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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 5/23/2017 through 5/25/2017. One complaint was investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 139 certified bed facility was 121 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents # 1 through 21) and three closed record reviews (Residents # 22 through 24).	F 000		
F 157 SS=D	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 treatment due to adverse consequences, or to	F 157		6/9/17

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

Electronically Signed | 06/09/2017

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F 157	Continued From page 1 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, facility document review, clinical record review and complaint investigation, the facility staff failed to immediately notify the physician of a fall and/or change in condition for three of 24 residents in the survey sample. Resident #23's physician was not immediately notified of an unwitnessed fall. Resident #6's physician was not promptly notified of a change in the frequency of pain. Resident #17's physician was not immediately notified of symptoms of a urinary tract infection.	F 157	F- 157 (NOTIFICATION OF CHANGES) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents #23, #6, & #17 As stated in your survey findings Resident #23 has passed, no further corrective action required for this resident.	

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F 157	Continued From page 2 The findings include: 1. Resident #23's physician was not immediately notified of an unwitnessed fall. The physician was not notified until 45 minutes after an unwitnessed fall when the resident experienced breathing difficulties and stopped breathing. Resident #23 was admitted to the facility on 3/16/10 and died in the facility on 5/14/16. Diagnoses for Resident #23 included Alzheimer's, Parkinson's disease, brain tumor, glaucoma, osteoporosis, breast cancer, anxiety and difficulty swallowing. The minimum data set (MDS) dated 5/11/16 assessed Resident #23 with moderately impaired cognitive skills. A facility reported incident document dated 5/17/16 documented Resident #23 called out for help and was found in the floor by her bed on 5/14/16 at 3:45 a.m. The form documented the resident was assessed with an abrasion to her right knee and right foot with bleeding on her 2nd toenail. The resident's blood pressure was assessed at 76/49, pulse rate 103, respirations at 16 with the resident's skin cool and clammy. The form stated the nurse was unable to obtain an oxygen saturation level, the resident's left pupil was dilated and the resident complained of a headache. This document stated, "Physician was not called at this point since the fall did not seem to be of acute proportions. The normal procedure for a 'routine' fall is to alert the physician in the morning." This document stated the resident's vital signs (blood pressure, pulse and respiration) and neurological checks were obtained at 4:00 a.m. and again at 4:15 a.m. The form stated on 5/14/16 at 4:30 a.m. the resident "was found	F 157	Resident # 6 received Oxycodone following a fall that she experienced on 10/22/16 which resulted in a pelvic fracture. At this time, Resident #6 has achieved relief from the pain and discomfort following the incident on 10/22/16. Resident #6 may occasionally rub her right thigh area and complain of generalized pain. Resident #6 has orders for Oxycodone, Duragesic Patch, & Lidocaine Patch to address her occasion discomfort. The occasion discomfort experienced by Resident #6 is a result of a previous episode of shingles which contributes to her occasional discomfort. Resident #17 has had a long standing relationship of thirty plus years with her primary care physician (PCP), (Dr. Schubert). It is not uncommon for this resident to proactively reach out to her physician for achieving self-control over her care needs. At this time, resident #17 has no active signs or symptoms of a UTI. Nursing will be mindful to proactively communicate with residents PCP and the resident to consistently address her care needs. We will encourage Resident #17 to be more forthcoming in her communication with us. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice if notifications of changes in resident's condition are not communicated effectively and efficiently. Clinical	

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F 157	Continued From page 3 gasping for breath and was not responding to verbal stimuli or sternal rub by nurses. At 4:32 am nurse called physician on call and left message with answering service...Resident ceased to breath at 4:33 am..." This form documented the physician called the facility at 4:35 a.m. and then gave an order to release the body to the funeral home. The form documented no autopsy was performed per requested of the family. Resident #23's clinical record documented no notification to the physician of the resident's fall on 5/14/15 until 45 minutes later when the resident was found unresponsive with breathing difficulties. The physician was not notified of the resident's post fall vital signs that included lower than normal blood pressure readings, a higher than normal pulse rate, no oxygen saturation readings and complaints of a headache. Nursing notes documented the following of 5/14/16. 3:45 a.m. - "Res. [Resident] was lying on floor bedside her bed with head at the foot of the bed, noted abrasion to right knee and right 2nd toenail bleeding scant amount. Bed was in lowest position. B/P [blood pressure] 76/49 [pulse] 103 - [respirations] 16...was cool and clammy -- blood sugar was 194 Was unable to get 02 sat. [oxygen saturation]... when asked if having pain, res. stated, 'I have a headache'... Noted right pupil reactive to light, left pupil dilated, res. has glaucoma. No c/o voiced." 4:00 a.m. - "vs [vital signs] 74/54 116 - 18...Res. alert at this time, talking with staff." 4:15 a.m. - vs 73/51 112 - 15...Res. was alert at this time, did c/o [complain of] stomach ache". (sic) 4:30 a.m. - When staff went in room to get neuro	F 157	Coordinators (CC's) will be responsible for conducting a thorough review of their household residents who experience a change in condition every 24 (twenty-four hours). The reporting of resident's change in condition will be communicated by the Charge Nurse (CN) to the CC. Resident condition changes will be evaluated by the CC, with appropriate follow- up to the responsible party and primary care physician (PCP), either by the CC or the CN. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. Initial measures to address this deficient practice include a facility wide mandatory Clinical Coordinator (CC) and Charge Nurse (CN) meeting facilitated by the Director of Nursing. The purpose for this mandatory meeting includes a review of identifying and addressing resident changes in a timely manner with a focus on physician notification as appropriate. Each CC and CN will be required to attend the mandatory meeting. This systematic change will be included in the orientation phase of new hires for CC's and CN's. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 157	Continued From page 4 [neurological] checks and vs, res. was gasping for breath, not responding to verbal stimuli or sternal rub." 4:32 a.m. - "Called MD [physician] on call and l/m [left message] with answering service." 4:33 a.m. - This nurse attempted to notify son...while on phone awaiting answer, Res. took last breath." Resident #23's clinical record documented the resident's blood pressure in the month prior to the fall ranged from 97/65 to 120/73 and pulse rates from 57 to 73 beats per minute. The clinical record documented the following blood pressure and pulse readings in the weeks prior to the resident's fall on 5/14/16. 4/13/16 - BP (blood pressure) 113/68, pulse rate 58 4/20/16 - BP 120/73, pulse 62 4/27/16 - BP 100/69, pulse 57 5/4/16 - BP 98/52, pulse 69 5/11/16 - BP 97/65, pulse 73 The record documented the resident had a history of a dilated left pupil. A post fall assessment dated 7/2/14 listed the resident's left pupil was not reactive to light. On 5/25/17 at 10:10 a.m. the registered nurse unit coordinator (RN#7) was interviewed about Resident #23's fall and lack of immediate notification to the physician. RN #7 stated from reviewing the incident the resident was assessed as alert and talking after the fall. RN #7 stated the nurses knew the resident well and were not going to call the physician in the night unless the resident was in acute distress. RN #7 stated the resident had a history of low blood pressures, a	F 157	The new systematic change will be incorporated in our current Quality Assurance Performance Improvement (QAPI) program. Each CC will ensure that notifications to the PCP and responsible party are made with any significant change in the residents health with life-threatening conditions, clinical complications, or changes needed for the current treatment plan. Monthly chart audits will be incorporated within the QAPI program to include medical record reviews within each respective household. The DON and QAPI Coordinator will be responsible for the monthly oversight of this process to ensure the program is sustained. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. The mandatory CC and CN meeting will be held June 21st and 28th. Integration of the QAPI process for inclusion of this plan will begin July 11, 2017.	

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dilated left pupil and often complained of a headache.

On 5/25/17 at 10:25 a.m. the licensed practical nurse (LPN #3) caring for Resident #23 at the time of the fall on 5/14/16 was interviewed about notification to the physician of the unwitnessed fall. LPN #3 stated, "We don't always call the doctor in the middle of the night." LPN #3 stated she had been told not to call the physician in the night unless it was an emergency. When asked the rationale for not calling the physician immediately about the unwitnessed fall, LPN #3 stated the resident was alert and talking when they initially assessed her. LPN #3 stated she did not remember why they were unable to get oxygen saturation levels. LPN #3 stated the resident had a history of a dilated left pupil and the resident complained of a headache and "general discomfort." LPN #3 stated she called the physician immediately when the resident was found gasping for breath. LPN #3 stated the resident stopped breathing and no resuscitation efforts were started because the resident was a "DNR" [do not resuscitate].

On 5/25/17 at 11:20 a.m. Resident #23's physician was interviewed by telephone about the resident's fall and death on 5/14/16. The physician stated he expected to be notified about an accident or change in condition "as soon as they [nursing staff] can reasonably do so." The physician stated his expectation for notification was the same during the night as in the day. The physician stated he did not know why they delayed in calling him on 5/14/16 unless they were busy assessing the resident. The physician stated in the past nurses in the facility had been very prompt with notifications. The physician

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stated he did not feel the 45 minutes delay in notification affected the outcome for Resident #23. The physician stated, "From a practical standpoint, there was very little they [nurses] could do." The physician stated the resident was 100 years old and was in very poor health with multiple significant health issues.

The clinical record documented no cause of death for the resident as the family did not want an autopsy performed.

These findings were reviewed with the administrator and director of nursing during a meeting on 5/25/17 at 3:50 p.m.

This was a complaint deficiency.

2. The facility staff failed to notify Resident # 6's attending physician of an increase in pain and an increase in the use of a PRN (as needed) pain medication in a timely manner.

Resident # 6 in the survey sample, a 95 year-old female, was admitted to the facility on 1/21/15, and most recently readmitted on 4/22/15 with diagnoses that included anemia, gastroesophageal reflux disease, arthritis, osteoporosis, Alzheimer's Disease, Non-Alzheimer's Dementia, anxiety disorder, depression, difficulty walking, vitamin deficiency, postherpetic polyneuropathy, generalized muscle weakness, neuritis and neuralgia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/12/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 1 out of 15.

