the DCS/designee for five (5) diabetic residents per week for three (3) months to ensure that hyperglycemic episodes are reported to the physician timely. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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F 157	Continued From page 3 01/10/17-4:00 p.m.=469 Nursing notes were then reviewed and no evidence was found to indicate that the physician had been notified of the high blood sugar levels for Resident # 3, two of which did not register (indicating an extremely high blood sugar reading by displaying HI as the result). On 03/22/17 at approximately 8:50 a.m., LPN (Licensed Practical Nurse) # 4 was interviewed regarding the above. The LPN looked in the nursing notes and stated that there was no documentation to indicate the physician had been notified. The LPN then looked in a communication book and stated, "Here is documentation, it looks like they [nurses] are writing in the communication book, but not writing in the nurses notes." The entry in the communication book did not have a date, a time, or a signature indicating when this entry was written or by who. This entry was in between an entry dated 01/07/16 and 01/08/17 and documented, to see Resident # 3 for 'very high' blood sugars. Entries within the communication book had lines drawn through to indicate that the entry had been seen/addressed by the physician. The LPN was asked what the line drawn through entries meant. The LPN stated that indicates that the physician seen that or addressed that issue. The entry for Resident # 3 did not have a line or mark to indicate that this issue had been addressed. LPN # 4 was asked if there was a protocol for issue like this. LPN # 4 stated that the nurses should have looked at the MAR to see if the resident has a sliding scale insulin to give for a blood sugar that high and give that if there is an	F 157		

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F 157	Continued From page 4 order, but to also notify the physician immediately. Resident # 3's CCP (comprehensive care plan) was reviewed and documented, "...at risk for metabolic complications related to Diabetes...monitor for signs and symptoms of hypo or hyperglycemia including changes in level of consciousness, sleepiness, fatigue, weakness, diaphoresis,...fruity breath, blurred vision...medications as ordered...notify MD [medical doctor] as indicated...blood glucose levels as ordered...obtain and monitor lab/diagnostic work as ordered, report results to MD and follow up as indicated..." The administrator and DON (director of nursing) were made aware in a meeting with the survey team on 03/22/17 at approximately 1:30 p.m. No further information and/or documentation was presented to evidence the physician was notified of high blood sugar readings for Resident # 3 prior to the exit conference on 03/23/17 at 12:30 p.m.	F 157		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and	F 164		4/25/17

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F 164	Continued From page 5 confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to maintain privacy and confidentiality of personal information for one of 24 residents in the survey sample: Resident # 13. Resident # 13's clinical record included the	F 164	1. For resident #13, the documentation was removed from the active chart. 2. For residents currently residing in the center a review was done by the	

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F 164	Continued From page 6 name of a resident with whom Resident # 13 had an altercation with. Findings include: Resident # 13 was admitted to the facility 12/24/13 with diagnoses to include, but not limited to: history of stroke, difficulty walking, dementia, and high blood pressure. The most recent MDS (minimum data set) was a quarterly review dated 2/24/17. Resident # 13 was coded with moderate impairment in cognition with a total summary score of 09 out of 15. During review of the clinical record 3/21/17 at 2:30 p.m. it was noted in the nursing progress notes an entry dated 1/1/17 at 10:00 a.m. Resident had an altercation with another resident who's name was included in Resident # 13's record. On 3/21/17 at 3:00 p.m. the unit manager, identified as RN (registered nurse) # 3 was made aware of the progress note. RN # 3 looked at this surveyor and shook her head. RN # 3 stated "Seeing who wrote that entry, I'm not surprised." On 3/22/17 during a meeting with facility staff beginning at 1:25 p.m. the administrator and DON (director of nursing) were informed of the above findings. No further information was provided prior to the exit conference.	F 164	DCS/designee center to ensure documentation in the medical record is compliant with HIPAA. 3. In-servicing has been provided to the current employees on observing HIPAA regulations when documenting in the medical record. A random weekly review will be conducted by the DCS/designee for five (5) resident's medical record per week for three (3) months to ensure that documentation is compliant with HIPAA guidelines. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25,2017	
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		4/25/17

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F 225	Continued From page 7 CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (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	F 225		

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F 225	Continued From page 8 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. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (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 staff interview, facility policy review and clinical record review, the facility staff failed to investigate an incident of potential abuse for one of 24 residents in the survey sample. A witnessed incident of Resident #7 hitting another resident was not thoroughly investigated by the facility. The findings include: Resident #7 was admitted to the facility on 8/6/15 with diagnoses that included Alzheimer's, dementia with aggressive behaviors, high blood	F 225	1. For resident #7, the MD/RP was made aware of the event and an investigation was completed for the event. 2. Residents currently residing in the center have the potential to be affected. A review has been conducted by the Administrator/designee of facility reported incidents within the last thirty (30) days to ensure that policies were implemented regarding allegations of abuse. 3. In-serving has been provided to	

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F 225	Continued From page 9 pressure, insomnia, diabetes, heart disease and anxiety. The minimum data set (MDS) dated 3/13/17 assessed Resident #7 with short and long-term memory problems and moderately impaired cognitive skills. Resident #7's clinical record documented a nursing communication form dated 12/22/16 stating, "Res. [resident] hit another res. Res. separated. Res. calmed easily 0 [no] further behavior issue. Calm + cooperative [with] care. ROM [range of motion] @ baseline. Pleasant..." (sic) The behavior evaluation section of this form documented, "hit another res. [resident]." This form documented the resident's physician and family were notified of the aggressive behavior on 12/22/16. Resident #7's clinical record made no further mention of this incident. Resident #7's clinical record documented the resident was observed hitting a resident on the back of the head with his fist on 12/31/16. Resident #7's care plan (revised 2/13/17) stated the resident had inappropriate behaviors that included being combative during personal care, being sexually inappropriate with staff, yelling and refusing care. The resident was prescribed/administered the antipsychotic medication Seroquel daily for management of dementia with aggressive behaviors. On 3/22/17 at 11:35 a.m. the director of nursing (DON) was interviewed about any investigation of Resident #7 hitting another resident on 12/22/16. After researching the DON stated he did not have a documented investigation of the incident on 12/22/16. The DON stated, "All the documentation we have is the note in the record." The DON was unable to identify the resident hit	F 225	current employees by the Administrator/designee regarding implementation of polices for abuse; including investigation abuse. A random weekly review for facility reportable incidents will be conducted by the Administrator/designee weekly for three (3) months to ensure that policies have been implemented including investigations for facility reportable incidents has been conducted as required for allegation of abuse. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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F 225	Continued From page 10	F 225		

by Resident #7 on 12/22/16 and stated there were no witness statements obtained regarding the incident.

On 3/23/17 at 9:50 a.m. the administrator was interviewed about an investigation of Resident #7 hitting another resident on 12/22/17. The administrator stated there was no documented investigation of the incident. The administrator stated the incident should have been investigated per their abuse prevention policy.

