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	495379	A. BUILDING _____ B. WING _____	C 10/19/2017

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SENTARA MEADOWVIEW TERRACE	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/17/17 through 10/19/17. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Three complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 168 certified bed facility was 149 at the time of the survey. The survey sample consisted of twenty-one current resident reviews (Residents 1 through 21) and three closed record reviews (Residents 22 through 24).	F 000		
F 279 SS=E	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279		11/30/17

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

Electronically Signed | 11/02/2017

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F 279	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 279	Disclaimer: Preparation and execution of	

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F 279	Continued From page 2 review, the facility staff failed to develop a comprehensive care plan for four of 24 residents in the survey sample. Residents #5 and #12 had no care plan developed regarding nutrition. Resident #8 had no care plan developed regarding an accurate resuscitation status. Resident #13 had no care plan developed regarding non-pharmaceutical interventions for pain. The findings include: 1. Resident #5, assessed with a significant weight loss, had no care plan developed regarding nutrition and/or weight loss. Resident #5 was admitted to the facility on 3/8/17 with a re-admission on 4/12/17. Diagnoses for Resident #5 included pneumonia, dementia with behaviors, anxiety, high blood pressure, renal failure and depression. The minimum data set (MDS) dated 7/18/17 assessed Resident #5 with short and long-term memory loss and moderately impaired cognitive skills. Resident #5's MDS dated 7/18/17 completed due to a significant change in condition, documented the resident weighed 81 pounds, had experienced a significant weight loss and was not on a physician prescribed weight loss program. This MDS included nutrition as a triggered problem in the care area assessment summary requiring the development of plan of care with the facility indicating a decision to proceed with a nutrition care plan. The registered dietitian's note dated 7/19/17 documented the resident had experienced a 6.9% weight loss in the last 30 days and 18.2% weight loss in the last 90 days. The resident was prescribed a mechanical soft	F 279	this plan of correction in no way constitutes an admission or agreement by Sentara MeadowView Terrace of the truth of the facts alleged in this statement of deficiency and plan of correction. This plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance. 1) a. Nutritional care plans for residents #5 and #12 were developed and implemented. b. DNR status care plan was updated for Resident #8. c. For resident #13 the care plan for pain was updated to include non-pharmacological intervention. 2) a. Residents who have been identified as at risk for weight loss have had care plans reviewed and updated as needed to meet the resident's nutritional needs. b. All code status care plans were audited and updated as needed. c. The care plans for all residents who are prescribed Hydrocodone/APAP will be audited for non-pharmacological interventions and updated as needed. 3) a. Dietary team will complete nutritional care plans on all residents who trigger on the MDS assessment for the nutritional CAA. b. Care Plan Team has been retrained on care plan formulation to include the CAA triggers (nutrition, code status, pain management).	

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F 279	Continued From page 3 diet with ground meats and thin liquids in addition to a liquid supplements three times per day. Resident #5's plan of care (revised 9/22/17) included no problems, goals and/or interventions regarding nutrition or the interventions in place for weight loss. On 10/17/17 at 3:50 p.m. the licensed practical nurse (LPN #5) caring for Resident #5 was interviewed about a nutrition care plan. LPN #5 stated the resident had been on hospice for several months and was not weighed during that time. LPN #5 stated the resident was discharged from hospice on 10/16/17 and received supplements and snacks for weight loss. LPN #5 did not know why the care plan did not include nutrition. On 10/18/17 at 8:00 a.m. the unit manager (LPN #3) was interviewed about a nutrition care plan for Resident #5. After reviewing the plan, LPN #3 stated she did not see anything on the care plan about nutrition or weight loss. LPN #3 stated the dietary clerk was responsible for adding items to the care plan. On 10/18/17 at 8:20 a.m. the dietary clerk was interviewed about Resident #5's nutrition plan. The dietary clerk reviewed the care plan and stated she did not see anything on the plan about nutrition. The dietary clerk stated the nutrition plan was removed after the resident went on hospice and was no longer being weighed. The dietary clerk stated the resident was discharged from hospice on 10/6/17. These findings were reviewed with the administrator and director of nursing during a	F 279	4) a. Dietician or designee will audit MDS assessment for nutritional triggers and the completion of nutritional care plans monthly, and report results to Nursing QA monthly. b. Social Services Manager or designee will audit all code status care plans for the residents who are on MDS assessment list monthly and report to QAI Committee quarterly. c. Nurse Managers or designee will monitor pain management care plans for residents on Hydrocodone/APAP weekly for 4 weeks and then monthly, and report to Nursing QA monthly.	

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meeting on 10/18/17 at 4:30 p.m.

2. Resident #12's had no care plan developed regarding nutrition.

Resident #12 was admitted to the facility on 6/9/16 with diagnoses that included dementia, adult failure to thrive, high blood pressure and diabetes. The minimum data set (MDS) dated 9/12/17 assessed Resident #5 with moderately impaired cognitive skills.

Resident#12's MDS dated 12/19/16, completed due to a significant change in condition, listed the resident weighed 109 pounds and included nutrition as a triggered problem area in the care area assessment summary requiring the development of a plan of care. This MDS indicated the facility decided to include nutrition as part of the resident's plan of care.

Resident #5's plan of care (revised 7/30/17) included no problems, goals and/or interventions regarding nutrition.

On 10/18/17 at 10:40 a.m. the licensed practical nurse (LPN #6) caring for Resident #12 was interviewed about a nutrition care plan. LPN #6 stated the resident was prescribed a regular diet and received Ensure supplement three times per day. LPN #6 stated she did not know why there was no care plan for nutrition and stated the dietary clerk added items to the care plan regarding meals/nutrition.

