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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495303	A. BUILDING ______ B. WING ______	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVALESCENT CNTR WE	**2960 CHELSEA ROAD** **WEST POINT, VA 23181**

(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 on 9/20/16 through 9/22/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long term Care requirements. The Life Safety Code Survey/Report will follow. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Resident #1 through #13 and Resident # 17) and 3 closed records (Residents #14 through #16).	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure 1 resident (Resident #9) of 15 residents in the survey sample were assessed to self administer medications. Resident #9 self administered Fluticasone (nasal spray). He had not been assessed to self administer his own medications. The findings included: Resident #9, a 68 year old, was admitted to the facility on 9/1/16. His diagnoses included femur	F 176	F176 1. The physician and responsible party were notified by the ADON on 9/21/16 that resident # 9 self-administered Fluticasone (nasal spray) and had not been assessed to self-administer his own medications. On 9/21/16 the Unit Supervisor completed the self administration assessment on resident # 9 who was evaluated as appropriate to self-administer the ordered Fluticasone (nasal spray). 2. All residents within the facility who request to self-administer medications are at risk for failure to be assessed for self-	10/28/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 10/13/2016

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

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F 176	Continued From page 1 fracture, hypertension, and benign prostatic hyperplasia. His most recent Minimum Data Set assessment was a 5 day assessment with an assessment reference date of 9/2/16. He was coded with a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment. He required assistance with his activities of daily living. Resident #9's medication administration was observed as part of the medication pour and pass observation. On 9/21/16 at 8:55 a.m., Licensed Practical Nurse B (LPN B) prepared Resident #9's medications. Upon entering the room, LPN B handed Resident #9 the cup of pills. She set the Fluticasone spray, which was in the box, on the bed side table. After Resident #9 swallowed the pills, he picked up the Fluticasone box. He removed the spray bottle and administered 2 sprays to the right nostril. At this time, LPN B told him to only spray once. Resident #9 administered 1 spray into the left nostril. Resident #9 had a physician order dated 9/8/16 for Fluticasone. The order read 1 spray both nostrils every day. On 9/21/16 at 10:00 a.m., the Assistant Director of Nursing (ADON) was notified that Resident #9 self administered the Fluticasone. She was asked to provide documentation that Resident #9 had been assessed to safely self administer medications. Later in the morning, the ADON provided a form	F 176	administration. A 100% audit was completed to ensure that all residents self-administering medications have had an assessment completed and documentation of the assessment in the medical record on 9/21/16 by DON/designee. 3. The licensed nurses will receive additional education on the facility policy and procedure regarding appropriate assessment of residents requesting self-administration of medications to be completed by October 21, 2016 by the DON/designee. 4. DON/designee will complete 3 residents medication administration audits per week for 4 weeks and 1 per week for 8 weeks to ensure residents who self-administer medications have self-administration assessment completed. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective action will be completed by October 28, 2016.	

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F 176	Continued From page 2 titled "Assessment for Self Administration of Medications" for Resident #9. The form was completed on 9/21/16 at 10:35 a.m. The form documented that Resident #9 was safe to administer medications through inhalation, specifically Fluticasone nasal spray. It was reviewed with the ADON that the form had been completed after Resident #9 was observed to self administer medications. At the end of day meeting on 9/21/16, the medication pour and pass observation was reviewed with the Administrator, Director of Nursing and corporate staff. It was reviewed with the facility staff that Resident #9 self administered Fluticasone without being assessed to self administer medications.	F 176		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to follow the professional standards of nursing for the documentation of a physician ordered supplement for one resident (Residents #7) in a survey sample of 17 residents. The facility staff failed to document the administration of Resident #7 's Ensure Plus on the Medication Administration Record on 5 days during July, 2016. The findings included:	F 281	1. On resident #7 the licensed nurses responsible for missed documentation were given additional education on the importance of appropriate documentation of medications per provider order, by the DON or designee beginning on 9/21/16. The Provider was notified of missing documentation on 9/21/16 by DON. No adverse effect has been identified for the resident. 2. All residents within the facility are at risk for omission of documentation of	10/28/16