The facility's policy titled Resident Abuse (revised 2/1/17) defined abuse as,"...the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm..." This policy defines physical abuse as, "Striking the resident with a part of the body or with an object; nontherapeutic shoving, pushing, pulling, or twisting any part of the resident's body; burning; or sticking a resident with an object...the Administration of The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers..." This policy stated concerning investigation, "The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse...The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...Report the results of all investigations to the Executive

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F 225	Continued From page 11 Director 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..." These findings were reviewed with the administrator and director of nursing during a meeting on 3/22/17 at 1:20 p.m.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 226		4/25/17

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F 226	Continued From page 12 (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review and clinical record review, the facility staff failed to follow their abuse prevention policy for investigating an incident of potential abuse for one of 24 residents in the survey sample. A witnessed incident of Resident #7 hitting another resident was not thoroughly investigated by the facility as require by their policy. The findings include: Resident #7 was admitted to the facility on 8/6/15 with diagnoses that included Alzheimer's, dementia with aggressive behaviors, high blood pressure, insomnia, diabetes, heart disease and anxiety. The minimum data set (MDS) dated 3/13/17 assessed Resident #7 with short and long-term memory problems and moderately impaired cognitive skills. Resident #7's clinical record documented a nursing communication form dated 12/22/16 stating, "Res. [resident] hit another res. Res. separated. Res. calmed easily 0 [no] further behavior issue. Calm + cooperative [with] care. ROM [range of motion] @ baseline. Pleasant..." (sic) The behavior evaluation section of this form documented, "hit another res. [resident]." This form documented the resident's physician and family were notified of the aggressive behavior on	F 226	1. For resident #7, the MD/RP was made aware of the event and an investigation was completed. 2. A review has been conducted by the Administrator/designee of facility reported incidents within the last thirty (30) days to ensure that policies were implemented regarding allegations of abuse. 3. In-serving has been provided to current employees by the Administrator/designee regarding implementation of polices for abuse; including investigation abuse. A random weekly review for facility reportable incidents will be conducted by the Administrator/designee weekly for three (3) months to ensure that policies have been implemented including investigations for facility reportable incidents has been conducted as required for allegation of abuse. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as	

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F 226	Continued From page 13 12/22/16. Resident #7's clinical record made no further mention of this incident. Resident #7's clinical record documented the resident was observed hitting a resident on the back of the head with his fist on 12/31/16. Resident #7's care plan (revised 2/13/17) stated the resident had inappropriate behaviors that included being combative during personal care, being sexually inappropriate with staff, yelling and refusing care. The resident was prescribed/administered the antipsychotic medication Seroquel daily for management of dementia with aggressive behaviors. On 3/22/17 at 11:35 a.m. the director of nursing (DON) was interviewed about any investigation of Resident #7 hitting another resident on 12/22/16. After researching the DON stated he did not have a documented investigation of the incident on 12/22/16. The DON stated, "All the documentation we have is the note in the record." The DON was unable to identify the resident hit by Resident #7 on 12/22/16 and stated there were no witness statements obtained regarding the incident. On 3/23/17 at 9:50 a.m. the administrator was interviewed about an investigation of Resident #7 hitting another resident on 12/22/17. The administrator stated there was no documented investigation of the incident. The administrator stated the incident should have been investigated per their abuse prevention policy. The facility's policy titled Resident Abuse (revised 2/1/17) defined abuse as,"...the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or	F 226	indicated to sustain substantial compliance. 5. April 25, 2017	

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F 226	Continued From page 14 mental anguish...Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm..." This policy defines physical abuse as, "Striking the resident with a part of the body or with an object; nontherapeutic shoving, pushing, pulling, or twisting any part of the resident's body; burning; or sticking a resident with an object... the Administration of The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers..." This policy stated concerning investigation, "The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse...The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...Report the results of all investigations to the Executive Director 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..." These findings were reviewed with the administrator and director of nursing during a meeting on 3/22/17 at 1:20 p.m.	F 226		
F 279 SS=E	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident	F 279		4/25/17

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assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

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F 279	Continued From page 16 (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on, staff interview and clinical record review, the facility staff failed to develop comprehensive care plan for four of 24 residents, Resident #'s 16, 18, 7, and 10. 1. Resident #16 did not have a comprehensive care plan to include hospice. 2. Resident #18 did not have a comprehensive care plan to include behaviors. 3. Resident #7 did not have a comprehensive care plan to include insomnia. 4. Resident #10 did not have a comprehensive care plan to include cognitive issues. Findings include:	F 279	1. For resident #16, the care plan has been updated to reflect hospice. For resident #18, the care plan has been updated to include behaviors. For resident #7, the care plan has been updated to include insomnia. For resident #10, the care plan has been updated to include cognitive issues. 2. A review has been conducted by the DCS/designee for resident residing in the center with hospice, behaviors, insomnia, and cognitive issues to ensure that residents have an appropriate care plan. 3. In-servicing has been provided to the interdisciplinary team by the DCS/designee regarding appropriately care planning the care of hospice, behaviors, insomnia, and cognitive issues.	

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F 279	Continued From page 17 Resident #16 was admitted to the facility on 1/16/17 with diagnoses including heart disease, depression, and failure to thrive. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/15/17. Resident #16 was assessed as being severely impaired cognitively. Resident #16's medical record was reviewed on 3/23/17 and evidenced, via comprehensive (significant change) MDS dated 2/15/17 section "O" that Resident #16 had been placed on hospice, but was not triggered for a care plan under section "V" of the MDS. Review of the facilities current matrix (CMS form 802) also triggered hospice for Resident #16. Hospice nursing notes evidenced that Resident #16 was admitted to hospice on 2/9/17. On 3/22/17 at 9:00 a.m. the MDS coordinator was interviewed concerning a hospice care plan for Resident #16. The MDS coordinator reviewed the care plan and verbalized that she was not sure why it was not on Resident #16's care plan. When asked who usually does care plans for things such as hospice, the MDS coordinator verbalized that she thought it would be the social worker. On 3/23/17 at 9:30 a.m. the social worker was interviewed regarding the above finding. The social worker verbalized that she was unaware that she was responsible for completing a care plan regarding hospice.	F 279	Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure that resident with hospice, behaviors, dx of insomnia and cognitive issues have accurate care plans. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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F 279	Continued From page 18 On 3/23/17 at 10:45 a.m. the above finding was brought to the attention of the director of nursing and administrator. No further information was presented prior to exit conference on 3/23/17. 2. Resident #18 did not have a comprehensive care plan regarding behaviors. Resident #18 was admitted to the facility on 1/9/17 with diagnoses including dementia and depression. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 1/16/17. Resident #18 was assessed as being severely impaired cognitively. Resident #18's medical record was reviewed on 3/22/17 and evidenced, via nursing note dated 1/11/17, that Resident #18 "[...]Wanders into other resident's rooms and becomes combative when redirected" and "Frequently attempts get out of bed and removes clothes.[...]" Nursing noted dated 1/24/17 evidenced Resident was combative, stripping clothes, wandering into other resident's rooms, aggressive towards staff. Review of the facilities current matrix (CMS form 802) also triggered behaviors for Resident #18. On 3/22/17 at 9:00 a.m. the MDS coordinator was interviewed concerning a behavior care plan for Resident #18. The MDS coordinator verbalized that she was not sure why it was not on Resident #18's care plan. When asked who usually does	F 279		

