TA/OB

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

PRINTED: 02/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495216	A. BUILDING _____ B. WING _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/08/16 through 02/10/16. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 117 at the time of the survey. The survey sample consisted of 26 current Resident reviews (Residents 1 through 21, 25 and 26) and 3 closed record reviews (Residents 22 through 24).	F 000	**The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of stae and federal regulations as outlines. To remain in compliance with all state and federal regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.**	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	**Meeting continued during survey. Staff will be in-serviced by SDC on resident rights and that resident council meetings are private and no interruption of these meetings. Also when doors are closed or locked do not continue to try and get in. This education will occur by March 15, 2016.** **Resident council meetings held every month will be held in the activity day room and the Activity Director will lock the door to the room while meeting is in progress and no one will be allowed to enter.** **Activity Director will report any non-compliance in meeting minutes to the QA committee for review and progressive disciplinary action as needed. Date of compliance March 15, 2016**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/2/2016

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

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The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and group interview, the facility failed to provide privacy during a group meeting.

The findings included.

During a group meeting held on 02/09/16 at approximately 11:00 a.m. the facility staff entered the area that the group meeting was being held numerous times disturbing the group meeting.

The group meeting was held in the dining area at the facility and was attended by 7 Residents.

Prior to the meeting the facility staff had placed signs on the entrance doors to the dining room to inform staff, visitors, and other Residents that there was a group meeting being held in this area.

Beginning at approximately 11:05 a.m. 10 different individuals that were not Residents of the facility entered the dining room interrupting the group meeting. These individuals would enter the dining room from the kitchen area and/or the hallway that lead into dining room.

The Residents in the group identified the individuals as staff of the facility. One male

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F 164	Continued From page 2 individual was identified by the group as being a painter. After the group meeting the surveyor spoke with activity personnel #1. Activity personnel #1 was made aware of the interruptions and stated that it was probably the kitchen staff. The DON (director of nursing) and nurse consultant were notified of the interruptions during the group meeting on 02/09/16 at approximately 4:10 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 164		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for 3 of 26 Residents, Residents #22, #19, and #14. 1. For Resident #22, the facility staff failed to administer the medications Prilosec and Trandate (labetalol) as ordered.	F 309	Resident #22 no longer in the facility. Resident #19 MD was notified of missing doses and medication not started as ordered on 2/19/16. Resident #14 order for Oxycodone was clarified with MD on 2/10/16. New script was obtained and pharmacy was made aware of new order on 2/10/16. Staff was given education of following MD orders and on how to clarify orders with physician when they are not clear directions. Current residents with orders for MVI and oxycodone were audited for accurate order and to assure that narcotics were labled as ordered. Unit Manager/designee will monitor new orders for MVI and oxycodone by using the daily orders report and corrections will be made to orders as needed.	

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2. For Resident # 19, the facility staff failed to administer a physician ordered vitamin as ordered.
3. For Resident #14, the facility staff failed to administer oxycodone as ordered by the physician

The findings included.

1. For Resident #22, the facility staff failed to follow the Residents pre-operative instructions. The facility staff did not administer the medications Prilosec and Trandate (labetalol) as ordered prior to a surgical procedure.

Resident #22 was admitted to the facility 12/18/15. Diagnoses included, but were not limited to, Alzheimer's disease, urinary retention, dysphagia, hypertension, GERD (gastroesophageal reflux disease), and diabetes. At the time of the survey the Resident had been discharged from the facility.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/25/15 had a summary score of 5 out of a possible 15 points.

The Residents clinical record included "PRE-OPERATIVE INSTRUCTIONS" regarding a surgical procedure scheduled on 01/12/16. These instructions read in part. "...Do not eat or drink anything after midnight. Do not take any medications the morning of surgery except: Trandate, Prilosec WITH A SIP OF WATER..."

When the order was transcribed to the clinical record LPN (licensed practical nurse) #1

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transcribed the following "**NPO (nothing by mouth) AFTER MIDNIGHT**MAY HAVE PRILOSEC WITH SIP OF WATER for procedure on 1/12/16 @ _____ (name omitted)." There was no reference to the Trandate.

Resident #22's clinical record included orders for labetalol (Trandate) 200 mg (milligram) 1 tablet by mouth one time a day for hypertension and omeprazole (Prilosec) 20 mg 1 tablet by mouth one time a day for GERD.

A review of the Residents eMAR (electronic medication administration record) indicated that LPN #2 had coded both the medications on the eMAR with a 14 on 01/12/16. Per the code on the eMAR a 14 indicated the Resident was unavailable.

The clinical record included a nurses entry dated 01/12/16 at 5:26 a.m. by LPN #2 indicating the Resident left the facility via wheelchair for surgery.