On 10/18/17 at 11:45 a.m. the dietary clerk was interviewed about a care plan regarding Resident #12's nutritional needs. The dietary clerk

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reviewed the plan and stated there were no entries on the plan about nutrition. The dietary clerk stated Resident #12 did not have a plan about nutrition because she was on a regular diet and had no problems with eating.

On 10/18/17 at 3:30 p.m. the registered nurse responsible for MDS assessments (RN #3) was interviewed about a nutrition care plan for Resident #12. After reviewing, RN #3 stated she did not find a nutrition care plan for Resident #12.

This finding was reviewed with the administrator and director of nursing during a meeting on 10/18/17 at 4:30 p.m.

3. The facility staff failed to develop a comprehensive care plan to correctly reflect Resident # 8's DNR (do not resuscitate) status.

Findings include:

Resident # 8 was admitted to the facility 4/13/17 with diagnoses to include, but not limited to: dementia, heart disease, high blood pressure, and osteoarthritis.

The most recent MDS (minimum data set) was a quarterly review dated 8/18/17. Resident # 8 was coded as having moderate impairment in cognition with a total summary score of 09 out of 15.

The clinical record was reviewed 10/17/17 at 2:25 p.m. During review it was noted a "Durable Do Not Resuscitate" form had been signed by the resident's RP (responsible party) and the physician 4/16/17. The care plan, dated 4/15/17, was then reviewed and revealed the code status

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for Resident # 8 included an "Advanced Directive" care plan identified the resident was a "Full Code." On the care plan, under "Problems/Strengths" created by the facility social worker, documented "Full Code- (name of resident) has not or does not wish to execute a DNR." Under "Goals" was document ted "(name of resident) wishes of resuscitation in the event of cardio pulmonary arrest will be upheld throughout los(sic) or until a change in code status is determined."

"Interventions" on the care plan included "SW (social worker) will discuss advance directives with (name of resident) and/or RP/family on admission." (This intervention was highlighted in yellow). ....."Staff will perform CPR in the event of cardio pulmonary arrest." The care plan had handwritten updates dated 5/22/17 and 8/21/17 indicating the care plan had been reviewed, and the code status was to continue.

On 10/17/17 at 3:20 p.m. LPN (licensed practical nurse) # 1 was asked about the care plan for the resident being a full code status, despite having a signed DNR form in the clinical record. LPN # 1 stated "The social worker does the updates for that section of the care plan; she [the social worker] has left for the day so let me see if I can get the unit manager to talk to you." A few moments later LPN # 1 returned with the social worker and stated "She hadn't left yet, so she has come over to talk to you." The social worker, identified as other staff (OS) # 1, was asked about the care plan for Resident # 8, and the discrepancy between the signed DNR and the full code status on the care plan. OS # 1 was also asked what the yellow highlighted intervention on the care plan indicated. OS # 1 stated "I'm new

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here and just getting to know the residents; I didn't realize there was a DNR signed. The yellow highlighted section means that intervention was resolved." OS # 1 was then asked when creating a care plan, where the information for the resident's code status was obtained. OS # 1 stated "From the resident's chart.....I must have just overlooked it. I can do a new care plan now."

On 10/17/17 at approximately 4:00 p.m. OS # 1 gave this surveyor a care plan dated 10/17/17 that reflected Resident # 8's correct code status.

On 10/18/17 during an end of the day meeting with facility staff beginning at 4:15 p.m. the administrator, assistant administrator, and DON (director of nursing) were informed of the above findings.

No further information was presented prior to the exit conference.

4. The facility failed to develop a care plan for Resident # 13 that included non-pharmacological interventions to address pain.

Resident # 13 in the survey sample, an 84 year-old male, was admitted to the facility on 6/3/16 with diagnoses that included right cerebral accident with left hemiparesis, contractures, pain, hypertension, gastroesophageal reflux disease, coronary artery disease, constipation, hyperlipidemia, thyroid disorder, status post hip fracture, seizure disorder, and chronic obstructive pulmonary disease. According to the most recent full Minimum Data Set, a Significant Change, with an Assessment Reference Date of 4/9/17, and the most recent Quarterly Minimum Data Set with

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an Assessment Reference Date of 9/1/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Resident # 13 had the following medication order: Hydrocodone/APAP tablet 5-325 mg (milligrams), 1 by mouth every four hours as needed for pain. According to the Medication Administration Record (MAR) for the month of September 2017, Resident # 13 received as needed pain medication 11 times. According to the MAR for the month of October 2017, as of 10/18/17, the date of clinical record review, Resident # 13 received as needed pain medication eight times.

Resident # 13's care plan, dated 6/22/16, and updated on 7/20/17, included the following problem in the area of pain, "Mr. (name of resident) is at risk for episodes of pain due to 1. Left (L) hand/wrist hemiplegia with contractures secondary to late effects of CVA (Cerebrovascular Accident). 2. His disease process." The goal for the problem was, "Resident's episodes of pain will be relieved after interventions this quarter."

Included as an intervention to the stated problem was the following, "Give pain medications at the first indications of pain if not contraindicated by MD."

A thorough review of Resident # 13's care plan failed to reveal any non-pharmacological interventions to address pain under the problem area of pain, or under any other care plan problem areas.