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Continued From page 3

Resident #7 was an 87 year old who was admitted to the facility on 7/23/07. Resident #7's diagnoses included Unspecified Disease of Salivary Gland, Gastro-Intestinal Reflux Disease, Fragile Skin Disorder, and Recurrent Urinary Tract Infections.
The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 8/18/16, coded Resident #7 as usually being able to understand and be understood by others. In addition, he was coded as requiring the assistance of 1 person for eating.
On 9/21/16 a review was conducted of Resident #7's clinical record, revealing the following signed Physician 's Order, " 7/1/16. Ensure Plus 8 oz. by mouth three times a day between meals. Diet - Pureed; Mechanical Soft Desserts and Snacks; No straws."
Resident #7 's Care Plan read, Potential for Gastric Distress. Administer medication as ordered by physician "
Resident #7 's Medication Administration Record was reviewed. The Ensure Plus was not documented as having been administered at 9:00 P.M. on the following dates: 7/2/16, 7/8/16, 7/16/16, 7/7/16, and 7/19/16.
Resident #7 ' s Weight Record was reviewed, revealing no weight loss or gain during July-August 2016. His weight remained at 142 pounds.
On 9/21/16 at 11:40 A.M., an interview was conducted at the nurse ' s station with the unit nurse (LPN-C). When asked about the importance of documentation of medication administration on the Medication Administration Record (MAR), she stated, " It 's a nursing standard to sign your name when you document on the MAR. When the resident refuses, I would put a circle and write on the back. The other

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physician ordered supplement and adherence to the facility policy and procedure.
3. The licensed nurses will receive additional education relating to facility policy and procedure regarding appropriate documentation of administration of physician ordered supplements and the 6 rights of medication administration by DON/designee by 10/21/16. The licensed nurses were given additional education on 9/21/16 by DON/designee to complete Medication administration capture exception report with oncoming and off going nurses for compliance in documentation. DON/designee will run the medications administration capture exception report for missed documentation for Morning meeting review. All missing documentations will be investigated with appropriate action implemented by the DON/Designee.
4. DON/designee will complete 3 MAR Audits weekly for 4 weeks to assure complete documentation 1 MAR Audits weekly for 8 weeks. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.
5. All corrective action will be completed by October 28, 2016.

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F 281	Continued From page 4 nurse didn ' t do it." She stated that the facility uses Mosby 's Potter and Perry as a nursing standard. Potter and Perry 's Fundamentals of Nursing (6th edition) page 482 read, " (Clinical) Records need to reflect accountability during the time frame of the entry. The entry needs to clearly show what was done, when it was done, and by whom. " The Facility policy on Medication Administration, dated February, 2010 was reviewed. It read, " Circle your initial on the front of the MAR and document the reason for non-administration of medication on the back of the MAR. " On 9/21/16 at 4:00 P.M., the facility Administrator (Administration C), and Director of Nursing (Administration B) were informed of the findings. No further information was received.	F 281		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure a medication pour and pass error rate of less than 5%. An error rate of 7.1% was calculated from 2 errors and 28 opportunities. The medication errors occurred during the medication pour and pass observation with the following Residents: Resident #9 self administered Fluticasone (nasal	F 332	1. The physician and responsible party were notified by the DON on 9/21/16 that resident # 9 self-administered Fluticasone (nasal spray) and had not been assessed to self-administer his own medications and that he had administered 2 sprays to one nostril when 1 spray was ordered. On 9/21/16 the ADON completed the self administration assessment on resident # 9 who was determined appropriate to self-administer. Resident #9 had no	10/28/16

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F 332 Continued From page 5

spray). Error 1- He had not been assessed to self administer his own medications. Error 2- He administered 2 sprays rather than 1 spray per physician order.

The findings included:

Resident #9, a 68 year old, was admitted to the facility on 9/1/16. His diagnoses included femur fracture, hypertension, and benign prostatic hyperplasia. His most recent Minimum Data Set assessment was a 5 day assessment with an assessment reference date of 9/2/16. He was coded with a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment. He required assistance with his activities of daily living.

On 9/21/16 at 8:55 a.m., Licensed Practical Nurse B (LPN B) prepared Resident #9's medications as part of the medication pour and pass observation. Upon entering the room, LPN B handed Resident #9 the cup of pills. She set the Fluticasone spray, which was in the box, on the bed side table.

After Resident #9 swallowed the pills, he picked up the Fluticasone box. He removed the spray bottle and administered 2 sprays to the right nostril. At this time, LPN B told him to only spray once. Resident #9 administered 1 spray into the left nostril.