On 02/10/16 at approximately 12:40 p.m. the surveyor interviewed RN (registered nurse) #1. RN #1 reviewed the clinical record and identified LPN #1 as the nurse who transcribed the pre-op orders. RN #1 verbalized to the surveyor that she did not know why the trandate was not added to the order. RN #1 checked the schedule and identified LPN #1 as being on leave.

The facility was able to provide the surveyor with a copy of the operative note from the procedure completed on 01/12/16. This operative note indicated "The patient had tolerated the procedure well...and was taken to the recovery room in stable condition."

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During a meeting with the survey team on 02/10/16 at approximately 3:40 p.m. the DON (director of nursing) and nurse consultant were notified that Resident #22's pre-operative orders were not followed.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. Facility staff failed to follow physician's orders for Resident #19's medication administration (MVT - multiple vitamin tablet.) The resident's clinical record was reviewed on 2/10/16 at 1:45 PM.

Resident #19 was admitted to the facility on 1/24/16. The diagnoses included: anemia, subarachnoid hemorrhage, dementia, and diabetes.

The resident's MDS (minimum data set) assessment, dated 1/29/16, coded the resident with significant cognitive impairment. The resident needed nursing staff assistance for all the ADLs (activities of daily living) with the exception of eating which was coded for set-up and oversite only.

The resident's CCP (comprehensive care plan) noted the problem "The resident has an alteration in hematological status R/T anemia...." The interventions included "Give medications as ordered."

Resident #19's current physician's orders, signed and dated 1/24/16, included "Multiple Vitamins-Minerals tablet. Give 1 tablet by mouth at bedtime...."

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Resident #19's January 2016 MAR (medication administration record) was reviewed. The MAR documented the MVT was not provided as ordered on 1/28/16 through 1/31/16 as ordered.

On 2/10/16 at 2:00 PM LPN (licensed practical nurse) I was interviewed about the missing doses of the MVT. She stated, "It wasn't given. I cannot find a reason it wasn't given."

On 2/10/16 at 4:30 PM the facility administrator and DON were informed of the surveyor's findings. No additional evidence was presented prior to the survey team exit.

3. The facility staff failed to administer the prescribed pain medication, Oxycodone, as prescribed by the physician for Resident #14. Resident #14 was admitted to the facility on 12/22/15 with the following diagnoses of, but not limited to diabetes, localized edema, encounter for removal of internal fixation (right knee replacement), pain and infection/inflammatory response due to internal fixation. The MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/19/16 coded Resident #14 as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was non-weight bearing on right lower extremity awaiting surgery to the right knee.

During the clinical record review of Resident #14's record on 2/9/16, the surveyor noted the following order on the Medication Administration Record (MAR) for the month of February, 2016: "Oxycodone 5 mg (milligram) Give 0.5 tablet by mouth every 4 hours as needed for pain. Give ½ tab (tablet) for pain 1-6". In the medication drawer of the medication cart was Oxycodone with the

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F 309	Continued From page 7 following label for Resident #14: Oxycodone 10 mg tablet EA (each), Give "1/2 tab (5 mg) by mouth every 4 hours as needed for mild pain 1-6 ...and 1 tab (tablet) (two half-tabs)by mouth every 4 hours as needed for pain 7-10 ...". The Unit Manager for Unit 1 and the surveyor both reviewed this at the same time and agreed that a half of a tablet of Oxycodone was equal to 5 mg according to the label provided by pharmacy. On the narcotic sign out sheet beginning 2/2/16 for Oxycodone for this resident, the following was documented: On 2/3/16 at 3:51 pm, the nurse signed out for Oxycodone 1 dose given and the narcotic count decreased by 1 unit dose. This occurred on 2/4/16 at 8:17 pm, 2/5/16 at 8:13 pm and again on 2/8/16 at 8:39 pm. At 2:45 pm on 2/9/16, the assistant director of nursing was notified of the above documented findings and stated, "I see. They didn't give it like it was suppose to be". The corporate nurse and director of nursing were notified of the above documented findings on 2/9/16 at 4 pm and again on 2/10/16 at 3:40 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 2/10/16.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312	**Residents #1 fingernails have been trimmed and cleaned. Resident Resident #3 tray was set up at time of survey. Resident #26 had handles applied at the time of survey. Current residents were assessed for assistance for feeding and personal hygiene of clean and trimmed fingernails. Current residents with feeding needs and special equipment for meals was also reviewed and added**	