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F 279	Continued From page 9 At 3:50 p.m. on 10/18/17, Resident # 13 was interviewed regarding the control of his pain. Asked if any pain control measures other than medication had been attempted, Resident # 13 replied, "No." When asked if he would like to try other measures, such as warm compresses, the resident said, "Yes. That's why I changed rooms yesterday (10/17/17). The cold bothers me. Heat helps my joints feel better." (NOTE: In his previous room the resident's bed was located at the door. In his new room, the resident's bed was located next to the heating unit.) The use of non-pharmacological interventions to address Resident # 13's pain were discussed during a meeting at 4:15 p.m. on 10/18/17 that included the Administrator, Director of Nursing, and the survey team.	F 279		
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	F 309		11/30/17

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F 309	Continued From page 10 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 care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, and staff interview, the facility staff failed for two of 24 residents in the survey sample (Residents # 13 and 19), to assess the resident's level of pain, to identify the location of pain, to offer non-pharmacological pain interventions, and to follow physician's orders. For Resident # 13, the staff failed to assess the resident's level of pain, to identify the location of pain, and failed to offer non-pharmacological pain interventions. For Resident # 19, the staff failed to withhold a dose of Digoxin (a heart medication) if the resident's pulse was below 60, and failed to notify the physician of the resident's pulse below 50. The findings include: 1a. For Resident # 13, the staff failed to assess the resident's level of pain, and failed to identify	F 309	1) a. Reviewed with nurses the assessment procedure for Resident #13 related to level and location of pain, as well as offering non-pharmacological interventions prior to administration of pain medication, and documenting. b. Nurse Manager immediately reviewed with nurses to notify physician when pulse is less than 50, and hold Digoxin if pulse is less than 60 for Resident #19. 2) a. Audit to be conducted of all MARS of residents who are on Hydrocodone/APAP for documentation of level and location of pain and non-pharmacological interventions used prior to PRN medication being administered. b. Audit to be conducted for MARs of	

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F 309	Continued From page 11 the location of the resident's pain prior to the administration of as needed pain medication. Resident # 13 in the survey sample, an 84 year-old male, was admitted to the facility on 6/3/16 with diagnoses that included right cerebral accident with left hemiparesis, contractures, pain, hypertension, gastroesophageal reflux disease, coronary artery disease, constipation, hyperlipidemia, thyroid disorder, status post hip fracture, seizure disorder, and chronic obstructive pulmonary disease. According to the most recent full Minimum Data Set, a Significant Change, with an Assessment Reference Date of 4/9/17, and the most recent Quarterly Minimum Data Set with an Assessment Reference Date of 9/1/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Resident # 13 had the following medication order: Hydrocodone/APAP tablet 5-325 mg (milligrams), 1 by mouth every four hours as needed for pain. According to the Medication Administration Record (MAR) for the month of September 2017, Resident # 13 received as needed pain medication 11 times. Review of the Nurse's Medication Notes on the reverse side of the September MAR revealed the as needed pain medication was administered on 9/1/17, 9/2/17, 9/6/17, 9/8/17, 9/15/17, 9/18/17, 9/21/17, 9/23/17, 9/24/17, and 9/27/17. None of the listed entries included an assessment of the resident's level of pain. There was also no assessment of the resident's level of pain in the Nurses Notes section of the clinical record.	F 309	residents receiving Digoxin for documentation of Digoxin being held if pulse is less than 60, and notification of physician for pulse lower than 50. 3) Re-educate nurses on the following: a. Assessing residents concerning level and location of pain, and the use of non-pharmacological interventions prior to PRN drug administration. b. Guidelines for the pulse rates related to holding Digoxin and notification of physician. 4) Nurse Manager or designee to monitor the following: a. Documentation of level and location of pain, and the use of non-pharmacological interventions for residents on Hydrocodone/APAP PRN. b. MARs of residents on Digoxin for documentation of pulse rate, holding drug for pulse under 60, and physician notification of pulse under 50. To be monitored weekly for 4 weeks and then monthly. Monitoring results to be reported to the Nursing QA Committee monthly.	

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For the administration entries of 9/6/17, 9/8/17, 9/15/17, 9/18/17, 9/21/17, 9/23/17, 9/24/17, and 9/27/17, the location of the resident's pain was not identified on the Nurse's Medication Notes or in the Nurses Notes.

As needed pain medication administered on 9/10/17 was noted on the front of the September MAR, but not on the Nurse's Medication Notes on the reverse side of the MAR.

According to the MAR for the month of October 2017, as of 10/18/17, the date of clinical record review, Resident # 13 received as needed pain medication seven times. Review of the Nurse's Medication Notes on the reverse side of the October MAR revealed as needed pain medication was administered on 10/3/17, 10/6/17, 10/7/17, 10/12/17, twice on 10/16/17, and once on 10/17/17. None of the listed entries included an assessment of the resident's level of pain or the location of the resident's pain.

1b. For Resident # 13, the staff failed to offer non-pharmacological pain interventions to address the resident's pain.

At 3:50 p.m. on 10/18/17, Resident # 13 was interviewed regarding the control of his pain. Asked if any pain control measures other than medication had been attempted, Resident # 13 replied, "No." When asked if he would like to try other measures, such as warm compresses, the resident said, "Yes. I would like to try warm compresses. That's why I changed rooms yesterday (10/17/17). The cold bothers me. Heat helps my joints feel better." (NOTE: In his previous room the resident's bed was located at the door. In his new room, the resident's bed was

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located next to the heating unit.)

The use of non-pharmacological interventions to address Resident # 13's pain were discussed during a meeting at 4:15 p.m. on 10/18/17 that included the Administrator, Director of Nursing, and the survey team.

2. The facility staff failed to follow physician orders to withhold the medication Digoxin (a heart medication) for Resident # 19 if the resident's pulse was below 60, and to notify the physician for a pulse below 50.