Resident #9 had a physician order dated 9/8/16 for Fluticasone. The order read 1 spray both nostrils every day.

On 9/21/16 at 10:00 a.m., the Assistant Director of Nursing (ADON) was notified that Resident #9

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adverse outcome was observed from the additional spray of fluticasone.

2. All residents within the facility are at risk for medication errors during medication administration.

3. The licensed nurses will receive additional education by DON/designee relating to facility policy and procedure regarding appropriate medication administration and the 6 rights of medication administration by October 21, 2016.

4. DON/designee will complete 3 residents□ medication administration audits per week for 4 weeks and 1 per week for 8 weeks to ensure residents who self-administer medications have the self-administration assessment completed and the 6 rights for med administration are followed. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.

5. All corrective action will be completed by October 28, 2016.

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F 332	Continued From page 6 self administered the Fluticasone. She was asked to provide documentation that he had been assessed to safely self administer medications. Later in the morning, the ADON provided a form titled "Assessment for Self Administration of Medications" for Resident #9. The form was completed on 9/21/16 at 10:35 a.m. The form documented that Resident #9 was safe to administer medications through inhalation, specifically Fluticasone nasal spray. It was reviewed with the ADON that the form had been completed after Resident #9 was observed to self administer medications. At the end of day meeting on 9/21/16, the medication pour and pass observation was reviewed with the Administrator, Director of Nursing and corporate staff. The facility staff were notified that 2 errors had occurred during the observation. First, Resident #9 self administered Fluticasone without being assessed to self administer medications. Second, Resident #9 did not administer the correct number of sprays. The facility staff were notified that a 7.1% medication administration rate was calculated from 2 errors and 28 opportunities.	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		10/28/16

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F 425	Continued From page 7 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure a medication was available for administration to one Resident (Resident #1) in a survey sample of 17 Residents. For Resident #1, the facility staff failed to ensure Diabetic Siltussin-DM was available for administration. "The generic name for Siltussin-DM is dextromethorphan and guaifenesin and in combination this medicine is used to treat cough and chest congestion caused by the common cold, infections, or allergies." drugs.com The findings included: Resident #1 was initially admitted to the facility on 7/5/10 and readmitted after a hospitalization on 5/31/15. Her diagnoses included hypertension, chronic obstructive pulmonary disease, Alzheimer's disease, and acute bronchitis.	F 425	. Resident #1s medication was available for administration on 9/21/16. No adverse outcome occurred related to the medication not being available from pharmacy. MD and RP were notified of omitted doses of medication on 9/21/16 by the DON. 2. All residents within the facility are at risk for medications not being available for administration. A 100% audit was completed on residents to ensure all medications were available to administer on 9/21/16 by DON/designee. 3. The licensed nurses received additional education related to facility policy and procedure regarding managing unavailable medications by DON/designee completed by October 21, 2016. The licensed nurses will report to DON/designee per procedure unavailable medications. The DON/Designee will review unavailable medications provided by nursing staff at the morning meeting	

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F 425	Continued From page 8 Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/18/16 was coded as a quarterly assessment. Resident #1 was coded a BIMS (Brief Mental Interview of Mental Status) score of 12, moderately impaired. She was also coded as needing set up to extensive assistance with her activities of daily living. A review of Resident #1's clinical record was conducted on 9/21/16 at 9:00 a.m. Resident #1's comprehensive care plan included a problem for an impaired respiratory system. A specific problem of cough congestion was dated 8/25/16 and interventions included, "Administer medications as per MD (medical doctor) orders. See MAR (Medication Administration Record)." Review of Resident #1's clinical record revealed a September 2016 MAR with an order entry that read, "Diabetic Siltussin - DM Max Strength 10 mg-200 mg(milligram) - oral liquid, every six hours starting 8/12/16 for Acute Bronchitis." Documentation on the MAR in the NON- PRN (as needed) MEDICATION NOTES revealed that Diabetic Siltussin-DM was not administered on 9/3 at 3:00 a.m.; 9/4 at 3:00 p.m.; 9/5 at 3:00 a.m.; 9/6 at 9:00 a.m., and 9/8 at 3:00 a.m. Under Notes on 9/4/16 was documented, "Not Administered, ordered by phone from pharmacy. Pharmacy states that it will be on next run as it was not available." Under Notes on 9/6/16 at 9:00 a.m. read, "Not Available-on first run." A valid corresponding physician's order read, " 8/11/16, Diabetic Siltussin-DM Max Strength 10 mg-200 mg/5 ml (milliliters))Oral Every Six Hours starting 8/12/16."	F 425	and validate delivery of medications. 4. DON/designee will complete 3 residents□ medication administration audits per week for 4 weeks and 1 per week for 8 weeks to ensure residents□ medications are available. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective action will be completed by October 28, 2016.	