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F 312	Continued From page 8 Based on observation, resident interview and clinical record review the facility staff failed to provide adequate ADL (activities of daily living) care for 3 of 26 residents (Residents #1, 3, and 26.) ~ Resident #1 - failed to provide adequate hygiene/nail care. ~ Resident #3 - Failed to provide adequate dining tray set-up/assistance. ~ Resident #26 - Failed to provide careplanned assistance with "build-up utensils" for eating. Findings: 1. Facility staff failed to provide Resident #1 with adequate hygiene with regards to nail care. The resident's clinical record review was conducted on 2/9/16 at 8:30 AM. Resident #1 was admitted to the facility on 9/4/13. Her diagnoses included: Parkinson's, diabetes, and anxiety. Resident #1's MDS (minimum data set) assessment dated 12/18/15 coded the resident with minimal cognitive impairment. She required facility staff support to accomplish the ADLs (activities of daily living) with setup/oversite only to eat her meals. The resident's CCP (comprehensive care plan) revised on 12/23/15 documented the the resident with care issues: "The resident has an ADL self-care performance deficit r/t Disease process (Parkinson's)....." The interventions included : "Personal hygiene/oral care: provide set-up and assist with oral/dental care and hygiene needs...." On 2/10/16 at 1:30 PM the resident was observed	F 312	to the care plan. New build up utensils have been ordered on 2/17/16. Staff recieved inservice training on ADL care and assistance with tray set up as needed. Unit Manager/designee will monitor nail care and feeding assistance at least 5 times per week on daily rounds that will occur at least at one meal time per day for 6 weeks then 3 weeks then random checks on rounds. Any non-compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action. Date of compliance is March 15, 2016.	

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while eating lunch in her room. The resident's finger nails were observed to be long, chipped and ragged. The resident's finger nails had evidence of polish in areas that had been chipped away in areas and needed repairing. The resident also had very dark debris under her nails.

The resident looked at her nails and told the surveyor "they needed some work." She said she didn't have nail trimmers--but the staff would cut them for her.

LPN (licensed practical nurse) I was asked to look at the resident's nails. She stated, "They need a little trimming--we'll get them cut." LPN I acknowledged the resident's nails also needed to be cleaned as she tended to accumulate fecal matter under her nails.

On 2/10/16 at 4:30 PM the facility administrator and DON were informed of the surveyor's findings. No additional evidence was presented prior to the survey team exit.

2. Facility staff failed to provide adequate dining tray set-up for Resident #3. The resident clinical record was reviewed on 2/9/16 at 9:45 AM.

Resident #3 was admitted to the facility on 10/22/08. The diagnoses included: Parkinson's, Alzheimer's. Schizophrenia, chronic obstructive pulmonary disorder hypertension and diabetes.

The MDS assessment dated 1/8/16 coded the resident with some cognitive impairment. The resident required assistance with all the ADLs--but set-up and oversite, only, to eat.

Resident #3's CCP, revised 1/13/16, documented

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the resident with a continuing potential for nutrition problem r/t medical diagnoses. The interventions included : "Provide, serve diet as ordered. Monitor Intake and record....Reinforce and encourage adequate meal consumption."

On 2/9/16 at 8:35 AM the resident was observed to be eating her breakfast, unassisted, in her room. The resident's meal tray was not set-up for the resident to select all foods at will. The grits still had a lid on them. The condiments (butter, pepper, salt, and artificial sweetener packets) lay unopened on the resident's tray.

The resident was asked about her breakfast (grits) and she told the surveyor she wasn't sure if she liked them--she didn't think she'd ever had any before. When the resident was asked if she wanted her pepper or butter opened and in her food the resident seemed confused and said she did not know. She demonstrated she could not get the lid off the bowl of grits.

The resident was also confused by one of the meal selections (Sausage STRATA) and indicated she could not cut it up appropriately to eat it. The strata/casserole was still in one big square and had not been cut into bite-size pieces the resident could consume.

RN (registered nurse) I was called into the resident's room and asked about the tray set-up, and in particular the unopened grits. RN I said the protocol was to set up every item on the tray so the residents could select whatever they wished to eat from the items offered. RN I said if the resident did not like grits an alternative should have been provided.

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RN I cut the strata into bite sized morsels and then called CNA I (certified nursing assistant I) into the room to ask her about Resident #3's food preferences. CNA I stated, "She doesn't eat them (grits)."

When the surveyor asked CNA I if she had offered the resident an alternative selection--the CNA said the resident would eat them "sometime." CNA I told the surveyor the resident liked butter and sweetener in her grits and proceeded to remove the lid and prepare the grits with butter and artificial sweetener.

The resident tried the grits and said that was just the way she liked them. She proceeded to eat more of the grits while the surveyor stood by and observed. The resident also consumed a portion of the strata after it had been cut up for her.

The CNA said the resident had eaten grits before and stated, "She gets confused sometime. She told me earlier she didn't want the grits."