Findings include:

Resident # 19 was admitted to the facility 7/17/17 with diagnoses to include, but not limited to: dementia, atrial fibrillation (A-Fib, an abnormal heart rhythm), high blood pressure, coronary artery disease, and anxiety.

The most recent MDS (minimum data set) was the admission assessment dated 7/24/17. Resident # 19 was coded as having short term and long term memory problems, and moderate impaired in daily decision making.

The clinical record was reviewed 10/19/17 at 8:45 a.m. The current POS (physician order summary) signed and dated by the physician 10/9/17 included the following orders carried forward from 7/17/17: "Digoxin Tab 0.125 MG (milligram) 1 by mouth daily for A-Fib Hold for pulse less than 60." "Notify MD if pulse less than 50 or greater than 110."]

The MAR (medication administration record) for September 2017 and October 2017 was then

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reviewed. For September 2017, the Digoxin was not held for a pulse of 57 on 9/29/17. (It should be noted here previous documentation of pulse less than 60 resulted in the medication date being circled and documented on the reverse side of the MAR that the medication was held). The September MAR also revealed that on three dates the resident's pulse was below 50: 9/11/17-pulse 36; 9/25/17-pulse 32; 9/27/17-pulse 40. A review of the nurses' notes for September 2017 failed to reveal documentation the MD was notified of the pulse less than 50.

On 10/19/17 at 9:15 a.m. LPN (licensed practical nurse) # 2 was asked for assistance to locate documentation of the physician notification of the resident's pulses less than 50. LPN # 2 stated the documentation would be located in the nursing notes. At that time, the unit manager, LPN # 3, was also present, and LPN # 2 deferred the question to her. LPN # 3 told this surveyor "If there's no documentation in the nurses' notes, there's also information in the computer communication to the doctors called Relay Health.....that may be where that information is." LPN # 3 then asked LPN # 2 to go into the system to see if there was any communication to the doctor for the three dates of low pulse. LPN # 2 gave LPN # 3 some printed communication forms. LPN # 3 reviewed the information, presented them to this surveyor stating "There's no information about the doctor being made aware of the pulse; even if there was communication in Relay Health, there should be a note reflecting that. We should be notifying him, and I will address this."

The administrator, assistant administrator, and DON (director of nursing) were informed of the

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F 309	Continued From page 15 above findings during a meeting 10/19/17 beginning at 1:00 p.m. No further information was presented prior to the exit conference.	F 309		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific	F 329		11/30/17

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F 329	Continued From page 16 condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to ensure one of 24 residents was free from unnecessary medications, Resident #14. Resident #14 received 17 doses of prn (as needed) Haldol and 62 doses of prn Alprazolam from 09/01/17 through 10/17/17 with little to no effect. Findings included: Resident #14 was originally admitted to the facility on 09/19/16 and readmitted on 04/26/17 with diagnoses including, but not limited to: Dementia with Behaviors, Anxiety, Congestive Heart Failure, Hypertension and Diabetes. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/31/17. Resident #14 was assessed as severely impaired in his short and long term memory skills and moderately impaired in his daily decision making skills. The clinical record for Resident #14 was reviewed on 10/18/17 at 8:20 a.m. Listed on his most recent POS (physician order sheet) dated 10/01/17 through 10/31/17 were the following	F 329	1) A discussion concerning the effectiveness of the use of Haldol and Xanax (alprazolam)for Resident #14 was held with the attending physician, with a conclusion to discontinue these PRN medications and monitor the resident's behaviors. 2) All residents with PRN orders for Haldol and Xanax (alprazolam) will be assessed for effectiveness. 3) Nurses to be re-educated or documentation of PRN medication (Haldol and Xanax) effectiveness and physician notification. 4) Nurse Managers or designee will monitor documentation of effectiveness of administration of PRN Haldol and Xanax (alprazolam) weekly for 4 weeks, then monthly. Results will be reported to Nursing QA Committee monthly.	

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medications: Lexapro 10 mg (milligrams) po (oral) qd (daily) for depression with behavioral disturbances, Trileptal 600 mg one po bid (twice daily) for dementia with behavioral disturbance, Buspar 5 mg po tid (three times daily) for anxiety, Aricept 10 mg po qd for dementia, Haldol 0.5 mg po at hs (bedtime) as needed for agitated behavior, and Alprazolam 0.5 mg one po every eight hours as needed for generalized anxiety disorder.

Subsequent review of the MAR's (medication administration sheets) for September and October 2017 included the following: Resident #14 received Haldol 0.5 mg by mouth on 9/2, 9/3, 9/5, 9/6, 9/7, 9/13, 9/14, 9/16, 9/27, 9/28, 10/1, 10/2, 10/6, 10/9, 10/12, 10/14, and 10/15. Resident #14 received Alprazolam 0.5 mg by mouth on 9/1, 9/2, 9/3, 9/4 (2-doses), 9/6 (2-doses), 9/7, 9/8 (2-doses), 9/9, 9/10, 9/11 (2-doses), 9/12 (2-doses),9/14 (2-doses), 9/15, 9/16, 9/17, 9/19 (2-doses), 9/20 (2-doses), 9/21 (2-doses), 9/22, 9/23 (2-doses), 9/24 (2-doses), 9/26, 9/27 (3-doses), 9/28, 9/30, 10/1, 10/2, 10/3, 10/4 (2-doses), 10/6, 10/7 (2-doses), 10/8 (2-doses), 10/9 (3-doses), 10/10, 10/11, 10/12, 10/13 (2-doses), 10/14, 10/15, 10/16 (2-doses), and 10/17 (2-doses).