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F 279	Continued From page 19 care plans for things such as behaviors, the MDS coordinator verbalized that she thought it would be the social worker. On 3/23/17 at 9:30 a.m. the social worker was interviewed regarding the above finding. The social worker reviewed Resident #18's care plan and verbalized that a care plan should have been put in place, but may have been missed. On 3/23/17 at 10:45 a.m. the above finding was brought to the attention of the director of nursing and administrator. No further information was presented prior to exit conference on 3/23/17. 3. Resident #7, medicated each evening for sleep problems, had no care plan developed regarding insomnia. Resident #7 was admitted to the facility on 8/6/15 with diagnoses that included Alzheimer's, dementia with aggressive behaviors, high blood pressure, insomnia, diabetes, heart disease and anxiety. The minimum data set (MDS) dated 3/13/17 assessed Resident #7 with short and long-term memory problems and moderately impaired cognitive skills. Resident #7's clinical record documented a physician's order dated 11/16/15 for Melatonin 3 mg (milligrams) to be administered at each bedtime for insomnia. The resident's medication administration records documented Melatonin was administered at 8:00 p.m. each evening as	F 279		

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ordered.

The resident's plan of care (revised 2/13/17) included no problems, goals and/or interventions regarding sleep problems or the use of Melatonin to enhance sleep.

On 3/22/17 at 9:25 a.m. the licensed practical nurse (LPN #1) routinely caring for Resident #7 was interviewed about a care plan regarding sleep issues. LPN #1 stated Resident #7 usually went to sleep at the initial bedtime but would wake up in the night and not go back to sleep. LPN #1 stated she was not sure if sleep problems were listed on the resident's care plan.

On 3/22/17 at 9:30 a.m. the registered nurse unit manager (RN #3) was interviewed about a sleep care plan for Resident #7. RN #3 stated the care plans were developed by the interdisciplinary team and the MDS coordinator was responsible for adding problem areas to the care plan.

On 3/22/17 at 9:50 a.m. the licensed practical nurse (LPN #2) responsible for MDS assessments was interviewed about a plan of care regarding Resident #7's sleep problems. After reviewing the care plan, LPN #2 stated she did not see any entries on the care plan regarding insomnia or the resident's daily use of Melatonin.

Melatonin is a synthetic hormone used for the treatment of jet-lag, adjusting sleep-wake cycles and is also used for treatment of insomnia (inability to fall asleep). (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 3/22/17 at 1:20 p.m.

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(1) Melatonin. WebMD, LLC 2005-2017. 3/24/17. http://www.webmd.com

4. The facility staff failed to develop a comprehensive care plan (CCP) for Resident # 10 address fluctuating status in cognition.

Resident # 10 was admitted to the facility 6/11/15, with a readmission date of 9/9/16. Diagnoses for Resident # 10 included, but were not limited to: anemia, COPD, end stage kidney disease, and diabetes.

The most recent MDS (minimum data set) was a quarterly review dated 3/18/17. Resident # 10 was coded as cognitively intact with a total summary score of 13 out of 15.

On 3/22/17 at 8:20 a.m. the clinical record, including the CAA's (care area assessment) were reviewed. Resident # 10 triggered for cognitive decline. The triggered area was decided to be care planned. A review of the care plan revealed no focus area to address the resident's cognitive decline.

On 3/22/17 at 10:50 a.m. LPN (licensed practical nurse) # 2, who was an MDS coordinator, was asked about the care plan. LPN # 2 stated "Let me look to see what I can find; it may be a resolved issue and that won't show up in the computer for you." At 11:50 a.m. LPN # 2 returned to the conference room and told this surveyor "We addressed the cognitive decline

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F 279	Continued From page 22 under his behaviors because he frequently refuses medications, dialysis, and medications. We probably could have worded it better; it doesn't really explain how that affects his cognition" LPN # 2 was then asked since the resident had the right to refuse, how that would be considered a cognitive decline. LPN # 2 stated "Well, when he refuses, then that affects his cognition." After a review of the care plan with LPN # 2, she was then asked if there was a care plan to specifically address a cognitive decline for the resident. LPN # 2 answered "No." On 3/22/17 during a meeting with facility staff beginning at 1:25 p.m. the administrator and DON (director of nursing) were informed of the above findings. No further information was provided prior to the exit conference.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 280		4/25/17

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other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the

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F 280	Continued From page 24 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to review and revise a comprehensive care plan (CCP) for two (2) of 24 residents in the survey sample, Residents #1 and #15. 1. Facility staff failed to include interventions for use of a cervical collar (C-collar) for Resident #1. 2. Resident #15's care plan was not reviewed and/or revised regarding safety interventions related to the resident's accidental ingestion of a topical protective cream and physical altercations with other residents.	F 280	1. Resident #1 no longer resides in the facility. For resident #15, the care plan has been revised regarding safety interventions related to the resident's accidental ingestion of a topical protective cream and physical altercations with other residents. 2. The DCS/designee will review care plans for residents currently residing in the center that have had an accidental ingestion of a topical protective cream and physical altercations with other residents within the last thirty (30) days to ensure	

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(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 280	Continued From page 25 Findings included: 1. Facility staff failed to include interventions for use of a cervical collar (C-collar) for Resident #1. Resident #1 was admitted to the facility on 02/15/2017 with diagnoses including, but not limited to: Fracture of 5th Cervical Vertebra, Non-Alzheimer's Dementia, Seizures, Bipolar Disorder, Dysphagia, Prostate Cancer and Glaucoma. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 02/22/2017. Resident #1 was assessed as moderately impaired in his cognitive status with a total cognitive score of nine (9) out of 15. Resident #1's CCP was reviewed on 03/21/2017 at approximately 3:00 p.m. Included in his care plan was a focus area that stated, "The resident has the potential for injury r/t (related to) hx (history) of falls...cervical collar to neck for fx (fracture) 5th cervical vertebra. Date Initiated: 03/07/2017..." Interventions were, "Be sure The (sic) resident's call light is within reach and encourage the resident to use it for assistance as needed. Keep needed items, water, etc, in reach. Medication as ordered." No interventions pertaining to use of his C-collar were included. There was a specific physician order written in the clinical record that stated, "C-Collar at all times. DO NOT REMOVE." There was no mention of use for a C-collar, care of a C-collar or care for the resident wearing a C-collar anywhere	F 280	that the care plan has been revised. 3. In-servicing has been provided to the interdisciplinary team by the DCS/designee regarding revising care plans for accidental ingestion of a topical protective cream and physical altercations with other residents. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure that the care plans have been revised to reflect the individual needs of the residents. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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in Resident #1's CCP.

The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 03/22/2017 at 1:30 p.m. The DON stated, "There should be interventions for use of his C-collar."

No further information was received by the survey team prior to the exit conference on 03/23/2017.

2. Resident #15's care plan was not reviewed and/or revised with individualized safety interventions related to the resident's accidental ingestion of a topical cream and physical altercations with other residents.