On 2/9/16 at 4:00 PM the facility ADON (assistant director of nursing) provided the surveyor with the facility policy/guidelines on tray set-up governing the CNAs meal service. The policy stated, "Remove food covers. Open cartons, cut food into bite sized pieces, butter bread and son, as needed. Season food as the person prefers and is allowed on the care plan."

The ADON was asked if the CNA's were trained to follow the facility policy. The ADON said the CNAs were to assist a resident as needed and set-up the tray if the resident was unable to do it. The ADON stated, "Of course the goal is to encourage the resident to do what they can for

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themselves."

The ADON said Resident #3 experienced varying levels of confusion due to her Alzheimer's diagnosis. She said this would necessitate varying levels of assistance by the CNAs.

On 2/10/16 at 4:30 PM the facility administrator and DON were informed of the surveyor's findings. No additional evidence was presented prior to the survey team exit.

3. Facility staff failed to assist Resident #26 with care planned "build-up utensils" to improve her grip on her fork and spoon used while dining. The resident's clinical record was reviewed at 2:00 PM.

Resident #26 was admitted to the facility on 12/26/06. The diagnoses included: Osteoarthritis, muscle weakness and diabetes.

The MDS assessment, dated 1/30/16, coded the resident with moderately impaired cognitive skills. The ADLs required a one-person assist with set-up/oversite only to eat her meals.

The CCP, revised on 2/9/16, documented the resident had a potential for nutrition problems r/t a weight loss trend over the past year. The interventions included "Adaptive feeding equipment (identified as build-up utensils."

On 2/10/16 at 1:30 PM the resident was observed eating her lunch meal in her room. The resident was eating unassisted.

The card on the resident's meal tray contained the instructions for the use of "Build-up utensils."

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F 312	Continued From page 13 Resident #26 was observed to be using an ordinary metal spoon and fork to eat. Two brown, rubberized cylindrical devices with holes through the center were observed on the resident's tray. The resident was asked if she could get the devices on her fork and spoon. She told the surveyor she could not and held up her hand and stated, "I have arthritis." The resident's hands were observed to have enlarged joints in the fingers which the resident pointed out and described as "painful." LPN I was asked to come into Resident #26's room and asked about the "build-up utensils." LPN I said the staff should have placed the build-up utensils on the resident's silverware for her and proceeded to slide the rubberized sleeves onto the fork and spoon. "We use these for her to help her eat because she has some arthritis and weakness in her hands. These help with her grip." On 2/10/16 at 4:30 PM the facility administrator and DON were informed of the surveyor's findings. No additional evidence was presented prior to the survey team exit.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315	**Resident #22 is no longer in the facility.** **Current residents with indwelling catheters were assessed to assure catheters are approptiate and orders are in place.** **Staff were educated by SDC on following MD orders for when to insert foley catheters.** **Unit Manager/designee will monitor on rounds that catheters are in place as**	

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F 315	Continued From page 14	F 315	ordered and new residents with catheters will be assessed for need and removed as indicated. Any non-compliance will be reported to QA committee or tracking and trending and progressive disciplinary action. Date of compliance is March 15, 2016.	

infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow physician orders regarding an indwelling foley catheter for 1 of 26 Residents, Resident #22.

The findings included.

The facility staff failed to reinsert an indwelling foley catheter when the Resident had not voided for 6 hours.

Resident #22 was admitted to the facility 12/18/15. Diagnoses included, but were not limited to, Alzheimer's disease, urinary retention, dysphagia, hypertension, GERD (gastroesophageal reflux disease), and diabetes. The Resident had been discharged from the facility during the time of the survey.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/25/15 had a summary score of 5 out of a possible 15 points. Section E (behavior) was coded to indicate the Resident did not have any behaviors in the look back period. Section H (bladder and bowel) was coded to indicate the Resident had an indwelling foley catheter and that the Resident was incontinent of bladder (the foley catheter had become dislodged during the look back period).

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The Residents clinical record included the following nursing entry dated 12/24/15 at 11:53 p.m. "Resident was sitting up on edge of bed. Checked and resident had pulled foley cath out. Spoke with on-call physician. New order; Monitor resident for urinary output. If resident does not void after 6 hours, may reinsert foley cath. Son in room and advised." This note had been documented by LPN (licensed practical nurse) #3.

A review of the Residents clinical record indicated that this order had been transcribed to read "Foley Cath: monitor resident for urinary output. If resident is unable to void after 6 hours, may reinsert foley cath, every shift."

With the assistance of RN (registered nurse) #2 it was determined that Resident #22 had not voided from the time the indwelling foley catheter was dislodged on 12/24/15 on the evening shift (3 p.m.-11 p.m.) shift until 12/25/15 on the night shift (11 p.m.-7 a.m.). This would have been at least 24 hours.