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On the most recent Quarterly MDS with an ARD of 4/6/17, Resident # 6 was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired skills for daily decision making.

A review of Resident # 6's electronic clinical record revealed she fell twice on 10/22/16, but sustained no apparent injuries. At the time of the falls, the resident had the following medication order in place:

Oxycodone (Roxicodone) 5 mg (milligrams) - Give 1 tablet po (by mouth) q4h (every 4 hours) prn (as needed) pain (pain scale 5 - 10), moaning, facial grimacing, guarding of body movements and agitation.

(NOTE: Oxycodone [Roxicodone] is an opiate analgesic used to control moderate to severe pain. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 894.)

Review of the Electronic Medication Administration Record (E-MAR) for the month of October 2016 revealed that prior to her falls on 10/22/16, she received two doses of Oxycodone on 10/1/16 and 10/11/16, and one dose on each of the following dates, 10/10/16, 10/17/16, and 10/21/17.

Following her falls on 10/22/16, the resident received two doses of Oxycodone on 10/25/16, and one dose on each of the following days, 10/26/16, 10/29/16, 10/30/16, and 10/31/16, for a total of six doses in five days. Review of the comments section on the reverse side of the October E-MAR, that coincided with the

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administration of the Oxycodone, revealed the following entries:

10/25/16 - 1:36 p.m. "Res [Resident] c/o [complained of] pain to R [right] hip."
10/25/16 - 2:12 p.m. "Res stated she still had some pan."
10/26/16 - 1:20 p.m. "Res c/o pain to R hip."

According to the E-MAR for the month of November 2016, the resident received two doses of Oxycodone on 11/7/16 and 11/8/16, and one dose on each of the following days, 11/1/16 through 11/6/16, and 11/9/16, for a total of 11 doses in nine days. Review of the comments section on the reverse side of the November E-MAR that coincided with the administration of the Oxycodone revealed the following entries:

11/4/16 - 8:24 p.m. "C/O pain to right thigh. Unable to rate pain numerically."
11/5/16 - 1:51 p.m. "Resident guarding and rubbing leg, stating that her leg hurt."
11/6/16 - 2:21 p.m. "Resident rubbing leg and stating that it was hurting."
11/8/16 - 9:20 a.m. "Res c/o pain to R thigh."

Interdisciplinary (Nurses) Notes noted the following regarding the resident's pain and medication use:

11/5/16 - 1:52 p.m. "Resident guarding and rubbing leg, stated that her leg hurt. 1 Oxycodone tab [tablet] administered at 1351 [1:51 p.m.]."
11/6/16 - 2:22 p.m. "Resident noted to be rubbing leg and when asked she stated that it hurt. 1 Oxycodone administered at 1421 [2:21 p.m.]."

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There was no documentation in Resident # 6's clinical record that her attending physician was advised of her increased pain, or of her increased use of prn pain medication until 11/11/16. On that date, the facility sent the following FAX message to the attending physician, "Res started on duragesic 12 mcg [micrograms] on 10/26. Scheduled Tylenol was d/c'd [discontinued]. There has been an increase in prn seroquel use as well as oxycodone use. Can we try increasing duragesic use?" The attending physician responded with a telephone order to "Increase Fentanyl to 25 mcg/hr patch. Apply q 3 d [every 3 days]."

(NOTE: Fentanyl [Duragesic] is an opioid analgesic used to control moderate to severe pain. Administration routes include the use of a transdermal patch that is changed every three days. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 496.)

The findings were discussed during a meeting at 4:00 p.m. on 5/25/17 that included the Administrator, the Director of Nursing, and the survey team.

3. Resident #17's physician was not immediately notified of symptoms of a urinary tract infection.

Resident # 17 in the survey sample, an 86 year-old female, was admitted to the facility on 3/4/13, and most recently readmitted on 8/9/16 with diagnoses that included anemia, hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, arthritis, history of hip fracture, chronic obstructive pulmonary disease, cataracts, pruritis, sleep apnea, spinal

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stenosis, auditory hallucinations, chronic pain syndrome, inflammatory polyarthropathy. According to the most recent full MDS, a Significant Change with an ARD of 8/16/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

According to the most recent Quarterly MDS with an ARD of 4/20/17, the resident's cognitive status under Section C (Cognitive Patterns) remained unchanged.

Resident # 17 had recently completed a course of antibiotics for a urinary tract infection as noted in the following Interdisciplinary (Nurses) Notes in the resident's electronic clinical record:

3/10/17 - Res [Resident] c/o [complained of] burning on urination, bilateral lower back pain. Afebrile. Faxed MD. Res. called the doctors office and made appointment for herself today at 1315 [1:15 p.m.]...Res. back from MD appointment with prescription for Cipro for UTI."

(NOTE: Cipro [Ciprofloxacin] is a broad spectrum antiinfective used to treat escherichia coli urinary tract infections. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 255.)

Further review of the Interdisciplinary (Nurses) Notes revealed the following entries:

4/30/17 - 1640 (4:40 p.m.) - "Resident c/o [complained of] 'burning' when she voids. She states that she has had s/s [signs and symptoms] for 'several days' but did not tell anyone. Fluids encouraged. Will continue to monitor."

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5/22/17 - 12:40 - "Resd [Resident] c/o urinary burning and frequency. Resd requesting to see MD. Resd was out for visit with MD last week but stated she didn't say anything to him about it [urinary burning and frequency] while she was there. MD notified and order for UA [Urinalysis] received. Will continue to monitor."

5/22/17 - 2303 (11:03 p.m.) - "Clarification order for U/A, to obtain I&O [In and Out] catheterization specimen scheduled for AM. Fluids encouraged...."

Additional review of the Interdisciplinary (Nurses) Notes confirmed Resident # 17 was out of the facility to see the physician on 5/16/17, at which time new orders were received. None of the new orders dealt with the resident's complaint of urinary burning.

At approximately 11:30 on 5/25/17, LPN # 3 (Licensed Practical Nurse), the Unit Manager on the Harmony Household, was asked if the results of Resident # 17's UA had been received. "The results just came back," LPN # 3 said, "She has a UTI [Urinary Tract Infection]. We are getting an order for an antibiotic now."

At approximately 2:30 p.m. on 5/25/17, LPN # 3 was interviewed regarding the assessment of the resident's complaint of burning when voiding. Asked why the physician wasn't notified on 4/30/17 and a UA obtained, LPN # 3 said, "I don't know why we wouldn't have done something. She [the resident] is usually right on it. She didn't complain again, she had no fever. She is vocal enough that if she still had burning or pain, she would have told us or she would have called the doctor herself, which she has done."

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F 157	Continued From page 12 On 5/25/17, the following telephone order was received, Ceftin 250 mg (milligrams) BID (two times a day) po (by mouth) for 10 days for UTI. (NOTE: Ceftin is a second generation cephalosporin antiinfective used to treat escherichia coli urinary tract infections. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 221.) The findings were discussed during a meeting at 4:00 p.m. on 5/25/17 that included the Administrator, the Director of Nursing, and the survey team.	F 157		
F 167 SS=B	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual	F 167		6/9/17

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F 167	Continued From page 13 to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post notice of the availability of the survey results in areas that are prominent and accessible. Notice of survey results was not posted on the Wellness unit and was not in a prominent place on the Unity unit. The Findings Include: On 5/25/17 at 11:30 a.m. general observations were conducted on the Wellness unit. Signage for the survey results could not be located, but after searching, the survey results were located. At this time this surveyor asked license practical nurse (LPN #6) to show where the survey results were located. After looking in the nurses office. LPN #6 then went out to the common area and found the results sitting on a table. This surveyor then asked where a notice (sign) was that indicated where the survey results where kept. LPN #6 searched throughout the unit and verbalized that she was unable to find a notice. 5/25/17 at 11:45 a.m. Unity unit was also observed for signage of the survey result book. The signage on a wall, not at or below eye level,	F 167	F □ 167 RIGHT TO SURVEY RESULTS □ READILY ACCESIBLE 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Signage for Survey Results were posted in a prominent location, front door entrance of the Wellness Household on 5-26-17. Signage for Survey results were moved to accommodate more accessibility at eye level at the front door within the Unity House on 6-5-17. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. To maintain continuity within each household for having Survey Results prominent and accessible for residents, family members, and guests we will re-locate our Survey Results signage to be posted in the front entrance of each household (just inside the entry door). Signage will be consistent throughout each household, and will be posted at eye level. Survey Result notebooks will be	

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F 167	Continued From page 14 was small and not in a prominent (high traffic) place. The above finding was presented to the director of nursing and administrator on 5/25/17 at 3:00 p.m. No other information was provided prior to exit conference on 5/25/17.	F 167	available for viewing in the residents living/common area on side tables. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. Household Coordinators will monitor the Survey Results signage for consistent locations within their respective households. Notebooks will be placed on tables within the residents living/common areas on side tables. Homemakers within their respective houses will be instructed to ensure that Survey notebooks are in place with their daily cleaning of the residents living/common area specifically the side tables. This new procedure for posting Survey materials will be reviewed with Household Coordinators and Homemakers. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Clinical Coordinators and Household Coordinators will incorporate this procedure into their household rounds. Household rounds are conducted weekly by both the Clinical Coordinator and Household Coordinator. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. The implementation of this new process	

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F 167	Continued From page 15	F 167	will be reviewed with Household Coordinators and Clinical Coordinators by June 21, 2017. The homemakers and teammates will receive in-servicing for this new procedure in locating Survey Results by June 28th, 2017.	
F 176 SS=D	RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE CFR(s): 483.10(c)(7) (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to conduct an assessment for self-administration of medications for one of 24 residents in the survey sample. Resident #21 self-administered and stored the medication Anbesol in his room without a prior assessment by the interdisciplinary team for safety. The findings include: Resident #21 was admitted to the facility on 4/24/17 with diagnoses that included fractured knee cap, bronchitis, rheumatoid arthritis, chronic kidney disease and insomnia. The minimum data set (MDS) dated 5/8/17 assessed Resident #21 as cognitively intact. Resident #21's clinical record documented a nursing note dated 5/21/17 stating, "Resident noted to have small sore under dentures, states that he gets these frequently when at home and	F 176	F-176 RESIDENT TO SELF-ADMINISTER DRUGS IF DEEMED SAFE 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #21 had the self-administration assessment completed during the survey period on May 25, 2017. The self-administration of Anbesol has been added to the residents plan of care as of 6-6-17. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The self-administration of medication by	6/9/17