Resident #15 was admitted to the facility on 11/8/13 with a re-admission on 12/18/13. Diagnoses for Resident #15 included Alzheimer's, psychosis, heart failure, depression and history of stroke. The minimum data set (MDS) dated 2/8/17 assessed Resident #15 with short and long-term memory problems and moderately impaired cognitive skills.

Resident #15's clinical record documented the resident accidentally ingested a topical cream on 12/24/16 and was hit and/or grabbed by other residents on three occasions since 12/31/16. A nursing note dated 12/24/16 documented, "Rsd [resident] was wandering on West unit, got ahold of Greer's Goo unopened. Attempted to eat/drink the Goo. [Physician] called + stated she would be fine + possible diarrhea..." (sic) A medication

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discrepancy form dated 12/24/17 documented the resident "got ahold of a new bottle of Greer's goo + put it to her mouth. found on the corners of her mouth." A communication form dated 12/31/16 documented the resident was "assulted [assaulted] hit Back of Head (punches)..." by another resident. A communication form dated 1/1/17 listed the resident was kicked in the leg by another resident when the resident rolled by in the hall. A communication form dated 2/18/17 documented when Resident #15 went into another resident's room the resident was grabbed on the arm causing the resident to cry.

The resident's care plan (revised 3/14/17) listed the resident was at risk of injury due to poor safety awareness related to poor communication skills and impaired cognition. The care plan also listed the resident had behaviors that included rummaging in other residents' belongings, hoarding, wandering, playing in feces and entering other residents' rooms. Resident #15's care plan made no mention of the physical altercations with other residents on 12/31/16, 1/1/17 and 2/17/17 or the incident of ingesting the Greer's Goo on 12/24/16. The injury prevention plan had been revised on 2/16/17 to include steps to ensure proper footwear and on 3/14/17 to include daily checks of the resident's Wanderguard safety device. With the exception of the Wanderguard checks and footwear, interventions for injury prevention had not been revised since 5/26/16. There were no interventions added related to the resident's ingestion of the Greer's Goo. Interventions regarding the resident's wandering and going into other residents' rooms had not been revised since 6/10/16 and made no mention of the resident being hit by other residents while

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F 280	Continued From page 28 wandering about the facility. On 3/23/17 at 8:10 a.m. the licensed practical nurse (LPN #2) responsible for care plans was interviewed about Resident #15. LPN #2 stated the nurses and the care team were responsible for updates to care plans. LPN #2 stated she updated the care plans anytime the nurses advised her of a needed revision. LPN #2 stated residents were discussed in daily meetings and needed updates were communicated during this meeting. Concerning Resident #15, LPN #2 stated the care plan had not been revised to reflect the accidental ingestion of Greer's Goo or the hitting/kicking incidents by other residents. Greer's Goo is topical formulation of hydrocortisone, nystatin and zinc oxide used for prevention of diaper rash. (1) These findings were reviewed with the administrator and director of nursing during a meeting on 3/23/17 at 10:45 a.m. (1) "Greer's goo." McGraw-Hill Concise Dictionary of Modern Medicine. 2002. The McGraw-Hill Companies, Inc. 24 Mar. 2017 http://medical-dictionary.thefreedictionary.com/Greer%27s+goo	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		4/25/17

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F 281	Continued From page 29 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow professional standards of nursing practice for one of 24 residents in the survey sample (Resident # 22) for the development of an initial care plan. The facility staff failed to ensure an initial care plan was developed for Resident # 22 upon admission; a care plan did not get initiated until 09/23/16, which was 15 days after admission. Findings include: Resident # 22 was admitted to the facility on 09/08/16. Diagnoses for Resident # 22 included, but were not limited to: cardiomyopathy, anemia, high blood pressure, after care for a AAA (abdominal aortic aneurysm) repair and a history of falls. The most current full MDS (minimum data set) was a 5 day admission assessment dated 09/15/16. This MDS assessed the resident as having a cognitive score of 15, indicating the resident was cognitively intact. An initial care plan for Resident # 22 could not be located within the clinical record to indicate the resident's plan of care for treatment and services. On 03/23/17 at approximately 8:00 a.m., LPN (Licensed Practical Nurse) # 2 stated that an initial care plan for Resident # 22 could not be located and that the initial care plans are	F 281	1. Resident #22 has been discharged from the center. 2. The DCS/designee will review the care plans of newly admitted residents to ensure an interim care plan was initiated timely, during clinical meetings. 3. In-servicing has been provided to the interdisciplinary team by the DCS/designee regarding initiating an admission interim care plan timely. Random weekly review will be conducted by the DCS/designee for five (5) resident per week for three (3) months to ensure admission interim care plan is completed timely. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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supposed to be completed on admission to help direct the resident's care until the comprehensive care plan is developed in correlation with the MDS assessment.

The administrator and DON (director of nursing) were made aware in a meeting with the survey team on 03/22/17 at approximately 10:45 a.m.

No further information or documentation was presented prior to the exit conference, to evidence that Resident # 22 had an initial care plan developed until 09/23/16 (15 days after admission).

The Lippincott Manual of Nursing Practice 10th edition states on page 6 concerning the nursing process and care plan development, "The nursing process is a deliberate, problem-solving approach to meeting the health care and nursing needs of patients. It involves assessment (data collection), nursing diagnosis, planning, implementation, and evaluation, with subsequent modifications used as feedback mechanisms to promote the resolution of the nursing diagnosis ... Assign priorities to the nursing diagnoses. Highest priority is given to problems that are the most urgent and critical ....Establish goals or expected outcomes derived from the nursing diagnoses ...Specify short-term, intermediate, and long-term goals as established by nurse and patient together ...Goals should be specific, measurable, and patient-focused and should include a time frame." Page 17 of this reference states common departures from standards of care include, "Failure to formulate or follow the nursing care plan ..." (1)

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F 281	Continued From page 31 (1)Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 281		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 309		4/25/17

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F 309	Continued From page 32 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on, medication pass observation, staff interview, clinical record review, and facility document review the facility staff failed to follow physician's orders for two of 24 residents, Resident #'s 16 and 10. 1. Resident #16 was not given pain medication (Norco) as ordered on time. 2. Resident #10 was not being monitored for fluid restriction as ordered. Findings include: Resident #16 was admitted to the facility on 1/16/17 with diagnoses including heart disease, depression, and failure to thrive. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/15/17. Resident #16 was assessed as being severely impaired cognitively. During medication pass observation conducted on 3/22/17 at 8:00 a.m. license practical nurse (LPN #3) was observed preparing medications to be given to Resident #16. At this time the medication Norco was pulled from the medication cart and prepared to be given. The order was reviewed by this surveyor and indicated that Resident #16 was to be given Norco four times a day at 12:00 a.m., 6:00 a.m., 12:00 p.m., and	F 309	1. For resident #16, the MD was immediately notified and determined that there were no adverse effects to resident identified related to the medication time variance. For resident #10, the order for the fluid restriction was discontinued. 2. Medication observations will be conducted by the DCS/designee for currently employed licensed nurses. Additionally, a review has been conducted by the DCS/designee of residents with fluid restrictions to ensure restrictions are being monitored. 3. In-servicing has been provided to the licensed nurses by the DCS/designee regarding the six (6) rights of medication administration including administering medications within the appropriate time frame. In-servicing has been provided to the licensed nurses by the DCS/designee regarding properly monitoring fluid restrictions for residents whose fluid restrictions are to be monitored. Random weekly review will be conducted by the DCS/designee for three (3) licensed nurses per week for three (3) months to ensure that the six (6) rights of medication administration are followed including correctly administering medications within the appropriate time frame. Additionally, a random weekly review will be conducted for five (5) residents weekly x's three (3)	