Per the clinical record the foley catheter was not reinserted until 12/29/15 by LPN #4.

On 12/29/15 at approximately 3:00 p.m. LPN #4 documented the following "Rsd alert with confusion noted. Pleasant and cooperative with staff at the time...Rsd. c/o (complains of) abdominal pain, upon assessment, noted rsd's abdomen was distended, reinserted foley catheter...Rsd tolerated well. UA (urinalysis) and stool sample collected. Son in with resident, made aware..."

Prior to this entry there was no documentation to

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indicate the Resident was under any distress. The facility staff had documented that the Resident had voided on 12/26, 12/27, 12/28, and 12/29/15.

On 02/09/16 at approximately 2:38 p.m. the surveyor interviewed LPN #4. LPN #4 verbalized to the surveyor that on 12/29/15 after she had checked the Resident she had called the on call doctor and reinserted the foley catheter. LPN #4 stated she obtained a lot of urine within the first 30 minutes "Maybe 800 cc maybe more." LPN #4 stated the Resident's bladder was distended and she was confused and combative but this was not unusual for the Resident.

On 02/09/16 at approximately 3:35 p.m. the surveyor interviewed LPN #3. LPN #3 verbalized to the surveyor that on 12/24/15 Resident #22's foley catheter had become dislodged near the end of the shift (evening shift). LPN #3 stated that they had called the physician and the physician had stated to try the Resident without the foley catheter but to watch her and make sure she voided. LPN #3 stated they had passed this along to the oncoming shift.

During an interview with LPN #5 on 02/10/16 at approximately 6:08 a.m. LPN #5 verbalized to the surveyor that she really didn't remember the Resident and didn't remember anything about the foley catheter coming out.

On 02/10/16 at approximately 8:55 a.m. during an interview with CNA (certified nursing assistant) #1. CNA #1 verbalized to the surveyor that the Resident did not void a lot and that they could remember the Resident voiding a lot once and the other times it was small amounts. CNA #1

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stated there were no changes in the Residents behavior during the timeframe the foley catheter was out.

On 02/10/16 at approximately 9:00 a.m., during an interview with CNA #2, CNA #2 verbalized to the surveyor that from their knowledge they did not recall the Resident voiding a lot and that the Resident would say she had to go but when they took her to the bathroom she wouldn't go. When asked about any behaviors. CNA #2 stated the Residents behaviors were consistent, never really changing. CNA #2 stated she had reported to LPN #6 and RN (registered nurse) #1 that the Resident was not voiding much.

On 02/10/16 at approximately 9:05 a.m., during an interview with LPN #6, LPN #6 verbalized to the surveyor that the Resident did not drink a lot and she did not appear to be in any pain or distress.

On 02/10/16 at approximately 10:40 a.m., during an interview with RN #1, RN #1 verbalized to the surveyor that she vaguely remembered the Resident and was not aware the Resident was not voiding. RN #1 stated the family visited often and never expressed any concerns to her.

Resident #22 had a consult with the urologist on 01/06/16 due to retention of urine and UTI's (urinary tract infections). During this consultation a foreign body was found in Resident #22's vaginal area. On 01/07/16 Resident #22 was seen by an OB/GYN this foreign body was identified as a pessary (device that fits into the vagina and provides support to vaginal tissues displaced by pelvic organ prolapse). The pessary was removed on 01/12/16 during a surgical

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F 315	Continued From page 18 procedure. Prior to the exit conference the DON (director of nursing) was notified by the surveyor that the facility staff failed to follow the physicians orders and reinsert the Residents indwelling foley catheter after the Resident had not voided for 6 hours. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 315		
F 323 SS=D	THIS IS A COMPLAINT DEFICIENCY. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based upon observation and staff interview, the facility staff failed to provide a safe and hazard free environment on 1 of 2 units in the facility. (Unit 1-Soiled Utility Room) The findings included: During the initial tour of the facility on 2/8/16 at 2:30 pm, the surveyor noted that the door to the Soiled Utility Room was unlocked and to the left side of that door was a cabinet that had a lock on it but was unlocked at the time of this	F 323	Door was locked at the time of the survey and also storage cabinet. New combination lock was ordered by the maintenance director and will be put in place as soon as received. Staff will be in serviced on the need for door to remain locked and the correct way to store chemicals and hazardous materials. Maintenance Director will monitor laundry room at least 5 times a week to assure door remains locked. Any non-compliance will be reported to QA committee for tracking and trending and progressive disciplinary action. Date of compliance is March 15, 2016.	