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F 176	Continued From page 16 uses special gel. Wife brought in medication from home, Md [physician] alerted..." Resident #21's clinical record documented a physician's order dated 5/21/17 for Anbesol gel to be applied four times per day for mouth pain with instructions that the resident may keep medication at the bedside. The resident's clinical record documented no assessment for safe self-administration of the Anbesol. Resident #23's care plan dated 4/24/17 made no mention of self-administration of medication. The resident's treatment record documented the Anbesol was administered as ordered starting on 5/21/17. On 5/25/17 at 11:05 a.m. the registered nurse (RN #8) caring for Resident #21 was interviewed about an assessment for safe self-administration of the Anbesol. RN #8 stated the self-administration assessment was not completed for Resident #21 prior to the administration of Anbesol. RN #8 stated the Anbesol was stored in the resident's bathroom cabinet. RN #8 stated the resident was assessed as cognitively intact upon admission but the self-administration assessment had not been completed concerning the Anbesol. These findings were reviewed with the administrator and director of nursing during a meeting on 5/25/17 at 3:50 p.m.	F 176	residents who are deemed safe procedure will be reviewed with the CC's and CN's. In addition to reviewing the procedure for this process we will educate the CC's and CN's for completing the self-administration assessment and Care Plan for this process during our mandatory meeting scheduled on June 21st and June 28th. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. Clinical Coordinators will identify residents who are currently exercising their right to self-administer medications safely. This information will be reviewed during updates to both the MDS and Care Plan. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This procedure will be reviewed by the Clinical Coordinator with monthly monitoring by our Answers on Demand (AOD) electronic medical record. Self-administered medications will be pulled from our AOD system to ensure that self-administration assessments, MDS, and Care Plans are consistent and complete for these individuals. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice.	

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F 176	Continued From page 17	F 176	The mandatory CC and CN meeting will be held June 21st and 28th. Implementation of the new process for AOD monitoring will begin July 1, 2017.	
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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	F 225		6/9/17

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F 225	Continued From page 18 abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (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 document review and clinical record review, the facility staff failed to report to the state agency an injury of unknown source timely for one of 24 residents in the survey sample, Resident #1. Resident #1 had a injury of unknown source	F 225	F-225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 225	Continued From page 19 resulting in fracture to the left leg that was not reported to the state agency timely. The findings include: Resident #1 was admitted to the facility on 9/23/15 with diagnoses that included left femur fracture, dementia, and Alzheimer's. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/15/17. Resident #1 was assessed as having long and short-term memory impairment along with severely impaired decision making skills. During initial tour conducted on 5/23/17 at 11:15 a.m. an interview was conducted with the unit manager (registered nurse, RN #4) asking if any of the residents had fallen recently and sustained injury. RN #4 verbalized that Resident #1 (unknown at the time) had been diagnosed with a fractured femur on 5/19/17, but did not know how the injury occurred. Subsequently Resident #1 was added to the survey sample. On 5/24/17 Resident #1's medical chart was reviewed. Nursing notes surrounding 5/19/17 evidenced the following: 5/16/17 bruising to bilateral tops of feet. 5/18/17, bruising to bilateral knees with swelling and facial grimacing. 5/19/17 x-ray was ordered revealing a fracture to the distal left femur. Review of the x-ray report documented a "displaced impacted fracture..."	F 225	The Survey Findings have been noted regarding the 2 hour notification for an "Injury of Unknown Source". The incident involving Resident #1 was investigated thoroughly with a full report and supporting documentation submitted to the VDH within "5 working days". 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The designated Clinical Coordinator, DON, and Administrator will thoroughly review and evaluate all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. Confirmed allegations will be reported to the VDH within the required 2 hour time frame if the allegations involve abuse or serious bodily injury. If the allegation does not involve abuse or serious bodily injury the incident will be reported to the VDH within 24 hours. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. Analyze occurrences of allegations to determine the need for changes in practice, policies, or protocols with regard to internal investigations and reporting mechanisms. Incidents are reviewed via the electronic medical record and are signed by both the Administrator and	

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F 225	Continued From page 20 Review of Resident #1's activity of daily living (ADL's) evidenced that Resident #1 is a total extensive assist for transfers, toileting, hygiene, and bathing. Resident #1 also used a mechanical lift when being moved from bed to chair. On 5/24/17 at 11:00 a.m. the director of nursing (DON) was interviewed regarding the reporting time line to the state agency. The DON verbalized that when Resident #1 was diagnosed with a fractured femur an investigation was started. The DON verbalized that she was unable to determine the source of the injury and was planning to send a report to the state agency within 5 days. The facility abuse policy was then reviewed. Under the heading titled "Reporting Of Abuse and Injuries Of Unknown Origin:" Documents the following: Incident "Injury of Unknown Source" Report to VDH (Virginia Department of Health) "Yes" When "Immediately." Results of the investigation "5 working days." On 5/25/17 at 2:50 p.m. the above finding was discussed in a meeting with the DON and administrator. The DON verbalized that she did not realize that the incident should have been reported immediately as she (DON) did not feel that it was abusive in nature. This surveyor verbalized that Resident #1 could not make her needs known, was a total assist in all aspects of ADL's, and due to the extent of the injury, neglect or mistreatment could not be ruled out when the incident occurred. No other information was presented prior to exit conference on 5/25/17.	F 225	DON. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. All Clinical Coordinators will receive copies of the Facility Reported Incidents (FRI) forms. The designated Clinical Coordinator, DON, and Administrator will thoroughly review and evaluate all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. Confirmed allegations will be reported to the VDH utilizing the FRI form within the required 2 hour time frame if the allegations involve abuse or serious bodily injury. If the allegation does not involve abuse or serious bodily injury the incident will be reported to the VDH within 24 hours. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. The new procedure for investigative reporting of allegations will begin immediately. Effective 6-5-17.	

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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. (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 document review and clinical record review, the facility staff failed to follow facility policy for reporting to the state	F 226	F-226 DEVELOPMENT OF ABUSE/NEGLECT, ETC POLICIES 1. Address how corrective action will be	6/9/17

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F 226	Continued From page 22 agency an injury of unknown source timely for one of 24 residents in the survey sample, Resident #1. Resident #1 had a injury of unknown source resulting in fracture to the left leg that was not reported to the state agency as per policy. The findings include: Resident #1 was admitted to the facility on 9/23/15 with diagnoses that included left femur fracture, dementia, and Alzheimer's. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/15/17. Resident #1 was assessed as having long and short-term memory impairment along with severely impaired decision making skills. During initial tour conducted on 5/23/17 at 11:15 a.m. an interview was conducted with the unit manager (registered nurse, RN #4). RN #4 verbalized that Resident #1 (unknown at the time) had been diagnosed with a fractured femur on 5/19/17, but did not know how the injury occurred. Subsequently Resident #1 was added to the survey sample. On 5/24/17 Resident #1's medical chart was reviewed. Nursing notes surrounding 5/19/17 evidenced the following: 5/16/17 bruising to bilateral tops of feet. 5/18/17, bruising to bilateral knees with swelling and facial grimacing. 5/19/17 x-ray was ordered revealing a fracture to the distal left femur. Review of the x-ray report documented a	F 226	accomplished for those residents found to have been affected by the deficient practice. The Survey Findings have been noted regarding the 2 hour notification for an "Injury of Unknown Source". The incident involving Resident #1 was investigated thoroughly with a full report and supporting documentation submitted to the VDH within "5 working days". Our policy regarding procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property will be reviewed with all leadership team members within each respective household. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The designated Clinical Coordinator, DON, and Administrator will thoroughly review and evaluate all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. Per our written policy all, confirmed allegations will be reported to the VDH within the required 2 hour time frame if the allegations involve abuse or serious bodily injury. If the allegation does not involve abuse or serious bodily injury the incident will be reported to the VDH within 24 hours. Additionally, results of the investigation will be submitted to VDH within 5 business days. 3. Address what measures will be put in place, or what systematic changes will be	

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F 226	Continued From page 23 "displaced impacted fracture..." Review of Resident #1's activity of daily living (ADL's) evidenced that Resident #1 is a total extensive assist for transfers, toileting, hygiene, and bathing. Resident #1 also used a mechanical lift when being moved from bed to chair. Resident #1 was also unable to make needs known. On 5/24/17 at 11:00 a.m. the director of nursing (DON) was interviewed regarding the reporting time line to the state agency. The DON verbalized that when Resident #1 was diagnosed with a fractured femur an investigation was started. The DON verbalized that she was unable to determine the source of the injury and was planning to send a report to the state agency within 5 days. The facility abuse policy was then reviewed. Under the heading titled "Reporting Of Abuse and Injuries Of Unknown Origin:" Documents the following: Incident "Injury of Unknown Source" Report to VDH (Virginia Department of Health) "Yes" When "Immediately." Results of the investigation "5 working days." On 5/25/17 at 2:50 p.m. the above finding was discussed in a meeting with the DON and administrator. This surveyor verbalized to the DON, that according to the facilities policy, injuries of unknown source are supposed to be reported to the state agency immediately. The DON verbalized that she did not realize that the incident should have been reported immediately and thought a report of investigation needed to be sent within 5 working days.	F 226	made to ensure the deficient practice will not recur. Analyze occurrences of allegations to determine the need for changes in practice, policies, or protocols with regard to internal investigations and reporting mechanisms. Incidents are reviewed via the electronic medical record and are signed by both the Administrator and DON. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Clinical Coordinators will receive copies of the Facility Reported Incidents (FRI) forms. The designated Clinical Coordinator, DON, and Administrator will thoroughly review and evaluate all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. Per our written policy, all confirmed allegations will be reported to the VDH utilizing the FRI form within the required 2 hour time frame if the allegations involve abuse or serious bodily injury. If the allegation does not involve abuse or serious bodily injury the incident will be reported to the VDH within 24 hours. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. Bridgewater Retirement Communities written policy for investigative reporting of allegations will begin immediately. Effective 6-5-17.	