Corresponding "Nurse's Notes" included the following documentation:

9/1/17 3:00 a.m. - "...resident sitting up in wheelchair in common area with staff at shift change. Occasional yelling out noted..."
9/1/17 8:20 a.m. - "Resident rolled up to another resident and started yelling "Get out of my way before I kill you, you SOB..."
9/1/17 2:00 p.m. - "Resident continues with yelling

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and threatening other residents and staff who he believes is in his way."
9/1/17 3:15 p.m. - "Resident attempts to roll up close to other residents feet and when redirected he said, "I am going to do it you bitch." Unable to redirect resident away from other residents..."
9/1/17 (no time) - "...Alert, talkative, intrusive, yelling. Moving about at all times w/c [wheelchair]..."
9/2/17 2:00 p.m. - "...Up in w/c propelling self in hallways. Continues to yell out and threaten other residents. Xanax prn given for anxiety with no effects seen..."
9/3/17 9:30 p.m. - "Resident has been verbal and verbally abusive majority of shift. Screaming at staff and residents that he wants to "kill them, " as well as he wanted "to die." Resident has shouted to the top of his lungs, very loud, disturbing and waking other residents. He has rolled his w/d into staff and residents and was not able to be redirected during this shift...Resident has shouted for most of shift. Threatening anyone who was in near contact with him..."
9/4/17 10:25 a.m. - "Resident has been very agitated and verbally abusive towards fellow residents. Tried to run over several residents feet with his wheelchair. Has been yelling and screaming out loud. Also has had crying spells.
9/6/17 8:55 p.m. - Resident up in w/c propelling self in hallways and in and out of resident rooms...Resident up yelling out and threatening staff and residents. Attempted to hit staff/residents. Xanax prn given with...temporary results. PRN Haldol given with...temporary results. At this time resident is in w/c yelling "Help!"", "Hey," "Hal," "I'm gonna kill you God Damn It." He is seen to ram his w/c into other chairs. Unable to engage in activities. Difficult to redirect..."

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F 329	Continued From page 19 9/7/17 9:16 p.m. - "...Continues with agitated and aggressive behavior. Resident is very difficult to redirect - does not engage in activities with staff. Attempting to hit staff on several occasions when it became necessary to move him away from other residents..." 9/8/17 11:00 a.m. - "...Beginning to move about, and sound apprehensive with agitation." 9/8/17 2:15 p.m. - "Resident up in w/c propelling self in and out of rooms and hallways...Crying spells this am about needing to go to see "mama" and "tell me what to do!" PRN Xanax given with minimal results. Continues to yell out and run his w/c into other residents. Yelling out "I'm gonna kill myself." 9/8/17 3:00 p.m. - "Resident continues to pace hallways running w/c into other residents. Yelling and screaming, cursing. Unable to redirect. Will not engage in activities..." 9/9/17 10:29 a.m. - "Resident is in wheelchair in common area. He has been redirected several times d/t [due to] attempts to roll over other resident's feet. Resident has been yelling at staff during those attempts to redirect..." 9/10/17 8:00 a.m. - Resident up in wheelchair yelling out at staff. He states, " I am going to run over everyone of yall." Redirection was unsuccessful. PRN medication was given..." 9/10/17 8:30 a.m. - Resident's PRN medication was ineffective..." 9/10/17 9:15 a.m. - "Resident in common area rolling his wheelchair on other resident's feet causing increased behaviors..." 9/10/17 10:15 a.m. - "Resident noted attempting to roll over other resident's feet. He yelled out, "I want to go to bed. I want to go to bed..." 9/10/17 5:30 p.m. - "...Resident being verbally aggressive to staff and residents. Redirection was unsuccessful. PRN medication was given.	F 329		

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Will follow up with effectiveness..."
9/10/17 6:15 p.m. - "PRN medication was ineffective. Resident continues to yell out at other residents and staff..."
9/12/17 6:45 a.m. - "...continued to continually yell out in spite of interventions rendered, continually removing bed clothes and bed linen covering him, when nurse assist with covering up, would become tearful and them become angry, cursing at, attempting to hit, Xanax 0.5 mg po given at 3:30 AM..."
9/13/17 6:45 a.m. - "...has been repeatedly yelling out loudly "Hey!" Help Me..."
9/13/17 9:15 a.m. - "...Up in w/c propelling self in hallways, forcing w/c between other residents or in spaces to narrow to fit. Yelling/screaming on and off throughout shift. Unable to redirect...Unable to engage in activities. Haldol PRN given at 7:40 p with minimal effectiveness noted by 8:30 pm."
9/14/17 6:00 p.m. - "Resident up in w/c propelling self in hallways; crying that he needs to to home to see his "ma-ma." Unable to redirect with activities. Continues to be tearful with snack...PRN Xanax given for anxiety..."
9/14/17 7:00 p.m. - "...Anxiety ...resident continues to roll w/c up and down hallways yelling out "Help! Help!"
9/14/17 7:30 p.m. - "Resident continues to yell out "Help! Help!" and "Shut the Hell Up!" "I'm gonna kill her." Unaable to engage in activities. Continues to yell out when engaged in 1:1 conversation. PRN Haldol given."
9/16/17 9:45 a.m. - "Resident noted yelling out in the common area. Redirection was unsuccessful. PRN medication given and was slightly effective..."
9/16/17 2:00 p.m. - "...Propelling self in w/c, running into other residents and inanimate