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observation. This soiled utility room was located off the main hallway on Unit 1 in the facility. The cabinet contained 4 shelves in which the following cleaning supplies were kept: Purell Instant Hand Sanitizer 30 containers, Foaming Antimicrobial Hand Wash 27 containers, Zena Spot Direct Carpet Spray 9 cans, Eliminator Carpet Spot and Stain Remover 5 cans, Reliable Odor Counteract ant Lemon Scent 29 containers, Clorox concentrated liquid 3 (3.57 Liters) containers and Total Performance Lemon Green detergent/disinfectant 1 one gallon container.
On 2/9/16 at 9:45 am, the surveyor noted that the soiled utility room as described above was found to be unlocked with the cabinet of cleaning supplies to be left unsecured. Housekeeping staff #1 was interviewed by the surveyor at this time. Housekeeping staff #1 stated, "We come and go out to the halls and get laundry. No one has to be in here all the time" .
Again, on 2/9/16 at 2:15 pm and 2/10 16 at 7:10 am, the soiled utility room, directly off the main hallway on Unit 1 was unlocked and the cabinet with cleaning supplies as described above remained unlocked as well.
The surveyor on the survey team that was assigned the task of Environmental Rounds was notified of each of these observations as they were made by this surveyor.
On 2/10/16 at 3:40 pm in the conference room, the corporate nurse and director of nursing was notified of the above documented observations as described above. The corporate nurse stated, "There has been a push button lock ordered for that door and it will be here in the morning to be put on" .
No further information was provided to the surveyor prior to the exit conference on 2/10/16.

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F 425 SS=D	Continued From page 20	F 425	Vial of insulin was removed from medication room. Audit was done of all current resident recieving insulin to assure that all vials were dated when open and if not were discarded. Staff were inserviced by the SDC on dating of open vials of solutions. Unit managers/designee will monitor medication rooms and medication carts weekly to assure that all open vials are dated appropriately. Any non-compliance will be reported to QA committee for tracking and trending and progressive disciplinary action. Date of compliance is March 15, 2015.	

F 425 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to date an opened bottle of insulin stored in the medication refrigerator on 1 of 2 units in the facility. (Unit #1)
The findings included:
During initial tour of the facility on 2/8/16 at 2:45 pm, the surveyor noted that an opened bottle of Lantis 100 units/ml (milliliter) with a resident's name on it was in the refrigerator in the medication room located on Unit 1 of the facility. On the bottle of insulin was a pharmacy label that

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F 425	Continued From page 21 instructed staff to "discard 28 days after opening". The assistant director of nursing (ADON) was with the surveyor at the time that this observation was made. The ADON stated, "The staff is to label the bottle when they open it". On 2/8/16 at 3:45 pm, the ADON brought the policy titled 'Storage and Expiration of Medications, ... " to the surveyor in the conference room. Under Section 5 the policy stated " ...Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened ... " On 2/9/16, at the end of the day conference with the survey team, the corporate nurse and director of nursing was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 2/10/16.	F 425		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered lab for 1 of 26 Residents, Resident #13. The findings included. The facility staff failed to obtain the lab test CBC (complete blood count) as ordered.	F 502	Resident #13 MD was notified of missing lab at time of survey. Current resident's labs will be audited for the last 30 days to assure that labs obtained in this time period had results for all labs and orders for labs obtained. Nursing staff will be inserviced by SDC on the lab tracking policy and when to notify MD. Unit manager/designee will review order report daily at least 5 times per week to assure that all labs ordered were obtained. Any non-compliance will be reported to QA committee for tracking and trending and progressive disciplinary action.	

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F 502	Continued From page 22	F 502	Date of compliance is March 15, 2016.	

Resident #13 was admitted to the facility 05/13/15 and had been readmitted on 12/28/15. Diagnoses included, but were not limited to hypertension, hypothyroidism, depressive disorder, anxiety, and dysphagia.

Section C (cognitive patterns) of the Residents readmission MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/04/16 was coded 14 out of a possible 15 points.

The Residents clinical record included an order for the lab test CBC. This order was dated 12/31/15.

During the clinical record review the surveyor was unable to locate the results for this CBC.

On 02/10/16 the facility staff provided the surveyor with a copy of a nursing entry dated 02/09/16 at 10:39 a.m. that read "_____ (name omitted) nurse practitioner made aware of CBC that was missed on 12/31 and that it was drawn on 1/6. No new orders at this time."

During a meeting with the survey team on 02/10/16 at approximately 3:40 p.m. the DON (director of nursing) and nurse consultant were notified of the above.

No further information regarding the CBC was provided to the survey team prior to the exit conference.

F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN	F 504	Resident #8 and 12 MD was notified of labs not being obtained as ordered. Current residents will have orders audited for the last 30 days to assure that labs ordered are obtained.