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F 226	Continued From page 24 No other information was presented prior to exit conference on 5/25/17.	F 226		
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 of practice, the comprehensive person-centered	F 309		6/9/17

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F 309	Continued From page 25 care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to accurately assess for pain, attempt non-pharmacological interventions for pain and assess the effectiveness of pain management for three of 24 residents in the survey sample, and for one of 24 residents in the survey sample, failed to follow physician's orders for the administration of an as needed pain medication. Residents #11, #20 and #21 were administered multiple doses of pain medications without a documented pain assessment indicating location of pain, any non-drug interventions attempted and/or the effectiveness of pain management interventions. The facility staff failed to follow physician's orders to administer a pain medication, Oxycodone, once every four hours as needed for Resident #6. The findings include: 1. Resident #11 was administered 5 doses of Oxycodone in May 2017 without a documented assessment of the pain location, pain rating, attempted non-pharmacological interventions to minimize pain and/or the effectiveness of the pain medication. Resident #11 was admitted to the facility on 12/30/13 with a re-admission on 11/25/14. Diagnoses for Resident #11 included Alzheimer's, dementia with delusions, behavioral disturbance, anxiety, arthritis and congestive heart failure. The minimum data set (MDS) dated 3/1/17 assessed Resident #11 with severely impaired	F 309	F-309 CARE/SERVICES FOR HIGHEST WELL BEING 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #11 now receives a pain assessment prior to administration of her ordered medication. In addition, Resident #11 now receives a pain rating when resident is able to verbalize the degree of pain that she is experiencing. If Resident #11 is unable to verbalize her pain due to her cognitive dysfunction nurse will utilize physical assessment which includes restlessness, facial grimacing, moaning to determine need for ordered medication. Resident #21 will receive a pain assessment and effectiveness rating for each administration of medication as ordered. Effective immediately, as of today 6-7-17. This procedure will be reviewed with current and new teammates within the Wellness Household to ensure that appropriate protocols are being followed. Resident #20 will have an effectiveness rating following the administration of medication as ordered. Effective immediately, as of today 6-7-17. This procedure will be reviewed with current	

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F 309	Continued From page 26 cognitive skills. Resident #11's clinical record documented a physician's order dated 3/16/17 for Oxycodone 5 mg (milligrams) to be administered every 4 hours as needed for pain. The resident's medication administration record (MAR) from 5/1/17 through 5/23/17 documented eight doses of Oxycodone administered. Five of the 8 doses administered in May 2017 included no associated pain assessment. Doses administered on 5/7/17, 5/15/17, 5/18/17, 5/21/17 and 5/22/17 listed a pain rating of zero (0) on a pain scale of 0 (no pain) to 10 (worst pain). There was no documented location of the resident's pain, any attempts at non-drug interventions to minimize pain or the effectiveness of pain medication. Resident #11's plan of care (dated 3/9/17) listed the resident had potential for pain due to arthritis, back pain, neuropathy and generalized complaints of pain. The care plan goals for Resident #11 included the resident's satisfaction with comfort level and the ability to participate in activities of daily living without discomfort. Interventions for pain management included use of positioning devices, analgesics as ordered, assessment of pain level, performance of a "comprehensive assessment of pain to include location, frequency, quality/intensity/severity..." The care plan listed non-drug interventions for Resident #11 included relaxation, music therapy, distraction and massage and stated to instruct the resident to use a pain scale describing "mild, moderate or severe" pain. On 5/24/17 at 2:30 p.m. the registered nurse (RN #4) unit coordinator was interviewed about the lack of pain assessment and interventions for	F 309	and new teammates within the Wellness Household to ensure that appropriate protocols are being followed. Resident #6 will receive PRN pain medications as ordered within the appropriate intervals. The policy for pain medication administration will be reviewed with the Unity Household to ensure that appropriate protocols are followed. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Clinical Coordinators will run a monthly report via their electronic medical record to identify residents within their respective households that receive PRN medications. The Clinical Coordinators will analyze and assess that the proper procedure and protocols are followed for medication administration with regard to pain assessment prior to medication administration and will documentation for effectiveness following the administration of the medication. PRN orders will be reviewed to ensure that medications are administered as ordered within the specified time frames. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. Additional measures to address this deficient practice include a facility wide mandatory Clinical Coordinator (CC) and Charge Nurse (CN) meeting facilitated by	

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F 309	Continued From page 27 Resident #11. RN #4 stated all doses of the as needed Oxycodone administered in May 2017 without an assessment were administered by a nurse that had worked in the facility since March 2017. RN #4 stated the zero (0) entered for the pain rating was the pain assessment after the medication was given and did not indicate the initial assessment rating from the resident. RN #4 stated she reviewed the record and did not find the location of pain, any non-drug interventions or the effectiveness of the medication documented on the MAR or in the clinical record. These findings were reviewed with the administrator and director of nursing during a meeting on 5/24/17 at 3:50 p.m. 2. Resident #21 was administered 14 doses of the medication Tylenol and 74 doses of the medication Oxycodone from 5/1/17 through 5/23/17 without a documented assessment indicating the location of the pain, any attempted non-drug interventions and/or the effectiveness of pain interventions. Resident #21 was admitted to the facility on 4/24/17 with diagnoses that included fractured knee cap, bronchitis, rheumatoid arthritis, chronic kidney disease and insomnia. The minimum data set (MDS) dated 5/8/17 assessed Resident #21 as cognitively intact. Resident #21's clinical record documented a physician's order dated 4/24/17 for Tylenol 650 mg (milligrams) to be administered every 4 hours as needed for pain rated 1 through 4 on scale of 0 (no pain) to 10 (worst pain). The record also	F 309	the Director of Nursing. The purpose for this mandatory meeting includes a review of proper procedure and protocols for medication administration with regard to pain assessment prior to medication administration and will include documentation for effectiveness following the administration of the medication. PRN policies and procedures will be reviewed to ensure medications are administered as ordered within the specified time frames. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Clinical Coordinators will run a monthly report via their electronic medical record to identify residents within their respective households that receive prn medications. The Clinical Coordinators will analyze and assess that the proper procedure and protocols are followed for medication administration with regard to pain assessment prior to medication administration and will documentation for effectiveness following the administration of the medication. PRN orders will be reviewed to ensure that medications are administered as ordered within the specified time frames. Failure to comply with the policy and/or protocol from nursing staff will result in corrective action. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. The mandatory CC and CN meeting will	

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F 309	Continued From page 28 documented a physician's order dated 4/26/17 for Oxycodone 5 mg to be administered every 4 hours as needed for pain rated 5 through 7. Resident #21's medication administration record (MAR) from 5/1/17 through 5/23/17 documented 14 doses of Tylenol 650 mg were administered and 74 doses of Oxycodone were administered without a documented assessment indicating the location of the pain or any attempted non-drug interventions and/or the effectiveness of pain interventions. Nine of the 14 doses of Tylenol and 54 doses of the Oxycodone given listed no location of the resident's pain. The MAR documented these as needed doses of Tylenol were administered on: 5/1/17, 5/2/17, 5/6/17, 5/7/17, 5/9/17, 5/10/17, 5/12/17, 5/13/17, 5/14/17, 5/15/17, 5/16/17, 5/20/17, 5/21/17 and 5/22/17. Oxycodone 5 mg was administered without a listed location of pain on: 5/1/17 (3 doses), 5/2/17, 5/3/17 (4 doses), 5/4/17 (5 doses), 5/5/17 (3 doses), 5/6/17 (5 doses), 5/7/17 (4 doses), 5/8/17 (3 doses), 5/9/17 (3 doses), 5/10/17 (4 doses), 5/11/17, 5/12/17 (3 doses), 5/13/17 (3 doses), 5/14/17 (3 doses), 5/15/17 (4 doses), 5/16/17 (4 doses), 5/17/17 (3 doses), 5/18/17 (3 doses), 5/19/17 (2 doses), 5/20/17 (4 doses), 5/21/17 (4 doses), 5/22/17 (2 doses) and 5/23/17 (3 doses). There was no documentation of any attempts at non-drug interventions for the Tylenol or Oxycodone administered. There was no documented assessment of the effectiveness of the pain medications given. The resident's plan of care (dated 4/24/17) listed the resident had the potential for pain due to chronic pain associated with rheumatoid arthritis	F 309	be held June 21st and 28th. Implementation of the new process through AOD monitoring of PRN meds will begin July 1, 2017.	

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and a patella fracture. Pain management goals listed the resident would demonstrate and/or verbalize satisfaction with comfort levels and be able to participate in activities of daily living without discomfort. Interventions for pain management included the use of pillows, cushions or positioning devices, analgesics as ordered and assessment of pain levels. Interventions included instructions to "Perform a comprehensive assessment of pain to include location, frequency, quality/intensity/severity..." Non-pharmacological interventions for Resident #21's pain included relaxation, guided imagery, music therapy, distraction, and massage.

On 5/25/17 at 11:05 a.m. the registered nurse (RN #8) caring for Resident #21 was interviewed about the assessments and documentation associated with pain medication administration. RN #8 stated there was a space in the medication administration system to enter notes indicating the location of pain, any interventions and the effectiveness of medications. RN #8 stated she did not see the location, effectiveness or non-drug interventions documented for many of the doses of pain medication administered to Resident #21 during May 2017.

These findings were reviewed with the administrator and director of nursing during a meeting on 5/25/17 at 3:50 p.m.

3. Resident #20 was not assessed for the effectiveness after pain medication was given.

Resident #20 was admitted to the facility on 11/9/13 with a readmission on 3/3/17 with diagnoses that included left femur fracture and pain.