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objects. Crying spells earlier today. Attempts to redirect were unsuccessful. PRN Xanax given...Continues with agitated behavior (yelling out and threatening)..."
9/16/17 9:30 p.m. - "...Has continually hollered out this shift and rolled around in his chair running into other residents and staff. Uses profanity with most of his speech and becomes angered easily when re-directed...PRN medication in use to no avail..."
9/17/17 12:00 a.m. - "Resident awake in bed yelling out "Hey," Help..."
9/17/17 4:00 a.m. - "Resident haws continued to holler out "Hey" and "Help me..."
9/17/17 1:00 p.m. - "...Up in w/c propelling self in hallway. Yelling out..."
9/20/17 6:45 a.m. - "...resident yelling out "Hey! Hey!" at beginning of shift and "Help,"when asked what was wrong, he tearfully stated, "I need to get out of here..."
9/21/17 6:45 a.m. - "...propelling self at times in wheelchair around unit; wandered into another resident's room.."
9/21/17 6:45 a.m. - "[Addendum]Also noted to be spitting on floor."
9/26/17 8:35 a.m. - "For 9-26-17 @6:45 AM; Resident repeatedly yelling out "Hey" and "Help, Help" @ beginning of shift...resident continued to yell out with anxious look on face and tearful at times; Xanax 0.5 mg PO given at 12:30 AM..."
9/27/17 6:45 a.m. - "Resident has been yelling out "Hey" and "Help, Help" repeatedly throughout the shift...would be tearful at times with nurse then ask where nurse going to be; would also become angry and curse and raised hand at nurse; when asked why he was yelling out, verbalized "I don't know;" Xanax 0.5 mg PO given at 12:45 AM without any effectiveness noted; has continued with aforementioned behavior..."

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F 329	Continued From page 22 9/27/17 10:30 p.m. - "Resident up in w/c propelling self in hallways and in and out of rooms. Resident is restless; anxious, agitated. Attempts at redirection were poorly received...Does not engage in activities. Interrupted med pass on multiple occasions by blocking med cart. Threatened physical violence (held closed fist up stating "I'm gonna kill you!) " when asked to move... 9/28/17 2:23 p.m. - "Resident has been yelling out all shift and attempting to run over resident's toes that are sitting in common area. PRN medication was given and was ineffective..." 9/30/17 (3-11) - "Resident yelled out entire shift "Hey," "Hey" loudly, keeping other residents from sleeping at Qhs [every bedtime] and disturbing their rest. Threatened other residents and staff and this nurse to "Kill them" throughout shift if asked to move or quiet down...PRN medication not effective." 10/2/17 10:18 a.m. - "Entry for 8AM on 10/2/17. Resident had increased anxiety and agitation and was yelling out at staff and other residents. PRN medications was given and was ineffective..." 10/4/17 6:45 a.m. - "Resident has been awake throughout the night yelling out "Hey" and "Help" very loudly...Xanax 0.5 mg po given at 12:15 AM. Continued to yell out loudly throughout the night in spite of interventions..." 10/6/17 10:00 p.m. - "...Yelling out this eve..." 10/10/17 10:35 a.m. - "For 10-10-17 @6:45 AM - Resident has been awake through out the night in his wheelchair; repeatedly yelling out "Hey" and "Help." Resident wandering unit propelling self in his wheelchair, wandering into others' room...did become agitated and anxious with redirection out of resident's rooms and began to yell, curse, and threaten staff, also raised hand at nurse as if to try to hit nurse; Xanax 0.5 mg PO given at 4:30	F 329		

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AM with minimal to no effectiveness noted."
10/11/17 (7-3) - "Resident has been very verbal throughout this shift yelling loudly "Hey, Hey" and attempting to argue and shout down residents and staff. Rolling his w/c up into and attempting to roll onto other's feet, invading personal space..."
10/11/17 9:33 p.m. - "Resident has been yelling out throughout the shift. Disruptive. Attempts to redirect/placate unsuccessful..."
10/11/17 11:30 p.m. - "...resident up in wheelchair in common area with staff; continues with yelling out loudly "Hey" and very restless. Unable to sit still in seat...resident has been agitated with staff cursing and threatening."
10/11/17 11:40 p.m. - "Xanax 0.5 mg PO given for anxiety and agitated behavior."
10/12/17 1:00 a.m. - "...Resident has been up in wheelchair in common area with staff and continues to do so has continually been yelling out loudly "Hey" and "Help"...continues to yell out loudly..."
10/12/17 3:30 p.m. - "Resident is seen laying in bed with eyes closed yelling out "Ah! Ah! Ah! Help please! Help please!"..."
10/12/17 4:00 p.m. - "Resident OOB [out of bed] yelling out "Hey! Hey!" while propelling self in hallways...Continues to yell out with 1:1 conversation."
10/12/17 5:34 p.m. - "Resident making circles through dining room. Attempting to force his way past another resident...Writer physically attempted to assist resident from the space and resident attempted to hit and kick writer..."
10/12/17 6:45 p.m. - "...Continues to yell out, "Hey! Hey! Answer me god damn it! I'm gonna kill you you Bitch!" Propelling self in hallways. Xanax PRN given."
10/12/17 7:30 p.m. - "PRN Xanax somewhat

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effective. Resident continues to yell out..."
10/12/17 8:40 p.m. - "Resident yelling out "Hey! Help! Help! Hey! Help me please!" Rolling his wheelchair up close to other residents and pulling their chairs...Spitting on floor. Disruptive to other residents. Attempting to enter other resident's rooms who are trying to sleep."
10/12/17 9:30 p.m. - "Resident propelling self in hallway crowding other residents while yelling...Resident asked by another resident to please back up and he would not...Resident became angry yelling...Haldol prn given."
10/14/17 (3-11) "Resident has been self propelling himself throughout this shift around the unit rolling himself into people's chairs and bumping into staff, tables and invading the space of others...Resident became easily angered and continually shouted/yelled out...Resident has also used excessive profanity this shift...PRN Xanax given for increased anxiety."
10/16/17 10:13 p.m. - "Resident up in w/c propelling self in hallway. At supper resident was tearful/crying...PRN Xanax given at 6:56 pm ..."
10/17/17 11:30 a.m. - "Resident in common area yelling at other residents and attempting to run over other resident's feet with wheelchair...PRN medication was given at 8 am and no effectiveness noted."