The facility must provide or obtain laboratory

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F 504	Continued From page 23	F 504	Nursing staff will be inserviced by SDC on the tracking policy and when to notify MD. Unit Manager/designee will review orders report daily at least 5 times per week to assure that all labs ordered are obtained. Any non-compliance will be reported to QA committee for tracking and trending and progressive disciplinary action. Date of compliance is March 15, 2015.	

services only when ordered by the attending physician.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to obtain a physician's order prior to obtaining a laboratory test for 2 of 26 Residents, Residents #8 and #5.

The findings included:

1. For Resident #8, the facility staff obtained a urinalysis and urine culture without a physician's order.

Resident #8 was admitted to the facility on 10/25/12 and readmitted on 05/02/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, urinary tract infection, diabetes mellitus, hyperlipidemia, dementia, anxiety, chronic kidney disease, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/05/15 coded the Resident as a 10 out of 15 in Section C, cognitive patterns.

Resident #8's clinical record was reviewed on 02/09/16. It contained laboratory results for urinalysis and urine culture dated 04/19/15. The surveyor could not locate a physician's order for these laboratory tests.

The DON (director of nursing) and nurse consultant were notified of the missing physician's orders on 02/09/16 at approximately 1600.

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The DON provided the surveyor with a nurse's note on 02/10/16, dated 04/19/15 which read in part "Resident c/o (complains of) burning when urinating, urine dipped and noted with 3+ leucocytes, nitrates, and blood. n.o. (new order) urine collected and sent to ....(name omitted) form (sic) processing. awaiting results. ....".

No order for the urinalysis was provided prior to exit.

2. The facility staff failed to obtain a physician order for a laboratory testing (Phenobarb level) drawn on Resident #12.

Resident #12 was admitted to the facility on 8/27/08 and readmitted on 3/12/12. The resident had the following diagnoses of, but not limited to, high blood pressure, dementia, anxiety, seizure disorder, depression, stroke, muscle weakness and difficulty in walking. A quarterly MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/4/16 coded Resident #12 as having a BIMS (Brief Interview for Mental Status) score of 13 out of a total score of 15. The resident was also coded as needing extensive assistance by 1 staff member for dressing, personal hygiene and total dependence for bathing.

During the clinical record review on 2/9/16, the surveyor noted that a physician order dated for 7/21/2015 had been entered in the computer system of the clinical record that stated to "discontinue" the "Phenobarb due Q (every) 6 MO (months) Dec" . There was a lab result in the clinical record dated for 12/22/15 for a "Phenobarbital" level which had a result of "<2.4" which was low according to the laboratory reference range for this medication that listed "15.0 - 40.0" to be within normal limits.

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F 504	Continued From page 25 Underneath the lab result was the following handwritten note on the result sheet: "No longer on Phenobarb, do you want to D/C (discontinue) Phenobarb level q (every) 6 months?" On 2/10/16 at approximately 3:40 pm, the corporate nurse and director of nursing were notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 2/10/16.	F 504		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based upon staff interview, facility document review and clinical record review, the facility staff failed to report abnormal laboratory results to the physician for 1 of 26 residents in the survey sample. (Resident #11) The findings included: Resident #11 was admitted to the facility on 1/13/16 with the following diagnoses of, but not limited to pneumonia, arthritis, high blood pressure, anxiety, convulsions, Multiple Sclerosis and Acute Respiratory Failure. On the MDS (Minimum Data Set, an assessment protocol) dated with an ARD (Assessment Reference Date) of 1/26/16, Resident #11 was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. The resident also coded as requiring extensive assistance from 2 or more staff members for dressing, personal hygiene and bathing. During the clinical record review of Resident #11's	F 505	Resident #11 MD was notified of lab results at the time of survey. Current residents will have audit of labs for the last 30 days to assure that MD was notified of lab results. Nursing staff will be inserviced by SDC on the lab tracking policy and when to notify MD. Unit Managers/Designee will review lab results daily at least 5 times per week to assure that MD was notified of lab results per policy. Any non compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action. Date of compliance is March 15, 2015.	

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clinical record on 2/10/16, it was noted that on 1/22/16, a Comprehensive Metabolic Profile was obtained from the resident and the blood was sent to a laboratory to obtain lab results. The following lab results were noted to be abnormal per laboratory reference ranges for Resident #11 on 1/22/16:

"Glucose H (high) 101 Reference Range for this test was 70-99 mg/dl (milligram per deciliter) ...and Total Protein L (low) 5.6 Reference Range for this test was 6.0-8.7 g/dl (grams per deciliter)".