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The most recent MDS (minimum data set) was a 30 day assessment with an ARD (assessment reference date) of 4/30/17. Resident #20 was assessed as being cognitively intact. Section "J" of Resident #20 MDS documented frequency of pain as occasionally.

On 5/25/17 at 8:00 a.m. Resident #20's chart was reviewed and document (via physicians orders) that Resident #20 could receive Oxycodone every 6 hours for pain.

Review of the medication administration record (MAR) evidenced that Resident #20 received Oxycodone 14 times between May 1st and May 23rd (2017).

The effectiveness of the pain medication given was then reviewed and did not evidence through documentation if the pain medication was effective. Nursing notes were also reviewed, but did not show effectiveness of pain medication given.

On 5/25/17 at 9:15 a.m. license practical nurse (LPN #6) where Resident #20 resided was interviewed. LPN #6 verbalized that she was not assigned to Resident #20 at this time (present day) but reviewed Resident #20's electronic MAR with this surveyor. LPN #6 showed this surveyor how to look up the effectiveness of a pain medication, but when reviewing Resident #20's medication effectiveness screen, LPN #6 verbalized the effectiveness was not documented for the dates in question. LPN #6 showed this surveyor the electronic screen evidencing that a nurse is supposed to document within 60 minutes of giving a pain medication the effectiveness.

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On 5/25/17 at 2:50 p.m. the above finding was brought to the attention of the director of nursing (DON) and administrator. When asked what the expectation was for assessing pain medication effectiveness, the DON verbalized that she would expect the nurses to be assessing the outcome of the pain medication.

No other information was provided prior to exit conference on 5/25/17.

4. The facility staff failed to follow physician's orders to administer a pain medication, Oxycodone, once every four hours as needed. Resident # 6 received Oxycodone for pain at intervals ranging from 36 minutes to 2 hours and 20 minutes instead of every four hours as needed.

Resident # 6 in the survey sample, a 95 year-old female, was admitted to the facility on 1/21/15, and most recently readmitted on 4/22/15 with diagnoses that included anemia, gastroesophageal reflux disease, arthritis, osteoporosis, Alzheimer's Disease, Non-Alzheimer's Dementia, anxiety disorder, depression, difficulty walking, vitamin deficiency, postherpetic polyneuropathy, generalized muscle weakness, neuritis and neuralgia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/12/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 1 out of 15.

On the most recent Quarterly MDS with an ARD of 4/6/17, Resident # 6 was assessed under

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Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired skills for daily decision making.

Resident # 6 had the following physician's order for a prn pain medication: Oxycodone (Roxicodone) 5 mg (milligrams) - Give 1 tablet po (by mouth) q4h (every 4 hours) prn (as needed) pain (pain scale 5 - 10), moaning, facial grimacing, guarding of body movements and agitation.

(NOTE: Oxycodone [Roxicodone] is an opiate analgesic used to control moderate to severe pain. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 894.)

Review of the Electronic Medication Administration Record (E-MAR) for the month of October 2016 revealed the following dates and administration times for the prn Oxycodone:

10/1/16 - 11:02 and 1350 (1:50 p.m.), an interval of 1 hour and 50 minutes.
10/11/16 - 11:45 and 12:50, an interval of 1 hour and 5 minutes.
10/25/16 - 1336 (1:36 p.m.) and 1412 (2:12 p.m.), an interval of 36 minutes.

Review of the E-MAR for the month of November 2016 revealed the following dates and administration times for the prn Oxycodone:

11/8/16 - 9:20 and 11:00, an interval of 1 hour and 40 minutes.
11/16/16 - 1837 (6:37 p.m.) and 2004 (8:04 p.m.), an interval of 1 hour and 27 minutes.
11/25/16 - 5:39 and 7:47, an interval of 2 hours and 8 minutes.

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F 309	Continued From page 33 11/28/16 - 1301 (1:01 p.m.) and 1420 (2:20 p.m.), in interval of 1 hour and 19 minutes. 11/29/16 - 4:09 and 6:29, an interval of 2 hours and 20 minutes. 11/29/16 - 6:29 and 8:10, an interval of 1 hour and 41 minutes. The findings were discussed during a meeting at 4:00 p.m. on 5/25/17 that included the Administrator, the Director of Nursing, and the survey team.	F 309		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and	F 315		6/9/17

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F 315	Continued From page 34 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed, for one of 24 residents in the survey sample (Resident # 17), who had a history of urinary tract infections, to assess and obtain treatment for a suspected urinary tract infection in a timely manner. Facility staff waited approximately three weeks before responding to the resident's complaint of burning when voiding. The findings were: Resident # 17 in the survey sample, an 86 year-old female, was admitted to the facility on 3/4/13, and most recently readmitted on 8/9/16 with diagnoses that included anemia, hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, arthritis, history of hip fracture, chronic obstructive pulmonary disease, cataracts, pruritis, sleep apnea, spinal stenosis, auditory hallucinations, chronic pain syndrome, inflammatory polyarthropathy. According to the most recent full Minimum Data Set (MDS), a Significant Change with an Assessment Reference Date (ARD) of 8/16/16,	F 315	F-315 - NO CATHETER, PREVENT UTI, RESTORE BLADDER 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #17 received her final dose of Cipro on 6/3/17. Resident is comfortable and has had no further complaints of pain. We will continue to encourage fluids for this resident and utilize the McGeer Criteria for UTI monitoring. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Per direction of Dr. Jonathan Shenk our Medical Director we utilize the McGeer Criteria for UTI monitoring. The McGreer criteria includes the following...Fever(=100º) or chills, Burning pain on urination, or frequency or urgency, Flank suprapubic	

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F 315	Continued From page 35 the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. According to the most recent Quarterly MDS with an ARD of 4/20/17, the resident's cognitive status under Section C (Cognitive Patterns) remained unchanged. Resident # 17 had recently completed a course of antibiotics for a urinary tract infection as noted in the following Interdisciplinary (Nurses) Notes in the resident's electronic clinical record: 3/10/17 - "Res [Resident] c/o [complained of] burning on urination, bilateral lower back pain. Afebrile. Faxed MD. Res. called the doctors office and made appointment for herself today at 1315 [1:15 p.m.]...Res. back from MD appointment with prescription for Cipro for UTI." (NOTE: Cipro [Ciprofloxacin] is a broad spectrum antiinfective used to treat escherichia coli urinary tract infections. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 255.) Further review of the Interdisciplinary (Nurses) Notes revealed the following entries: 4/30/17 - 1640 (4:40 p.m.) - "Resident c/o [complained of] 'burning' when she voids. She states that she has had s/s [signs and symptoms] for 'several days' but did not tell anyone. Fluids encouraged. Will continue to monitor." 5/22/17 - 12:40 - "Resd [Resident] c/o urinary burning and frequency. Resd requesting to see MD. Resd was out for visit with MD last week but stated she didn't say anything to him about it	F 315	pain and tenderness, Change in character of urine, Worsening of mental or functional status. This protocol has been implemented facility wide. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. Additional measures to address this deficient practice include a facility wide mandatory Clinical Coordinator (CC) and Charge Nurse (CN) meeting facilitated by the Director of Nursing. The purpose for this mandatory meeting includes a review of the McGreer Criteria for monitoring UTI in Nursing Homes. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The monitoring for UTI performance is included in our monthly Quality Assurance Performance Improvement plan. Data is reviewed and monitored on a monthly basis. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. The mandatory CC and CN meeting will be held June 21st and 28th. McGeer's criteria is currently in place along with our	

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F 315	Continued From page 36	F 315	QAPI program for monitoring Infection Control.	

[urinary burning and frequency] while she was there. MD notified and order for UA [Urinalysis] received. Will continue to monitor."

5/22/17 - 2303 (11:03 p.m.) - "Clarification order for U/A, to obtain I&O [In and Out] catheterization specimen scheduled for AM. Fluids encouraged...."

Additional review of the Interdisciplinary (Nurses) Notes confirmed Resident # 17 was out of the facility to see the physician on 5/16/17, at which time new orders were received. None of the new orders dealt with the resident's complaint of urinary burning.

At approximately 11:30 on 5/25/17, LPN # 3 (Licensed Practical Nurse), the Unit Manager on the Harmony Household, was asked if the results of Resident # 17's UA had been received. "The results just came back," LPN # 3 said, "She has a UTI [Urinary Tract Infection]. We are getting an order for an antibiotic now."

At approximately 2:30 p.m. on 5/25/17, LPN # 3 was interviewed regarding the assessment of the resident's complaint of burning when voiding. Asked why the physician wasn't notified on 4/30/17 and a UA obtained, LPN # 3 said, "I don't know why we wouldn't have done something. She [the resident] is usually right on it. She didn't complain again, she had no fever. She is vocal enough that if she still had burning or pain, she would have told us or she would have called the doctor herself, which she has done."

On 5/25/17, the following telephone order was received, Ceftin 250 mg (milligrams) BID (two times a day) po (by mouth) for 10 days for UTI.