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F 425	Continued From page 9 On 9/21/16 at 10:00 a.m., the DON (Director of Nursing) was interviewed and asked about the Diabetic Siltussin - DM that was documented as not being available for administration. The DON reviewed Resident #1's September MAR and said the Siltussin - DM was most likely available. She added, "I think the nurses that were working at that time were from the agency." The DON did not provide any follow-up information or documentation regarding the Siltussin - DM that was documented as not having been available for administration. The facility's emergency (STAT) medication supply list was reviewed. Diabetic Siltussin - DM was not included in the Stat Box inventory list. The facility's policy/procedure for Medication Administration stated, "Medications must be given accurately and appropriately for the resident to receive the intended therapeutic effect." Guidance for nursing practice for the administration of medications was included in, Fundamentals of Nursing 7th Edition, page 336, "The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." On 9/22/16 at 1:45 p.m., the administrator, DON, and corporate nurse were informed of the failure of the staff to ensure Diabetic Siltussin - DM was available for administration to Resident #1. No additional information was provided	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		10/28/16

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F 428	Continued From page 10 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure pharmacy recommendations were addressed by the physician for 1 resident (Resident #4) of 17 residents in the survey sample. For Resident #4, the pharmacist made recommendations on 8/9/16 and 9/7/16. The recommendations had not been addressed by the physician. The findings included: Resident #4, an 84 year old, was admitted to the facility on 12/3/14. Her diagnoses included hypertension, diabetes, dementia, depression, and elevated lipids. Resident #4's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/27/16. She was coded to have moderate cognitive impairment and required extensive assistance with her activities of daily living. The monthly medication regimen reviews	F 428	1. Resident # 4□s pharmacist recommendation was completed on 9/22/16 and 9/25/16 by the nurse practitioner. 2. All residents within the facility are at risk for pharmacy recommendations not being addressed by the provider. An audit was completed on residents to ensure all pharmacy recommendations had been addressed by a provider on 9/23/16 by DON/designee. No other pharmacy recommendations had been found as not addressed by the provider. 3. The providers received additional education regarding addressing pharmacist recommendations by DON/designee on September 22, 2016. DON/designee will present pharmacist recommendations to the provider for review and signature within 30 days of recommendation. All approved recommendations by the provider for order changes will be immediately implemented.	

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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 428	Continued From page 11	F 428		

completed by the pharmacist were reviewed in the clinical record. It was documented that the pharmacist had made recommendations to decrease medication amounts on 8/9/16 and 9/7/16. The recommendations read:

-8/9/16 "(Resident name) has been taking omeprazole 20 mg (milligram) QD (every day) for GERD (gastroesopheageal reflux disease) since 12/14. If appropriate, may want to decrease the omeprazole to 20 mg every OTHER day, with possible taper to DC (discontinue)?"

-9/7/16 "Recommend decreasing the pravastatin to 10 mg (milligram) q (every) HS (at bedtime)" (Pravastatin is used to lower cholesterol <https://www.drugs.com/mcd/high-cholesterol> and triglycerides (types of fat) in the blood.)

According to the September 2016 Medication Administration Record (MAR), Resident #4 currently received omeprazole 20 mg every day and pravastatin 20 mg every day.

At the end of day meeting on 9/21/16, the facility staff were asked if the 8/9/16 and 9/7/16 medication reviews had been reviewed by the physician.

On 9/22/16 at 10:50 a.m., copies of the medication review forms for both dates were provided by the Assistant Director of Nursing (ADON). Neither form had been signed by the physician. The ADON stated that she did not think the regulation indicated a time period for which pharmacy recommendations needed to be addressed. It was explained that the regulation does not specify a time period, but it is expected

4. DON/designee will complete 5 residents pharmacy audits to ensure pharmacist recommendations are reviewed and signed timely by physician monthly for 3 months. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.