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F 309	Continued From page 33 6:00 p.m. LPN #3 was asked why is she giving Norco at 8:00 a.m. when it was supposed to be given at 6:00 a.m. by the night shift nurse. LPN #3 verbalized that according to documentation Norco was not given by the night shift nurse, but did not know why. LPN #3 entered Resident #16 room, LPN #3 woke Resident #16 and verbalized that it was time for Resident #16's medications. Resident #16 asked if she (LPN #3) had a pain pill. LPN #3 verbalized that she did have Resident #16's pain medication and proceeded to administered Resident #16's medications. After leaving Resident #16's room, this surveyor asked LPN #3 to assess Resident #16's pain level and location. LPN #3 and this surveyor went back into Resident #16's room. When asked the level of pain, Resident #16 verbalized that the pain level was an 8 out of ten (ten being the worst pain) and was on the left side radiating down the left leg. After leaving Resident #16 room, LPN #3 was asked what is the allowable time range a scheduled medication can be given. LPN #3 verbalized that a scheduled medication can be given a hour before or after the time scheduled. Upon request the facility provided a policy regarding timeliness of scheduled medication pass times. A policy titled Medication Administration Times was presented and read in part "[...] The Facility should commence medication administration within sixty (60) minutes before the designated times of	F 309	months to ensure residents who have fluid restrictions are being monitored properly. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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administration and sixty (60) minutes after the designated times of administration."

On 3/22/17 at 2:00 p.m. the above finding was brought to the attention of the director of nursing and administrator.

No further information was presented prior to exit conference on 3/23/17.

2. The facility staff failed to monitor a physician ordered fluid restriction for Resident # 10.

Resident # 10 was admitted to the facility 6/11/15, with a readmission date of 9/9/16. Diagnoses for Resident # 10 included, but were not limited to: anemia, COPD, end stage kidney disease, and diabetes.

The most recent MDS (minimum data set) was a quarterly review dated 3/18/17. Resident # 10 was coded as cognitively intact with a total summary score of 13 out of 15.

During review of the clinical record 3/22/17 at 8:20 a.m. it was noted the current POS (physician order summary) included an order carried forward from 2/16/17 for "1.5 (1500 cc) fluid restriction." This POS also included an order to "Limit Ginger-Ale at Bedside." Further review of the clinical record failed to reveal any documentation for the monitoring of fluids for Resident # 10.

On 3/22/17 at 9:45 a.m. the unit manager, identified as RN (registered nurse) # 3 was asked for assistance in locating the documentation for monitoring fluid intake for Resident # 13. RN # 3 stated "There's a sheet on the MAR (medication

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F 309	Continued From page 35 administration record) that has the amount of fluid the resident can have daily. It's not documented anywhere how much throughout the day he gets." On 3/22/17 at 11:50 a.m. the DON (director of nursing) confirmed the above statement by RN # 3. The DON stated "It's not written down as an order to write down how much fluid the resident is getting. The DON was then asked how staff were keeping up with the amount of fluid the physician wanted the resident to have to ensure the resident was not getting too much fluid, or not enough fluids? The DON did not answer. On 3/22/17 at 1:15 p.m. the DON told this surveyor "While there's no order to document the amount of fluid the resident is receiving, we should have been documenting that." On 3/22/17 during a meeting with facility staff beginning at 1:25 p.m. the administrator and DON (director of nursing) were informed of the above findings. No further information was provided prior to the exit conference.	F 309		
F 318 SS=D	INCREASE/PREVENT DECREASE IN RANGE OF MOTION CFR(s): 483.25(c)(2)(3) (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives	F 318		4/25/17

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F 318	Continued From page 36 appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure ROM (range of motion) treatment and services were provided in a timely manner for one of 24 residents in the survey sample, Resident # 9. The facility staff failed to ensure Resident # 9 received restorative nursing services for ROM therapy after being discharged from OT/PT (occupation/physical therapy) services. Findings include: Resident # 9 was admitted to the facility on 02/20/17 for rehabilitative services. Admitting diagnoses for Resident # 9 included, but were not limited to: anemia, COPD (chronic obstructive pulmonary disease), muscle weakness and a fracture to the left leg. The most recent MDS (minimum data set) was a 14 day assessment dated 03/06/17, which assessed the resident with a cognitive score of 12 indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from staff for all ADL's (activities of daily living). During the initial tour of the facility on 03/21/17 at approximately 11:25 a.m., the resident was observed in her bed eating lunch, with her daughter (POA /power of attorney) at the bedside. The daughter stated that during the resident's	F 318	1. For resident #9, a Restorative Nursing Program was started on 3/21/17. 2. The DCS/designee will review referrals from therapy to restorative nursing for the past thirty (30) days to ensure a RNP was started timely. 3. In-servicing has been provided to the IDT and therapy employees by the DCS/designee on the proper communication when therapy makes a referral for a resident to restorative nursing. Random weekly review will be conducted by the DCS/designee for five (5) residents per week fro three (3) months to ensure referrals from therapy to restorative nursing are initiated timely. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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stay that she had been getting OT and PT and was supposed to have started in the RNP (restorative nursing program) last week and that the resident had basically been laying in bed for a week without any type of therapy from staff.

During clinical record review, no therapy notes were found. The DON (director of nursing) was asked for therapy notes on 03/22/17.

OT (occupational therapy) and PT (physical therapy) notes were reviewed and documented that the resident was being discharged from both on 03/15/17 (Wednesday) and it was recommended by both therapies that resident receive restorative nursing to maintain strength and functional mobility at current level.

According to Resident # 9's restorative nursing documentation, the resident's restorative nursing program did not start until 03/21/17, 6 days later.

The OTA (occupation therapy assistant) was interviewed regarding Resident # 9 on 03/23/17 at approximately 9:20 a.m. The OTA went and retrieved Resident # 9's information and returned stating that the resident was recommended for RNP on 03/14/17 and that the information is shared with restorative aids on the floors that day and a copy of the RNP referral from therapy was put in the ADON (assistant director of nursing) mail box and wasn't sure when the restorative started for the resident.