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F 315	Continued From page 37 (NOTE: Ceftin is a second generation cephalosporin antiinfective used to treat escherichia coli urinary tract infections. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 221.) The findings were discussed during a meeting at 4:00 p.m. on 5/25/17 that included the Administrator, the Director of Nursing, and the survey team.	F 315		
F 323 SS=E	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 (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.	F 323		6/9/17

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F 323	Continued From page 38 (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 observation and staff interview, the facility failed ensure call bells were accessible for use on 3 of six unit bathrooms. The facility did not have call bells in place in bathrooms on three units that were accessible to Residents. The Findings Include: On 5/25/17 at 10:50 a.m. during general observations throughout the facility, unisex bathrooms in a common hall area adjacent to the units dinning area and accessible to residents were observed. The bathrooms in question were on the Harmony, Tranquility, and Unity units. Each bathroom did not have a call bell system and the door to the bathroom could be locked from the inside. On 5/25/17 at 2:30 p.m. the director of maintenance (Other Staff, OS #5) was interviewed concerning the above finding. OS #5 verbalized that he was unaware that the bathrooms did not have a call bell system in place, but would pass this information along. On 5/25/17 at 2:50 p.m. the above finding was brought to the attention of the Director of nursing and administrator. The administrator verbalize that he had been made aware of this issue. No other information was presented prior to exit conference on 5/25/17.	F 323	F-323 FREE OF ACCIDENT HAZARD/SUPERVISION/DEVICES 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The unisex bathrooms located in the houses of Harmony, Tranquility, and Unity had the necessary call bells installed during the survey visit. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Routine maintenance checks are performed monthly within our respective households. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. All future projects and renovations for bathrooms where residents have access, will include call bells. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This project will have direct oversight by	

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F 323	Continued From page 39	F 323	the Director of Maintenance. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. This deficient practice has been corrected.	
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 371	F371 - FOOD PROCURE,	6/9/17

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F 371	Continued From page 40 facility staff failed to store food in a sanitary manner in the Main Kitchen, and failed to prepare and serve food in a safe and sanitary manner on the Wellness Household. In the Main Kitchen, there were food items that were not properly covered, not dated, and items that exceeded the expiration date. On the Wellness Household, cold food items were not at the proper temperature, hot foods were not handled in a sanitary manner during preparation. The findings include: 1. In the Main Kitchen, there were food items that were not properly covered, not dated, and items that exceeded the expiration date. During the orientation tour at approximately 11:15 a.m. on 5/23/17, the following was observed in the Main Kitchen: In the walk-in cooler, a box of leaf lettuce was open and lettuce in the box was open to the air. The box was marked with a received date of 5/12/17, but there was no use by date on the box. According to the Food Service Manager, who accompanied the surveyors on the tour, the lettuce should have been covered and the box should have been marked with a use by date. In the walk-in freezer the following was observed: An open box was observed on top of a storage rack. At the request of the surveyors, the Food Service Manager took the box off the shelf. The box was found to contain one dozen, iced, frozen cup cakes. The box was not covered and there were no dates on the box indicating when the cup cakes were placed in the freezer.	F 371	STORE/PREPARE/SERVE - SANITARY 1. Address how corrective action will be accomplished for those residents found to have been affected by deficient practice. Wellness House meal preparation service As part of Bridgewater Home's culture change initiatives and creating a more homelike living experience for its residents, Bridgewater Home team members occasionally prepare meals in the residential style kitchen located in the Wellness Household. In this instance, members of the Wellness House team were preparing a special meal of pork chops, baked potatoes, lettuce salad, and Ambrosia as requested by the residents in the household. During survey, it was observed the Wellness House meal was being prepared by CNA #3 and Homemakers #1 and #2 (the food and environmental service team members in the house). Upon observation, it was noted that CNA #3 was not properly changing gloves when handling the food items, specifically the pork chops and baked potatoes. Proper food safety and sanitation would require the changing of gloves between handling various food items throughout the cooking process. CNA #3 will be reeducated on proper food safety handling techniques as presented by the ServSafe certification. Additionally, Homemaker #1 was	

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F 371	Continued From page 41 A box containing several bags of chicken legs was on a storage rack shelf. The top bag was open and the contents were exposed to the air. There were two chicken legs on top of the open bag. Also on a storage rack shelf was a package of turkey cutlets that was open and the contents were exposed to the air. On another storage shelf, a package of popcorn chicken that had been opened was loosely twisted closed and not tightly sealed. In the dry storage area, the following was observed: There were several packages of tortillas in a stack on a storage shelf. On top of the stack was a package of tortillas that had been opened and rewrapped in saran wrap. There was no date on the package to indicate when the tortillas were opened. On the bread rack, there were two loaves of whole wheat bread with the expiration date of 5/16/17. The Food Service Manager accompanied the surveyors on the tour of the Main Kitchen and also observed the surveyor's findings. The findings were also discussed during a meeting at 4:00 p.m. on 5/24/17 that included the Administrator, the Director of Nursing, and the survey team. 2. On the Wellness Household, cold food items	F 371	observed taking the temperature of both the large bowl of lettuce salad and Ambrosia waiting to be served. The large bowl of lettuce salad and Ambrosia each registered a temperature outside of acceptable food safety range. Rather than immediately returning those food items to the refrigerator to be cooled as dictated by food safety practices, Homemaker #1 waited approximately ten minutes to place them back in the refrigerator. Furthermore, in obtaining the temperature of those two food items, Homemaker #1 used the same alcohol wipe to disinfect the thermometer rather than using a clean wipe as dictated by proper food safety handling practices. Homemaker #1 will be reeducated on proper food safety handling techniques as presented by the ServSafe certification. Main kitchen food storage Upon inspection, it was noted that multiple food items were found to be not properly contained, dated and/or exceeded expiration dates in the main kitchen area. All dining services cooks will be reeducated regarding proper storage, labeling and dating precautions as it relates to food safety guidelines. Additionally, the morning shift scheduled cook will make daily rounds to inspect food items for proper storage, labeling and dating. 2. Address how the facility will identify other residents having the potential to be	

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F 371	Continued From page 42 were not at the proper temperature, hot foods were not handled in a sanitary manner during preparation. From approximately 11:50 a.m. to 12:40 p.m. on 5/23/17, the following was observed on the Wellness Household kitchen area: A. In the kitchen area was a female, Certified Nursing Assistant # 3 (CNA), who was preparing pork chops for cooking. CNA # 3, who was wearing latex gloves, had taken pork chops from a package obtained from a grocery store and placed approximately 15 on each of two baking sheets. Using a hot pad, CNA # 3 took a baking sheet of baked potatoes out of the oven and placed it on top of the stove. She then placed the two sheets of pork chops, one on each shelf, in the oven. CNA # 3 then took the baked potatoes off the baking sheet and placed them in a disposable, aluminum pan, and covered the pan with foil. When asked if it was part of her job to cook the food, CNA # 3 replied, "We cook our (for the residents) own food on Wednesdays. We don't usually cook except on Wednesday." Approximately half way through the 15 minute cooking cycle, CNA # 3 took a set of silver ware wrapped in a napkin for resident meal use and removed the fork. She then removed the top baking sheet of pork chops from the oven and placed it on top of the stove. CNA # 3 then proceeded to turn the pork chops over using the fork. When a pork chop would not slide off the fork, she would push it off using the index finger of her gloved left hand. CNA # 3 then placed the baking sheet of pork chops back in the oven to	F 371	affected by the same deficient practice. Wellness House meal preparation service The food service process is to be overseen by Wellness Household team members who have successfully completed the ServSafe certification. A list of all ServSafe certified team members is maintained by a supervisor in the dining services department of Bridgewater Home. That list is monitored to ensure certifications remain current. Main kitchen food storage The main kitchen food storage area services ALL residents of Bridgewater Home, therefore, there is no additional exposure. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Wellness House meal preparation service According to Bridgewater Home policy, household meal preparation service will be overseen by a team member who is ServSafe certified. This policy will be reviewed with the Wellness House team members responsible for overseeing the food service process. Main kitchen food storage The scheduled morning shift cook will be	

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F 371	Continued From page 43 continue cooking. At the end of the cooking cycle, CNA # 3 took the top baking sheet of pork chops out of the oven, placed it on top of the stove, and moved the second baking sheet of pork chops to the top shelf in the oven. Homemaker # 2 then moved to the stove and proceeded to check the temperature of the pork chops. Homemaker # 2 then returned the baking sheet of pork chops to the bottom shelf of the oven. Approximately half way through the second 15 minute cooking cycle, CNA # 3 slid the baking sheet of pork chops part way out of the oven and turned the pork chops over in the same manner as the first baking sheet. As with the first baking sheet, if a pork chop did not slide off the fork, CNA # 3 would push it off using the index finger of her gloved left hand. At the end of the cooking cycle, CNA # 3 took the top baking sheet of pork chops out of the oven and placed it on top of the stove. Homemaker # 2 then took the temperature of one pork chop near the center of the baking sheet. CNA # 3 then removed the pork chops from the baking sheet and placed them in a stainless steel pan to be placed on the steam table. As she had the two previous times, if a pork chop did not slide off the fork, CNA # 3 would push it off using the index finger of her gloved left hand. It should be noted that at no time did CNA # 3 change her gloves while she was preparing food, including placing raw pork chops on the baking sheets, removing baked potatoes from the oven, removing the baking sheets of pork chops from	F 371	required to sign off on daily rounds. That documentation will be maintained in the dining services office of Bridgewater Home. 4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. Wellness House meal preparation service Bridgewater Home will continue to monitor the status of team members with ServSafe certifications and, as an added precaution, Bridgewater Home dining services managers will make weekly rounds to ensure appropriate food safety precautions are being maintained. Main kitchen food storage Bridgewater Home dining services managers will review the rounds documentation performed by the scheduled morning shift cook. 5. Include dates when the corrective action will be completed for each identified deficient practice. Wellness House meal preparation service ServSafe certification review - Ongoing CNA #3 reeducation - 06/15/2017 Homemaker #1 reeducation - 06/15/2017 Dining Services manager meal rounds - To begin effective 06/12/2017	

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F 371	Continued From page 44 the oven, turning the pork chops over, and moving the pork chops to the stainless steel steam table pan. B. When the surveyors arrived at the kitchen area of the Wellness Household, there was a large salad bowl containing sliced cucumbers, halved cherry tomatoes, and lettuce, a small single serving bowl of salad, and a container of what was identified as Ambrosia. The three containers were sitting on two rectangular frozen blocks, used to keep the salads cold. At approximately 12:30 p.m., Homemaker # 1 took the temperatures of the three salads. The temperature of the large bowl of salad was 41.3 degrees, the single serving bowl of salad was 39 degrees, and the Ambrosia was 43.7 degrees. Approximately 10 minutes after taking the temperature of the salads, Homemaker # 1 took the large salad bowl and the Ambrosia to the room adjacent to the kitchen and place them in a large refrigerator to be cooled. While Homemaker # 1 was taking the temperature of the salads, he used the same alcohol wipe to clean the thermometer probe after checking each salad. At approximately 1:05 p.m. on 524/17, the Food Service Manager was interviewed regarding the observations on the Wellness Household. Regarding the salads, the Food Service Manager said, "They should have been placed in the refrigerator when they arrived and taken out just prior to being served." As to the manner in which the pork chops were handled, he said, "She (CNA # 3) should have use a spatula or tongs to turn the pork chops over."	F 371	Main kitchen food storage Morning shift cook rounds - 06/12/2017 Dining services manager reviews - Ongoing	