On 10/18/17 at approximately 10:25 a.m., LPN #4 (licensed practical nurse) was interviewed regarding Resident
#14 and effectiveness of his prn medications.
LPN #4 stated, "No, not really, but when he is yelling out and crying you feel like you should do something to help and that is all we have."

LPN #3, also the unit manager, was interviewed on 10/18/17 at 2:10 p.m. LPN #3 stated, "I have

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F 329	Continued From page 25 to be careful what I say. As you can see in the record, he has been sent out several times and they always send him back stating there is nothing wrong with him. We essentially treat him as a 1:1. Someone is watching him all the time." The Medical Director was interviewed on 10/18/17 at 2:40 p.m. The Medical Director stated, "I just increased his Lexapro. We do have a prn psychiatrist on staff. Maybe I should get him to look at him for a second opinion and maybe adjust his medications. I don't really think psychotherapy is going to work because he is so demented. If it did work, he wouldn't remember it in five minutes." Regarding the prn Haldol and Xanax orders and the staff statements they really don't work when given the Medical Director stated, "Right." The increased Lexapro dose and to have the other psychiatrist see this resident for possible medication changes was confirmed by the Medical Director when he stated, "Yes." The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 10/18/17 at approximately 4:30 p.m. No further information was received by the survey team prior to the exit conference on 10/19/17.	F 329		
F 371 SS=E	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	F 371		11/30/17

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F 371	Continued From page 26 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 observation, facility document review and staff interview the facility failed to prepare and serve food in a sanitary manner from the main kitchen. A counter mounted can opener was dirty. The filter in the hood above the dishwasher was dirty and damaged. A dietary worker entered the kitchen and handled clean dishes/utensils without prior hand washing. An employee with facial hair was in the kitchen during food preparation without a beard guard. The findings include: On 10/17 17 at 1:00 p.m. accompanied by the assistant administrator, the main kitchen was inspected. The counter mounted manual can opener near the back of the kitchen was observed dirty. Sticky black/brown accumulated debris was present on the can opener blade,	F 371	1)a. Can opener was removed from service and cleaned the day of inspection. b. The filter over the dishwasher was removed and cleaned the day of the inspection and a new filter ordered. c. Beard guards ordered, received, and put into use. d. A staff meeting was held and the importance of proper hand hygiene when returning to the kitchen area was discussed with staff. 2)a. All can openers were inspected and cleaned as necessary. b. No other dishwasher hoods are in the facility. c. No other areas require beard guards. d. No additional findings.	

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F 371	Continued From page 27 gear, gear housing and the can opener bracket. The filter in the hood above the dishwasher was also dirty with black accumulated debris. The filter was completely covered with black debris with damage noted to the mesh filter covering. The metal bracket around the filter opening was covered with a peeling brown substance. The assistant administrator, with facial hair was in the kitchen during this tour without use of a beard guard. On 10/17/17 at 1:10 p.m. the assistant administrator was interviewed about the dirty can opener and filter. The assistant administrator stated the can opener was supposed to be wiped down after each use and run through the dishwasher weekly. The assistant administrator stated he was not sure who maintained the hood filter but he would check and advise. On 10/17/18 at 2:45 p.m. the assistant administrator stated the hood filter was supposed to be cleaned at least monthly and the filter was usually cleaned by running it through the dishwasher. The assistant administrator stated he did not know when the filter was last cleaned. On 10/18/17 at 11:20 a.m. employees were observed in the main kitchen preparing food items for lunch. A dietary employee entered the kitchen from the cafe entrance and walked through the food preparation area to the dry storage room before putting on a hair net. This same employee, without performing hand hygiene, proceeded to the dishwasher and picked up the clean mixing bowl and clean utensils and placed them in the food preparation area for use. The assistant administrator with facial hair was in the kitchen during this time of food preparation without use of a beard guard.	F 371	3) Staff meeting held with re-education on the following: a. Can opener cleanliness to include importance of cleanliness, cleaning instructions to wipe down with each use and wash in dishwasher each week. Can opener to be inspected daily by evening cook. b. Dishwasher filter to be cleaned monthly by running through dishwasher and inspected for damage. c. Beard guards and hair nets have been placed at entrances to kitchen. Guidelines and new processes for obtaining and use were reviewed. d. Review was held of proper hand hygiene in food preparation areas, and when returning to the kitchen. Staff instructed not to handle clean items or food before proper hand washing. 4) a. Evening cook to inspect can openers daily and document. b. Director of Food Services will monitor and audit the following: 1. Cleanliness of can opener weekly for 4 weeks then monthly. 2. Cleanliness of dishwasher filter and inspection for damages monthly. 3. The proper use of beard guards and hair nets weekly for 4 weeks then monthly. 4. Staff for proper hand washing weekly for 4 weeks, then monthly. c. All findings will be reported to Safety Committee bi-monthly.	