5. All corrective action will be completed by October 28, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495303	A. BUILDING ______ B. WING ______	09/22/2016

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F 428	Continued From page 12 that the pharmacy recommendations are addressed in a timely manner. The ADON was asked how frequently the physician was in the building. She stated the physician and nurse practitioner were in the building at least every week. On 9/22/16 at 11:05 a.m., an interview was conducted with Licensed Practical Nurse A (LPN A). LPN A stated that she would give the pharmacy recommendations to the doctor or put them in the doctor box on the desk where the doctor usually sat when at the facility. She stated that the doctor did not always review the recommendations when they were left in the box. LPN A stated she would sometimes give the recommendations to the nurse practitioner. At the end of day meeting on 9/22/16, the Administrator, Director of- Nursing and corporate staff were notified that Resident #4's pharmacy recommendations had not been reviewed by the physician. No further information was provided.	F 428		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514		10/28/16

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F 514	Continued From page 13 and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for one Resident (Resident #7) in a survey sample of 17 residents. The facility staff failed to document administration of Resident #7 's Ensure Plus on 5 days during July, 2016. The findings included: Resident #7 was an 87 year old who was admitted to the facility on 7/23/07. Resident #7 ' s diagnoses included Unspecified Disease of Salivary Gland, Gastro-Intestinal Reflux Disease, Fragile Skin Disorder, and Recurrent Urinary Tract Infections. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 8/18/16, coded Resident #7 as usually being able to understand and be understood by others. In addition, he was coded as requiring the assistance of 1 person for eating. On 9/21/16 a review was conducted of Resident #7's clinical record, revealing the following signed Physician 's Order, " 7/1/16. Ensure Plus 8 oz. by mouth three times a day between meals. Diet - Pureed; Mechanical Soft Desserts and Snacks; No straws. " Resident #7's Care Plan read, Potential for Gastric Distress. Administer medication as ordered by physician " Resident # 7's Medication Administration Record was reviewed. The Ensure Plus was not documented as having been administered at 9:00 P.M. on the following dates: 7/2/16, 7/8/16,	F 514	On resident #7 the licensed nurses responsible for missed documentation were provided additional education on the importance of appropriate documentation of medications per provider order, by the DON or designee beginning on 9/21/16. The Provider was notified of missing documentation on 9/21/16 by DON. No adverse effect has been identified for the resident. 2. All residents within the facility are at risk for and an incomplete and accurate medical record related to omission of documentation of physician ordered supplement. 3. The licensed nurses will receive additional education relating to facility policy and procedure regarding appropriate documentation of administration of physician ordered supplements and the 6 rights of medication administration by DON/designee by 10/21/16. The licensed nurses received additional education 9/21/16 by DON/designee to complete Medication administration capture exception report with oncoming and off going nurses for compliance in documentation. DON/designee will run the medications administration capture exception report for missed documentation for Morning meetings. All missing documentations will be investigated with appropriate action	

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F 514	Continued From page 14 7/16/16, 7/7/16 and 7/19/16. Resident #7's Weight Record was reviewed, revealing no weight loss or gain during July-August 2016. His weight remained at 142 pounds. On 9/21/16 at 11:40 A.M., an interview was conducted at the nurse's station with the unit nurse, Licensed Practical Nurse, (LPN-C). When asked about the importance of documentation of medication administration on the Medication Administration Record (MAR), she stated, "It 's a nursing standard to sign your name when you document on the MAR. When the resident refuses, I would put a circle and write on the back. The other nurse didn't do it." She stated that the facility uses Mosby ' s Potter and Perry as a nursing standard. Potter and Perry 's Fundamentals of Nursing (6th edition) pg. 482 read, " (Clinical) Records need to reflect accountability during the time frame of the entry. The entry needs to clearly show what was done, when it was done, and by whom. " The Facility policy on Medication Administration, dated February, 2010 was reviewed. It read, " Circle your initial on the front of the MAR and document the reason for non-administration of medication on the back of the MAR. " On 9/21/16 at 4:00 P.M., the facility Administrator (Administration C), and Director of Nursing (Administration B) were informed of the findings. No further information was received.	F 514	implemented by the DON/Designee 4. DON/designee will complete 3 MAR Audits weekly for 4 weeks to assure complete documentation 1 MAR Audits weekly for 8 weeks. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective action will be completed by October 28, 2016.	