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F 371	Continued From page 45 The findings were also discussed during a meeting at 4:00 p.m. on 5/24/17 that included the Administrator, the Director of Nursing, and the survey team.	F 371		
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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. (a) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		6/9/17

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	495370	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER HOME , INC.	302 NORTH SECOND STREET BRIDGEWATER, VA 22812

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F 431	Continued From page 46 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, facility staff failed to store liquid Ativan in a permanently affixed box in the refrigerator on three of six units and to store injectable Ativan in a permanently affixed box in the refrigerator on one of six units. Facility staff failed to store liquid po (oral) Ativan in a permanently affixed box in the refrigerator on three of six units, Serenity House, Harmony House and Joy House and to store injectable Ativan in a permanently affixed box in the refrigerator on Wellness House. Findings included: On 5/24/17 at 8:30 a.m. accompanied by	F 431	F-431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON has contacted Wellness Concepts for the purchase of inside mounted refrigerator permanently affixed storage boxes that require a double lock to secure the liquid Ativan. The inside mounted permanently affixed storage boxes will be placed in each household refrigerator. All household medication	

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F 431	Continued From page 47 registered nurse (RN) #5, the medication storage room on the Serenity unit was inspected. Stored in the medication refrigerator was a 30 ml (milliliter) bottle of liquid Lorazepam 2 milligram/milliliter concentrate labeled for a current resident. The Lorazepam was stored in the door shelf of the refrigerator and was not in a separate, permanently affixed box. RN #5 stated at the time of the observation the liquid Lorazepam was stored separate from the other controlled medications because it required refrigeration. On 5/24/17 at 4:45 p.m. the unit coordinator (RN #4) was interviewed about the Lorazepam stored in the medication room refrigerator. RN #4 stated the medication room and the refrigerator were locked but they did not have a lock box inside the refrigerator for medication storage. On 05/24/2017 at approximately 4:00 p.m. a tour of the medication room on Harmony House was conducted. The door to the medication room was locked, but the medication refrigerator was not locked. Inside of the refrigerator was a 30cc (cubic centimeter) bottle of liquid Ativan labeled 2mg (milligrams) per ml (milliliter). RN #1 (registered nurse) was interviewed regarding the refrigerator not being locked and containing liquid Ativan. RN #1 stated, "No, we don't lock the fridge." The medication room on Wellness House was observed on 05/24/17 at approximately 4:10 p.m. The door to the medication room was locked, but the lock on the refrigerator was broken and had to be opened with a screwdriver. Inside of the refrigerator was a vial of Lorazepam 2mg/ml. The vial was inside of a plastic bag marked, "For	F 431	refrigerators have been repaired and secured appropriately. Nursing has been instructed that ALL medication refrigerators need to be consistently locked. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The secured and permanently affixed storage boxes within the medication refrigerator will be maintained by our Maintenance Department. Nursing (licensed team members) will inform maintenance when issues arise for keeping refrigerators or storage boxes secured. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. Additional measures to address this deficient practice include a facility wide mandatory Clinical Coordinator (CC) and Charge Nurse (CN) meeting facilitated by the Director of Nursing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This project will have direct oversight by the Director of Maintenance. 5. Include date(s) when the corrective action will be completed for each of the	

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F 431	Continued From page 48 Refrigerator Stat Box." No "Refrigerator Stat Box" was observed by this surveyor or RN #2. RN #2 stated, "The key to the refrigerator lock is broken, so they fixed this lock that opens with a special screwdriver." The medication room on Unity House was observed on 05/24/17 at approximately 4:20 p.m. The medication room door was locked, but the refrigerator door was not locked. No narcotics were observed inside of the refrigerator. LPN #1 (licensed practical nurse) stated, "We would lock if Ativan or something was in there." The medication room on Joy House was observed on 05/24/17 at approximately 4:30 p.m. The medication room door was locked and the refrigerator door was locked, however inside the refrigerator was four separate bottles of liquid po Ativan labeled for specific resident use. All four bottles included 30 cc's of Ativan 2mg/ml. LPN #2 was interviewed regarding the liquid Ativan not being contained in a separate permanently affixed box inside of the refrigerator. LPN #2 stated, "This is how we have always stored it." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 05/24/17 at approximately 5:00 p.m. This surveyor asked for a policy pertaining to refrigerator narcotic storage or storage of drugs with potential for abuse. On 05/25/17 at 9:00 a.m. the DON brought a copy of the facility policy for Medication Administration to this surveyor. This policy did not include any specific information pertaining to narcotic storage or storage of medications with potential for abuse. The DON was asked if there	F 431	identified deficient practice. The mandatory CC and CN meeting will be held June 21st and 28th. All refrigerators are secured at this time. The secured and permanently affixed storage boxes within the medication refrigerator have been ordered, with a projection date of delivery and installation by July 10, 2017.	

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F 431	Continued From page 49 was a specific policy for storage of said medications. The DON stated, "I will check and get back with you." At approximately 12:06 p.m. the DON approached this surveyor and stated, "I don't have anything other than this [referring to the Medication Administration policy]. I have searched high and low." No further information was received by the survey team prior to the exit conference on 05/25/17 at 6:00 p.m.	F 431		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the	F 441		6/9/17

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F 441	Continued From page 50	F 441		

facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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

(f) Annual review. The facility will conduct an annual review of its IPCP and update their

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F 441	Continued From page 51 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on, observation, staff interview and facility document review the facility staff failed to follow infection control practices during a meal observation and failed to follow infection control practices during a dressing change for one of 24 residents in the survey sample, Resident #12. 1. Certified nursing assistant (CNA #4) did not wash her hands after coughing into her hand. 2. License practical nurse (LPN #5) did not use good infection control practices during a dressing change on Resident #12. The Findings Include: 1. During a meal observation conducted on 5/23/17 at 12:15 p.m. this surveyor along with a federal oversight surveyor observed CNA #4 setting up a Residents food plate on the table in front of a Resident. At this time CNA #4 coughed into her hand and continued to unwrap food items. CNA #4 then stroked back the Resident's hair with the same hand she had coughed into. CNA #4 then went across the dinning room picked up a plastic cup from a stack of cups and separated the cup from the stack of cups by placing her finger tip into the lip of the stacked cup and pulling down. CNA #4 then returned to the Resident unwrapped a straw with her hands and placed the straw down into the cup and began feeding the Resident. During this time, CNA #4 had coughed two other times but used her inside elbow as a shield. On 5/23/17 at 12:45 p.m., CNA #4 was	F 441	F-441 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Infection control protocols and procedures will be reviewed with CNA team members and licensed team members. Emphasis will be placed on appropriate hand hygiene and dressing changes. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Observations will be made in daily rounding by the Clinical Coordinators for infection control issues. Our comprehensive Quality Assurance Performance Improvement program analyzes and monitors potential areas of concern related to infections facility wide. 3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur. As stated previously, the infection control practices and outcomes are monitored and analyzed on a weekly/monthly basis. Additional measures to address this deficient practice include a facility wide	

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F 441	Continued From page 52 interviewed concerning the above observation. CNA #4 agreed she coughed into her hand and then into the inside of her elbow, but verbalized that she used sanitizer when she had coughed into her hand. This surveyor asked where did she get the sanitizer from, CNA #4 verbalized that she had went to the medication cart and got it. CNA #4 was not observed leaving the dinning room at anytime during the meal observation by both surveyors. The facilities policy tilled "Hand Hygiene Policy" was obtain and reviewed and read in part "[...] Hands must be washed with non-antimicrobial soap or antimicrobial soap and running water [...]when soiled with body fluids or other potentially infectious material [...] or preparation of food." On 5/24/17 at 4:00 p.m. the above finding was brought to the attention of the director of nursing and administrator. No other information was presented prior to exit conference on 5/25/17. 2. License practical nurse (LPN #5) did not use good infection control practices during a dressing change on Resident #12. Resident #12 was admitted to the facility on 11/25/15 with diagnoses that included breast cancer with cyst and open lesions to the left breast. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 5/2/17. Resident #12 was assessed as being severely cognitively impaired.	F 441	mandatory Clinical Coordinator (CC) and Charge Nurse (CN) meeting facilitated by the Director of Nursing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This process for performance will be monitored through our Quality Assurance Performance Improvement. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. The mandatory CC and CN meeting will be held June 21st and 28th. Review of Infection Control Protocols (Hand Hygiene & Dressing Changes) & QAPI program for monitoring Infection Control.	

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F 441	Continued From page 53 On 5/24/17 Resident #12's medical record was reviewed an indicated (via physician's orders), Resident #12 was to receive dressing changes to the left breast three times a day. On 5/25/17 at 9:00 a.m. this surveyor observed Resident #12's dressing change being done by LPN #5. LPN #5 had already cleaned off the bedside table and prepped the dressing materials on the bedside table. LPN #5 then went into the bathroom and washed her hands. After LPN #5 washed hands, LPN #5 pushed back the privacy curtain (using hands) opened up Resident #12's closet (using hands) and pulled out a pair of gloves (touching the outside of the gloves with her hands) and donned the gloves. LPN #5 then proceeded to pick up the dressings (three dressings) and apply the dressings to the breast and touching the breast with her hands. On 5/25/17 at 9:35 a.m. LPN #5 was interviewed concerning the above observation. After explaining to LPN #5 objects that were touched after washing hands and coming into contact with Resident #12's wound. LPN #5 verbalized understanding and also verbalized that the gloves should have been placed on the table prior to dressing change and she should have used her upper arm to move the privacy curtain back. On 5/25/17 at 2:50 p.m. the above finding was brought to the attention of the director of nursing and administrator. No other information was presented prior to exit conference on 5/25/17.	F 441		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		6/9/17

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F 514	Continued From page 54 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: Based on staff interview and clinical record review, the facility staff failed to ensure complete and accurate clinical records for three of 24	F 514	F-514 RESIDENT RECORDS, COMPLETE/ ACCURATE/ACCESIBLE	

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residents in the survey sample. Resident #3's clinical record documented an inaccurate order for the frequency of administration for the medication Coumadin. Resident #21's treatment record documented an incorrect setting for the resident's hinged knee brace. Facility staff failed to document all administrations of an as needed pain medication, Oxycodone, to Resident # 6.