On 03/23/17 at approximately 9:50 a.m., the ADON was interviewed and asked about Resident # 9's RNP. The ADON stated that the she (ADON) likes to speak with therapy and the staff, the restorative aides and have a meeting to

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F 318	Continued From page 38 ensure resident safety. The ADON was asked when she got the referral for Resident # 9. The ADON stated that she got it on Monday (March 20th) and the restorative was started the next day. The ADON was asked why it took so long for her to get it, the ADON stated that she did not know. The ADON was asked if she was off work during that time. The ADON stated that she was off on Friday, Saturday and Sunday. The ADON was asked who takes over when she is off or on vacation. The ADON stated that the DON (director of nursing) will pick those up. The ADON stated that sometimes restorative will start the next day and sometimes it will take up to a week before it starts. The ADON was made aware that Resident # 9 had been without any therapy or restorative for a week and that the daughter felt the resident would lose what she had gained in therapy. The DON and administrator were made aware in a meeting with the survey team on 03/23/17 at approximately 10:45 a.m. No further information or documentation was presented prior to the exit conference on 03/23/17 at 12:30 p.m., to evidence that the resident did not have a delay in treatment from the restorative nursing program.	F 318		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		4/25/17

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F 323	Continued From page 39 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide supervision and individualized safety interventions to prevent accidents/injuries for one of 24 residents in the survey sample. Resident #15, assessed with poor safety awareness and a history of wandering about the facility, ingested the topical medicated "Greer's Goo" cream after wandering into another resident's room unsupervised. The resident was hit by other residents three times since 12/31/16 while wandering about the facility. Resident #15 had no new interventions implemented to promote safety and minimize unsafe wandering following these incidents. The findings include:	F 323	1. For resident #15, there were no adverse affects from the consumption of the topical medication. Resident #15 did not receive any injuries from a resident to resident altercation. Resident #15's care plan was updated to include interventions for safety. 2. A review has been conducted by the DCS/designee to ensure Greer's Goo is secured and stored properly. Additionally, a review has been conducted by the Administrator/designee of current residents to ensure that individual safety interventions are appropriate. 3. In-servicing will be provided to current	

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F 323	Continued From page 40 Resident #15 was admitted to the facility on 11/8/13 with a re-admission on 12/18/13. Diagnoses for Resident #15 included Alzheimer's, psychosis, heart failure, depression and history of stroke. The minimum data set (MDS) dated 2/8/17 assessed Resident #15 with short and long-term memory problems and moderately impaired cognitive skills. Resident #15's clinical record documented a nursing note dated 12/24/16 stating, "Rsd [resident] was wandering on West unit, got ahold of Greer's Goo unopened. Attempted to eat/drink the goo. [Physician] called + stated she would be fine + possible diarrhea..." (sic) A communication form dated 12/31/16 documented the resident was "assulted [assaulted] hit Back of Head (punches)..." by another resident. A communication form dated 1/1/17 listed the resident was kicked in the leg by another resident when the resident rolled by in the hall. A communication form dated 2/18/17 documented when Resident #15 went into another resident's room the resident was grabbed on the arm causing the resident to cry. There was no documented investigation or incident form regarding Resident #15's ingestion of the Greer's Goo other than a medication discrepancy form dated 12/24/16. This form documented, "[Resident #15] was on West, got ahold of a new bottle of Greer's goo + put it to her mouth. found on the corners of her mouth." Measures taken to prevent recurrence stated, "Took Greer's Goo out of rsd's [resident's] room..." The physician's response documented, "...states 0 [no] harm to pt. [patient] may cause diarrhea."	F 323	employees on proper storage of topical creams to include proper storage of Greer's Goo. Additionally, in-servicing has been provided to current employees by the administrator/designee regarding implementation of polices for resident to resident altercations and ensuring the safety of our residents. A random weekly review will be conducted by DCS/designee weekly x's three (3) months to ensure Greer's Goo is stored properly. Additionally, random weekly review will be conducted by the Administrator/designee weekly for three (3) months to ensure that policies have been implemented for reporting resident to resident altercations. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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F 323	Continued From page 41 The facility's investigation dated 12/31/16 documented Resident #7 hit Resident #15 in the back of her head with his fist. A witness statement dated 12/31/6 documented, "Walked around corner [Resident #7] was hitting [Resident #15] in the back of the head with his fist...went to check on [Resident #15]. She stated her head hurt..." The facility's investigation dated 1/1/17 documented Resident #15 was rolling by another resident in the hall when the other resident kicked Resident #15 in the leg with no resulting injury. An investigation form dated 2/18/17 stated Resident #15 was in another resident's room and was grabbed by the arm by the other resident. A witness statement dated 2/18/17 of this incident stated, "Witnessed [Resident #17] in visiting [another resident] and [Resident #17] was pulling [Resident #15's] R [right] upper arm to remove her...[Resident #15] was crying while [Resident #17] had a hold on her RUE [right upper extremity]...no injury noted..." The resident's care plan (revised 3/14/17) listed the resident was at risk of injury due to poor safety awareness due to poor communication skills and impaired cognition. The care plan also listed the resident had behaviors that included rummaging in other residents' belongings, hoarding, wandering, playing in feces and entering other residents' rooms. Interventions regarding the resident's wandering behaviors included approach in calm manner, assess behaviors for underlying medical causes, assess/treat for pain as indicated, medications as ordered, monitor for increase in behaviors or unsafe behaviors and observe for medication side effects. These interventions had not been updated since 6/10/16.	F 323		

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The care plan listed the resident was at risk of injury due to poor safety awareness, poor communication and impaired cognition. Interventions to prevent injury included call light within reach, encourage resident to ask for assistance, anticipate needs, proper footwear, needed items within reach, medications as ordered and a Wanderguard safety device. The care plan did not include individualized interventions regarding re-direction or diversion activities to minimize unsafe wandering. The care plan had not been updated or revised with new goals and/or interventions following the accidental ingestion of Greer's Goo or the three wandering/hitting incidents involving other residents.

On 3/23/17 at 7:40 a.m. the registered nurse (RN #1) caring for Resident #15 was interviewed about the resident's wandering and the ingestion of Greer's Goo. RN #1 stated she did not recall an incident with the resident ingesting Greer's Goo. RN #1 stated the resident was a known wanderer about the facility and self-propelled about the facility when up in her wheelchair. RN #1 stated, "We mostly just monitor her. It's an ongoing thing." RN #1 stated they attempted to re-direct the resident if seen going in others' rooms and separated residents if there was a physical altercation.

On 3/23/17 at 8:00 a.m. the director of nursing (DON) was interviewed about Resident #15. The DON stated the resident was wandering about and got the Greer's Goo from a bedside cabinet in another resident's room. The DON stated the Greer's Goo was a resident's "own personal cream" and was stored in the bedside table. The

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DON stated the Greer's Goo was removed from the resident's bed table after the ingestion incident. The DON stated Resident #15 had been in the facility for years, had progressive dementia and wandered constantly about the facility when in her wheelchair. The DON stated they had taken interventions with the residents that hit Resident #15 but they did not want to restrict Resident #15's wandering.

On 3/23/17 at 8:10 a.m. the licensed practical nurse (LPN #2) responsible for care plan updates was interviewed about Resident #15. LPN #2 stated the nurses and the care team were responsible for updates to care plans. LPN #2 stated she updated the care plans anytime the nurses advised her of a needed revision. LPN #2 stated residents were discussed in daily meetings and needed updates were communicated during this meeting. Concerning Resident #15, LPN #2 stated the care plan had not been revised to reflect the accidental ingestion of Greer's Goo or the hitting/kicking incidents with other residents.