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F 371	Continued From page 28 On 10/18/17 at 11:40 a.m. the assistant administrator was interviewed about hand washing and hair nets in the kitchen. The assistant administrator stated employees were supposed to come into the kitchen through the back entrance and not through the food preparation area. The assistant administrator stated clean hair nets were stored and available for employees in the dry storage room. The assistant administrator stated employees were supposed to wash their hands upon entering the kitchen and prior to handling clean dishes. The assistant administrator stated he should have put on a beard guard to cover his facial hair. The facility's policy titled Hair Restraints (undated) stated, "Staff and others shall wear hair restraints to fully contain hair and prevent hair from contacting exposed food, clean equipment, utensils and linens while in food preparation areas. Hair restraints include head and beard covers." The facility's policy titled Hand Hygiene (undated) stated, "All personnel must wash hands...Before beginning work...When returning to work...Dishwasher should always wash their hands before handling clean dishes..." These findings were reviewed with the administrator and director of nursing during a meeting on 10/18/17 at 4:30 p.m.	F 371		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional	F 514		11/30/17

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F 514	Continued From page 29 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 clinical record review and staff interview, the facility staff failed for two of 24 residents in the survey sample (Residents # 3 and 13), to ensure complete and accurate clinical records. Resident # 3 had a glucometer reading that was not entered on her clinical record. Resident # 13 had missing and incorrect	F 514	1) a. Glucometer history of ACCU Check revealed the blood sugar testing was completed for 9/10/17, a late entry was documented on the form for resident #3. b. The MAR and Narcotic Count Sheet (controlled substance form) for resident #3 were reviewed and a time line was	

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F 514	Continued From page 30 medication administration entries. The findings include: 1. Resident # 3 had a glucometer reading that was not entered on her clinical record. Resident # 3 in the survey sample, an 89 year-old female, was admitted to the facility on 1/6/15 with diagnoses that included gastroesophageal reflux disease, depression, hypertension, constipation, dementia, Vitamin B-12 deficiency, atrial fibrillation, coronary artery disease, congestive heart failure, hyponatremia, hyperkalemia, hyperlipidemia, osteoporosis, arteriosclerotic heart disease, and diabetes mellitus. According to the most recent Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/8/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15. Resident # 3 had the following physician's order, FSBS (Finger Stick Blood Sugar) every month at 6:00 a.m. Review of the Accu Check Monitoring Sheets in the resident's clinical record revealed there was no blood sugar reading entry for the month of September 2017. Review of the September 2017 Medication Administration Record (MAR) revealed the date 9/10/17 for the FSBS was highlighted, but there was no blood sugar reading entry. During a meeting at 1:00 p.m. on 10/19/17, that included the Administrator, Director of Nursing,	F 514	created which revealed a clerical error occurred. The errors were corrected. 2) a. Residents with monthly FSBS orders will be reviewed for entry on ACCU Check form. b. MAR and controlled substance form for residents receiving PRN Hydrocodone/APAP tablets will be reviewed for discrepancies related to dates of administration. 3) a. Staff nurses will be re-educated on proper documentation of monthly FSBS results on ACCU Check form. b. Staff nurses will be re-educated on medication administration to include correct procedure of entry of PRN medications (Hydrocodone/APAP) on the controlled substance form and MAR. 4) a. Nurse Managers will review ACCU Check form for monthly documentation of results of orders for monthly FSBS. This will be monitored monthly and results reported at Nursing QA monthly. b. Nurse Managers will monitor MAR and Controlled Substance Forms weekly for date comparison for Hydrocodone/APAP for 4 weeks, then monthly. Results will be reported to Nursing QA monthly.	

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and the survey team, the lack of a blood sugar reading for September on the Accu Check Monitoring Sheet was discussed. After the meeting, the Administrator produced documentation that the FSBS was done on 9/10/17 as scheduled, and that the result was stored in the Glucometer. The Administrator agreed that the blood sugar reading was not transferred to the Accu Check Monitoring Sheet.

2. Resident # 13 had discrepancies regarding medication administration entries on the MAR and the Narcotic Count Sheet.

Resident # 13 in the survey sample, an 84 year-old male, was admitted to the facility on 6/3/16 with diagnoses that included right cerebral accident with left hemiparesis, contractures, pain, hypertension, gastroesophageal reflux disease, coronary artery disease, constipation, hyperlipidemia, thyroid disorder, status post hip fracture, seizure disorder, and chronic obstructive pulmonary disease. According to the most recent full MDS, a Significant Change, with an ARD of 4/9/17, and the most recent Quarterly MDS with an ARD of 9/1/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Resident # 13 had the following medication order: Hydrocodone/APAP tablet 5-325 mg (milligrams), 1 by mouth every four hours as needed for pain.

(NOTE: Hydrocodone/APAP is a Schedule II Controlled Substance used to treat mild to moderate pain. Ref. Mosby's 2017 Nursing Drug

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Reference, 30th Edition, page 589.)

Review and comparison of the October 2017 MAR with the Controlled Substance Count Sheet revealed the following discrepancies:

Pain medication noted on the October MAR as being given on 10/7/17, was incorrectly dated as 10/8/17 on the Controlled Substance Count Sheet.

Pain medication noted on the October MAR as being given on 10/11/17, was incorrectly dated as 10/10/17 on the Controlled Substance Count Sheet.

Pain medication noted on the Controlled Substance Count Sheet as being given on 10/13/17, was not signed off as being given on the MAR.

Pain medication noted on the October MAR as being the second of two doses given on 10/17/17, was incorrectly dated.

During a meeting at 4:15 p.m. on 10/18/17 that included the Administrator, Director of Nursing, and the survey team, the discrepancies between the October MAR and the Controlled Substance Count Sheet were discussed. At approximately 10:30 a.m. on 10/19/17, the Administrator provided the surveyor with a timeline indicating that the discrepancies were clerical errors by the staff.