The findings include:

1. Resident #3's clinical record documented an inaccurate order for the frequency of administration for the medication Coumadin. The resident's computerized physician orders listed Coumadin was to be administered six times per day when it was ordered and administered six times per week.

Resident #3 was admitted to the facility on 10/28/14 with a re-admission on 2/24/17. Diagnoses for Resident #3 included rheumatoid arthritis, pneumonia, osteoporosis, dementia, neuropathy, history of pulmonary embolism and obesity. The minimum data set (MDS) dated 3/21/17 assessed Resident #3 with moderately impaired cognitive skills.

Resident #3's clinical record documented a physician's order dated 4/21/17 for Coumadin 4 mg (milligrams) to be administered each day on Saturday, Sunday, Monday, Tuesday, Wednesday and Thursday each week for the treatment of chronic embolism/blood clots. The resident's medication administration record documented the Coumadin was administered each day as ordered. The computerized clinical record for Resident #3 listed the Coumadin to be administered six times per day instead of six

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #3's clinical record has been corrected to reflect Coumadin six times per week versus six times per day. Resident #21's hinged brace setting has been changed to reflect the ordered 30º setting versus 0. Resident# 6 PRN doses have been recorded as given.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

Medical Records will be reviewed for accuracy monthly by the Clinical Coordinators. Clinical Coordinators will review their electronic medical records to identify residents within their respective households that receive treatments/ medications. The Clinical Coordinators will analyze and assess that the proper procedure and protocols are followed for treatment/medication administration. PRN orders will be reviewed to ensure that medications are administered as ordered within the specified time frames.

3. Address what measures will be put in place, or what systematic changes will be made to ensure the deficient practice will not recur.

Additional measures to address this deficient practice include a facility wide mandatory Clinical Coordinator (CC) and

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F 514	Continued From page 56 times per week as ordered. On 5/24/17 at 3:35 p.m. the licensed practical nurse (LPN #1) caring for Resident #3 was interviewed about the Coumadin order in the computer record indicating a frequency of six times per day. LPN #1 stated the order was entered into the computer with the wrong frequency and should have indicated six times per week. LPN #1 stated the frequency for the Coumadin administration was selected from a drop down menu and the nurse that entered the order selected with wrong frequency. These findings were reviewed with the administrator and director of nursing during a meeting on 5/24/17 at 5:00 p.m. 2. Resident #21's treatment record documented an incorrect setting for the resident's hinged knee brace. The treatment record documented Resident #21's hinged leg brace setting at 0 degrees when the actual order required a 30 degree setting. Resident #21 was admitted to the facility on 4/24/17 with diagnoses that included fractured knee cap, bronchitis, rheumatoid arthritis, chronic kidney disease and insomnia. The minimum data set (MDS) dated 5/8/17 assessed Resident #21 as cognitively intact. Resident #21's clinical record documented a rehabilitation activity order dated 5/16/17 for the resident's hinged knee brace to be set at 30 degrees at all times for transfers and ambulation. The resident's computerized clinical record documented a physician's order dated 5/17/17 for	F 514	Charge Nurse (CN) meeting facilitated by the Director of Nursing. The purpose for this mandatory meeting includes a review of proper procedure and protocols for medication/treatment administration. PRN policies and procedures will be reviewed to ensure medications are administered as ordered within the specified time frames. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Medical Records will be reviewed for accuracy monthly by the Clinical Coordinators. Clinical Coordinators will review their electronic medical records to identify residents within their respective households that receive treatments/ medications. The Clinical Coordinators will analyze and assess that the proper procedure and protocols are followed for treatment/medication administration. PRN orders will be reviewed to ensure that medications are administered as ordered within the specified time frames. 5. Include date(s) when the corrective action will be completed for each of the identified deficient practice. The mandatory CC and CN meeting will be held June 21st and 28th. Implementation of the new process through AOD monitoring of PRN meds will begin July 1, 2017.	

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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
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the resident's hinged knee brace to be set at 0 degrees. The resident's treatment record for May 2017 listed the hinged knee brace to be on at all times and set at 0 degrees. A nursing note dated 5/21/17 documented the resident's hinged knee brace was set at 30 degrees.

On 5/25/17 at 11:05 a.m. the registered nurse (RN #8) caring for Resident #23 was interviewed about the conflicting settings for the hinged knee brace. RN #8 stated the knee brace settings were determined and set by therapy and presented a copy of the rehabilitation activity order dated 5/16/17 indicating a 30 degree setting for the brace. RN #8 stated the brace setting was entered wrong into the computer system and the order should have indicated 30 degrees instead of 0 degrees. RN #8 stated the incorrect entry of 0 degrees was reflected on the treatment record. RN #8 stated the "3" was left off the order when it was entered into the computer so "0" was entered instead of the ordered setting of 30.

These findings were reviewed with the administrator and director of nursing during a meeting on 5/25/17 at 3:50 p.m.

3. Facility staff failed to document all administrations of an as needed pain medication, Oxycodone, to Resident # 6.

Resident # 6 in the survey sample, a 95 year-old female, was admitted to the facility on 1/21/15, and most recently readmitted on 4/22/15 with diagnoses that included anemia, gastroesophageal reflux disease, arthritis, osteoporosis, Alzheimer's Disease, Non-Alzheimer's Dementia, anxiety disorder, depression, difficulty walking, vitamin deficiency,

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	495370	A. BUILDING _____ B. WING _____	C 05/25/2017

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postherpetic polyneuropathy, generalized muscle weakness, neuritis and neuralgia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/12/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 1 out of 15.

On the most recent Quarterly MDS with an ARD of 4/6/17, Resident # 6 was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired skills for daily decision making.

Resident # 6 had the following physician's order for a prn (as needed) pain medication: Oxycodone (Roxicodone) 5 mg (milligrams) - Give 1 tablet po (by mouth) q4h (every 4 hours) prn pain (pain scale 5 - 10), moaning, facial grimacing, guarding of body movements and agitation.

(NOTE: Oxycodone [Roxicodone] is an opiate analgesic used to control moderate to severe pain. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 894.)

Review of the remarks section on the reverse side of the Electronic Medication Administration Record (E-MAR) for the month of October 2016 revealed Resident # 6 received two doses of Oxycodone on 10/1/16 and 10/11/16. On the front of the E-MAR, the time for the one dose of Oxycodone on 10/1/16 was recorded as 1350 (1:50 p.m.). There was no time recorded for the second dose of Oxycodone. The time for the one dose of Oxycodone on 10/11/16 was recorded as 12:50 p.m., there was no time recorded for the

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second dose of Oxycodone.

Review of the remarks section on the reverse side of the E-MAR for the month of November 2016, the resident received two doses of Oxycodone on 11/7/16, 11/8/16, 11/12/16, 11/16/16, 11/21/16, 11/23/16, 11/24/16, 11/26/16, 11/27/16, and 11/30/16; three doses of Oxycodone on 11/11/16, 11/13/16, and 11/25/16; four doses of Oxycodone on 11/18 and 11/29; and five doses of Oxycodone of 11/28/16.

On the front of the E-MAR for November 2016, the following dose times for Oxycodone were documented:

The time for the one dose on 11/7/16 was recorded as 1345 (1:45 p.m.). There was no time recorded for the second dose.

The time for the one dose on 11/8/16 was recorded as 11:00 a.m. There was no time recorded for the second dose.

The time for the one dose on 11/12/16 was recorded as 1643 (4:43 p.m.). There was no time recorded for the second dose.

The time for the one dose on 11/16/16 was recorded as 2004 (8:04 p.m.). There was no time recorded for the second dose.

The time for the one dose on 11/21/16 was recorded as 2109 (9:09 p.m.). There was no time recorded for the second dose.

The time for the one dose on 11/23/16 was recorded as 2001 (8:01 p.m.). There was no time recorded for the second dose.

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The time for the one dose on 11/24/16 was recorded as 2035 (8:35 p.m.). There was no time recorded for the second dose.

The time for the one dose on 11/26/16 was recorded as 2139 (9:39 p.m.). There was no time recorded for the second dose.

The time for the one dose on 11/27/16 was recorded as 2036 (8:36 p.m.). There was no time recorded for the second dose.

The time for the one dose on 11/30/16 was recorded as 2136 (9:36 p.m.). There was no time recorded for the second dose.

The time for the one dose on 11/11/16 was recorded as 2140 (9:40 p.m.). There was no time recorded for the second and third doses.

The time for the one dose on 11/13/16 was recorded as 2010 (8:10 p.m.). There was no time recorded for the second and third doses.

The time for the one dose on 11/25/16 was recorded as 2019 (8:19 p.m.). There was no time recorded for the second and third doses.

The time for the one dose on 11/18/16 was recorded as 2044 (8:44 p.m.). There was no time recorded for the second, third, and fourth doses.

The time for the one dose on 11/29/16 was recorded as 1715 (5:15 p.m.). There was no time recorded for the second, third, and fourth doses.

The time for the one dose on 11/28/16 was recorded as 2130 (9:30 p.m.). There was no time

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F 514	Continued From page 61 recorded for the second, third, fourth, and fifth doses. The findings were discussed during a meeting at 4:00 p.m. on 5/25/17 that included the Administrator, the Director of Nursing, and the survey team.	F 514		