On 3/23/17 at 9:00 a.m. the certified nurses' aide (CNA #1) routinely caring for Resident #15 was interviewed about the Greer's Goo ingestion and the resident's wandering. CNA #1 stated Resident #15 was constantly "on the go" when up in her wheelchair. CNA #1 stated the resident was not on her living unit but on the West unit when she went into another resident's room and got into the Greer's Goo. When asked about safety interventions for Resident #15, CNA #1 stated everyone knew the resident and tried to re-direct her if she was wandering into others' rooms. CNA #1 stated they tried to monitor Resident #15 and keep her out of the way of other residents.

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F 323	Continued From page 44 Greer's Goo is topical formulation of hydrocortisone, nystatin and zinc oxide used for prevention of diaper rash. (1) These findings were reviewed with the administrator and director of nursing during a meeting on 3/23/17 at 10:45 a.m. (1) "Greer's goo." McGraw-Hill Concise Dictionary of Modern Medicine. 2002. The McGraw-Hill Companies, Inc. 24 Mar. 2017 http://medical-dictionary.thefreedictionary.com/Greer%27s+goo	F 323		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		4/25/17

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F 329	Continued From page 45 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 24 residents was free from unnecessary medication. Resident #8 was administered the medication Reglan twice per day for over three months following a pharmacy recommendation and physician instructions for a dose reduction. The findings include: Resident #8 was admitted to the facility on 12/2/15 with a re-admission on 4/29/16. Diagnoses for Resident #8 included adult failure to thrive, obesity, GERD (gastroesophageal reflux disease), constipation, depression, sleep apnea, Bell's palsy, congestive heart failure and bronchitis. The minimum data set (MDS) dated 2/28/17 assessed Resident #8 as cognitively intact.	F 329	1. For resident #8, the physician was notified and new orders received. There were no adverse effects from the medication variance. 2. A review has been conducted by the DCS/designee of pharmacy recommendations for the past ninety (90) days to ensure recommendations are being followed. 3. In-servicing has been provided to the licensed nurses by the DCS/designee regarding the procedure on following pharmacy recommendations that have been approved by the physician. A random weekly review will be conducted by the DCS/designee for five (5) residents monthly for three (3) months to ensure pharmacy recommendations that have	

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F 329	Continued From page 46 Resident #8's clinical record documented a physician's order dated 5/5/16 for the medication Reglan (metoclopramide) 10 mg (milligrams) to be administered twice per day for the treatment of GERD. The resident's medication administration records (MARs) documented the Reglan was administered as ordered. A pharmacy recommendation report dated 11/11/16 stated, "[Resident #8] has been receiving metoclopramide for greater than 12 weeks. Metoclopramide is considered a high risk medication in the elderly due to increased risk for extrapyramidal movements. Treatment for longer than 12 weeks should be avoided in all but rare cases where therapeutic benefit is thought to outweigh the risk of developing tardive dyskinesia... Please consider tapering the daily dose of metoclopramide by 50% for 2 weeks until 5 mg per day then discontinue." The resident's physician signed this recommendation on 12/2/16 with instructions stating, "I accept the recommendation(s) above, please implement as written." There was no physician's order entered for a dose reduction and/or discontinued use of Reglan for Resident #8. The resident's medication records from December 2016 through 3/21/17 documented Resident #8 continued to receive the 10 mg dose of Reglan twice per day. On 3/22/17 at 9:20 a.m. the licensed practical nurse (LPN #1) administering medications to Resident #8 was interviewed about the resident's Reglan administration. LPN #1 stated the resident was currently administered Reglan 10 mg twice per day. Concerning Resident #8's recommended Reglan dose reduction, LPN #1	F 329	been approved by the physician are implemented. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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stated, "It looks like it [dose reduction] did not get done." LPN #1 stated the order was never written for the dose reduction and the recommendation got filed without orders written for the changes. LPN #1 stated, "It [pharmacy recommendation] got filed and completely missed." LPN #1 stated after the physician signed or provided instructions on the pharmacy recommendation sheet, a telephone order was supposed to be written/entered for the changes.

On 3/22/17 at 11:35 a.m. the director of nursing (DON) was interviewed about Resident #8's Reglan. The DON stated the physician approved dose reduction for Resident #8's Reglan was not implemented.

The Nursing 2017 Drug Handbook on pages 960 through 962 describes Reglan (metoclopramide hydrochloride) as a dopamine antagonist used for the management of nausea/vomiting associated with GERD, cancer chemotherapy and delayed gastric emptying due to diabetic gastroparesis. This reference documents Reglan has a black box warning stating, "Drug can cause irreversible tardive dyskinesia, even after drug is stopped. Risk increases with duration of therapy and total cumulative dose; there is no treatment. Discontinue drug if signs and symptoms occur. Except in rare cases, avoid treatment for longer than 12 weeks." (1)

These findings were reviewed with the administrator and DON during a meeting on 3/22/17 at 1:20 p.m.

(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.

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F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 428		4/25/17

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F 428	Continued From page 49 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to act upon a pharmacy recommendation for one of 24 residents in the survey sample. Resident #8's physician approved pharmacy recommendation for a dose reduction of the medication Reglan was not implemented by the facility. Resident #8 was administered the same dose of Reglan twice per day for over three months following pharmacy/physician instructions for a reduced dose. The findings include: Resident #8 was admitted to the facility on 12/2/15 with a re-admission on 4/29/16. Diagnoses for Resident #8 included adult failure to thrive, obesity, GERD (gastroesophageal reflux disease), constipation, depression, sleep apnea, Bell's palsy, congestive heart failure and bronchitis. The minimum data set (MDS) dated 2/28/17 assessed Resident #8 as cognitively intact. Resident #8's clinical record documented a	F 428	1. For resident #8, the physician was notified and new orders received. There were no adverse affects from the medication variance. 2. A review has been conducted by the DCS/designee of pharmacy recommendations for the past ninety (90) days to ensure recommendations are being followed. 3. In-servicing has been provided to the licensed nurses by the DCS/designee regarding the procedure on following pharmacy recommendations that have been approved by the physician. A random weekly review will be conducted by the DCS/designee for five (5) residents monthly for three (3) months to ensure pharmacy recommendations that have been approved by the physician are implemented. 4. Results of the reviews will be discussed by the Administrator/designee	

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	495344	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 428	Continued From page 50 physician's order dated 5/5/16 for the medication Reglan (metoclopramide) 10 mg (milligrams) to be administered twice per day for the treatment of GERD. The resident's medication administration records (MARs) documented the Reglan was administered as ordered. A pharmacy recommendation report dated 11/11/16 stated, "[Resident #8] has been receiving metoclopramide for greater than 12 weeks. Metoclopramide is considered a high risk medication in the elderly due to increased risk for extrapyramidal movements. Treatment for longer than 12 weeks should be avoided in all but rare cases where therapeutic benefit is thought to outweigh the risk of developing tardive dyskinesia... Please consider tapering the daily dose of metoclopramide by 50% for 2 weeks until 5 mg per day then discontinue." The resident's physician signed this recommendation on 12/2/16 with instructions stating, "I accept the recommendation(s) above, please implement as written." There was no physician's order entered for a dose reduction and/or discontinued use of Reglan for Resident #8. The resident's medication records from December 2016 through 3/21/17 documented Resident #8 continued to receive the 10 mg dose of Reglan twice per day. On 3/22/17 at 9:20 a.m. the licensed practical nurse (LPN #1) administering medications to Resident #8 was interviewed about the resident's Reglan administration. LPN #1 stated the resident was currently administered Reglan 10 mg twice per day. Concerning Resident #8's recommended Reglan dose reduction, LPN #1 stated, "It looks like it [dose reduction] did not get	F 428	at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25, 2017	

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F 428	Continued From page 51	F 428		

done." LPN #1 stated the order was never written for the dose reduction and the recommendation got filed without orders written for the changes. LPN #1 stated, "It [pharmacy recommendation] got filed and completely missed." LPN #1 stated after the physician signed or provided instructions on the pharmacy recommendation sheet, a telephone order was supposed to be written/entered for the changes.

On 3/22/17 at 11:35 a.m. the director of nursing (DON) was interviewed about Resident #8's Reglan. The DON stated the physician approved dose reduction for Resident #8's Reglan was not implemented.

The Nursing 2017 Drug Handbook on pages 960 through 962 describes Reglan (metoclopramide hydrochloride) as a dopamine antagonist used for the management of nausea/vomiting associated with GERD, cancer chemotherapy and delayed gastric emptying due to diabetic gastroparesis. This reference states Reglan has a black box warning stating, "Drug can cause irreversible tardive dyskinesia, even after drug is stopped. Risk increases with duration of therapy and total cumulative dose; there is no treatment. Discontinue drug if signs and symptoms occur. Except in rare cases, avoid treatment for longer than 12 weeks." (1)

These findings were reviewed with the administrator and DON during a meeting on 3/22/17 at 1:20 p.m.

(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.

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F 514	Continued From page 52	F 514		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 514		4/25/17

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F 514	Continued From page 53 Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for one of 24 residents in the survey sample: Resident # 11. Resident # 11 had an allergy to Tylenol identified on a red label affixed to inside panel of the clinical record, and also had the allergy documented on the POS (physician order summary). Findings include: Resident # 11 was admitted to the facility 11/3/13 with diagnoses to include, but not limited to: diabetes, high blood pressure, dementia, anemia, and low thyroid function. The most recent MDS (minimum data set) was a quarterly review dated 2/11/17. Resident # 11 was coded as having severe impairment in cognition with a total summary score of 06 out of 15. On 3/22/17 at 7:45 a.m. during review of the clinical record, it was noted the resident was identified as having an allergy to Acetaminophen (Tylenol). Included on the current POS was an order for "Acetaminophen 325 mg tablet 1 every 4 hours as needed for headache....." The MAR (medication administration record) was then reviewed and it was noted the resident had not been administered the Tylenol in over a year. On 3/22/17 at 8:00 a.m. the unit manager, identified as RN (registered nurse) # 3 was asked about the allergy, and also about the order. RN # 3 stated the resident did not use the Tylenol. She further stated she did not know why the allergy was on the record.	F 514	1. For resident #11, physician was notified and an order was obtained to discontinue the allergy to acetaminophen. 2. A review has been conducted by the DCS/designee of the medical records to ensure that correct allergies are listed in the medical record. 3. In-servicing has been provided to the licensed nurses by the DCS/designee on ensuring that allergies are correct in the medical record in accordance with their medication list. A random weekly review will be conducted by DCS/designee for five (5) residents weekly for three (3) months to ensure allergy list is accurate. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25,2017	

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F 514	Continued From page 54 On 3/22/17 at 8:30 a.m. the ADON (assistant director of nursing) told this surveyor "I'm going to call the doctor and clarify this allergy." A few minutes later, at 8:45 a.m. the ADON told this surveyor "The doctor said to d/c (discontinue) the allergy. He stated it was not a "true" allergy; apparently in the past the Tylenol caused her liver enzymes to be elevated, but it's not an allergy." On 3/22/17 during a meeting with facility staff beginning at 1:25 p.m. the administrator and DON (director of nursing) were informed of the above findings. No further information was provided prior to the exit conference.	F 514		
F 518 SS=D	TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS CFR(s): 483.75(m)(2) The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure one of 9 employees interviewed was knowledgeable of emergency procedures. Certified nurses' aide (CNA #2) did not know actions to take in case of a fire or of red outlets available for use during a power outage. The findings include: On 3/21/17 at 3:20 p.m. CNA #2 was interviewed	F 518	1. CNA #2 was educated on emergency procedures. 2. A review has been conducted by the DCS/designee for current employees to ensure they are knowledgeable about emergency procedures. 3. In-servicing has been provided to current employees by the DCS/designee on the facility's emergency procedures. A	4/25/17

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F 518	Continued From page 55 about her role during a fire emergency and/or power outage. When asked to describe her role during a fire drill, CNA #2 stated she was not sure and would need to go ask someone. When asked how she knew the location of a fire during a drill, CNA #2 stated she was not sure and needed to ask someone and get back with me. When asked if she had any role with the fire extinguishers, CNA #2 stated she was shown how to use the extinguisher during orientation but was not sure when or if she was to take the extinguisher to the location of a fire. When asked about protocols during a power outage, CNA #2 stated the generator came on and powered the outlets in the facility. When asked if the facility had red or special outlets to use during an outage, CNA #2 stated she thought the generator powered "everything." CNA #2 stated she had been employed at the facility for about two months. On 3/21/17 at 3:45 p.m. the licensed practical nurse (LPN #1) working on the unit with CNA #1 was interviewed about the emergency protocol. LPN #1 stated an assignment sheet was posted each shift giving instructions to staff members concerning their roles during an emergency. LPN #1 stated the assignment sheet listed which staff members were responsible for taking the extinguisher to the location of the fire, those assigned as runners and those assigned to do head counts. LPN #1 stated the location of the fire was announced on the intercom system and they had designated red outlets for use during a power outage. On 3/22/17 at 2:50 p.m. the registered nurse staff development coordinator (RN #2) was interviewed about CNA's responses during the	F 518	random weekly review will be conducted by DCS/designee for five (5) employees weekly for three (3) months to ensure they are knowledgeable about the facility's emergency procedures. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. April 25,2017	

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emergency protocol interview. RN #2 stated monthly emergency/fire drills were conducted and all employees were educated during orientation on emergency procedures.

On 3/23/17 at 10:10 a.m. the maintenance director was interviewed about CNA #2's lack of knowledge concerning emergency protocols. The maintenance director stated education on emergencies was conducted with employees during orientation and following the monthly drills as needed. The maintenance director stated nurses were responsible for determining the location of the fire from fire panels and announcing the location over the intercom. The maintenance director stated each unit posted assignments for employees each shift for a runner, fire extinguisher person and head counter. The maintenance director stated aides were responsible for clearing hallways of equipment during a drill in addition to moving the residents to a safe area. The maintenance director stated the facility had designated red outlets for use during a power outage.

CNA #2's orientation records documented education regarding facility safety practices, fire and disaster drills, fire types and fire extinguisher operation was signed off by the employee on 1/17/17.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/23/17 at 10:45 a.m.