On 2/10/16 at approximately 3:40 pm in the conference room, the corporate nurse and director of nursing were notified of the above documented findings in Resident #11's clinical record. The surveyor asked what the process was in the facility for notifying the physician of abnormal lab results. The director of nursing stated, "There is a Lab Tracking Log that the nurses are to fill out each time a physician is called and notified of abnormal lab results". The surveyor asked the director of nursing if there was documentation of this occurring when the nurse received abnormal lab results on Resident #11 from the lab performing the lab test. The director of nursing stated she would go and see if the resident's name, date and name of abnormal lab results were called to the physician. The surveyor also requested the policy on notifying the physician of abnormal lab results. The director of nursing returned to the conference room at approximately 4:20 pm with copies of the "Lab Tracking Form" and the policy as requested earlier by the surveyor. The "Lab Tracking Form" was dated for 1/22/16 with the resident's name and name of lab test that was performed on this date. The CMP (Comprehensive Metabolic Profile) was listed for 1/22/16 for this resident but

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F 505	Continued From page 27 the rest of the line remained blank under the columns of the following: Date results received, date MD (medical doctor) notified, how MD was notified, Nurse's notes entry, Nurse's initials and comments. The policy titled "Laboratory Tracking" was also given to the surveyor. Under the section of "Lab Orders" in the policy the following was noted: " ...7. Upon receipt of lab results, a licensed nurse will document the date the results were received on the appropriate Lab Tracking form. 8. A licensed nurse will then notify the physician as soon as possible of any abnormal lab result ... 9. Once the physician has been notified of lab results, the nurse will document the date of notification and the method of notification in the appropriate space(s) on the appropriate Lab Tracking Log and place his/her initials in the nurse initial column on the form ... " The surveyor went back into the clinical record in the computer at the facility on 2/10/16. There was no documentation in the nurses' notes found that stated these abnormal lab results were called and/or faxed to the physician. No further information was provided to the surveyor prior to the exit conference on 2/10/16.	F 505		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514	Resident #22 is no longer in the facility. Resident #12 progress note obtained from MD. Current residents were audited by Medical Records Director to assure MD notes and visits had occured per regulation for last 90 days. Medical Records Director was inserviced by Nurse Consultant on requirements for obtaining MD	

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information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to maintain a complete and accurate clinical record for 4 of 26 Residents, Residents #22, #12, #17, and #20.

The findings included.

1. For Resident #22, the facility staff had documented that they had provided foley catheter care, when in the fact the foley catheter had been removed on the previous shift. The facility staff also documented on 12/27/15 that the Resident's continence status was not rated due to an indwelling catheter when in fact the catheter had been out since 12/24/15.

Resident #22 was admitted to the facility 12/18/15. Diagnoses included, but were not limited to, Alzheimer's disease, urinary retention, dysphagia, hypertension, GERD (gastroesophageal reflux disease), and diabetes. The Resident had been discharged from the facility during the time of the survey.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/25/15 had a summary score of 5 out of a possible 15 points. Section H (bladder and bowel)

F 514 progress notes and what to do when not obtained.
Residents #17 and 20 on fluid restrictions had orders clarified and set up in the computer for proper documentation.
Current residents with catheters were audited to assure that catheter care orders were appropriate.
Current residents with fluid restriction orders were verified with the MD for need of this order and was set up in the system for proper tracking and monitoring.
Nursing staff were inserviced by the SDC on how to correct documentation in the medical record when errors are documented, and the policy on fluid restriction and how to set this up for correct documentation by March 12, 2016.
Unit manager/Designee will monitor catheter care documentation on a daily basis at least 5 times per week to assure appropriately.
Medical Records Director will monitor MD visits and progress notes by using MD visit tracking log weekly.
Unit Manager/Designee will monitor MAR documentation to assure fluid restriction documented is appropriate weekly.
Any non-compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed.
Date of compliance is March 15, 2016.

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was coded to indicate the Resident had an indwelling foley catheter.

The Residents clinical record included the following nursing entry dated 12/24/15 at 11:53 p.m. "Resident was sitting up on edge of bed. Checked and resident had pulled foley cath out. Spoke with on-call physician. New order; Monitor resident for urinary output. If resident does not void after 6 hours, may reinsert foley cath. Son in room and advised."

Per the clinical record the foley catheter was not reinserted until 12/29/15 by LPN #4.

A review of the Residents eTAR (electronic treatment administration record) indicated that LPN #5 had initialed the block beside the foley catheter on 12/24/15 on the night shift and had also initialed the block beside the order that read "Foley care q (every) shift."

During an interview with LPN #5 on 02/10/16 at approximately 6:08 a.m. LPN #5 verbalized to the surveyor that she really didn't remember the Resident and didn't remember anything about the foley catheter coming out.

A review of Resident #22's bowel/bladder elimination record indicated that on 12/27/15 at 13:15 (1:15 p.m.) the facility staff had documented "Continence Not Rated due to Indwelling Catheter." The documentation before and after this entry indicated the Resident was incontinent.

During a meeting with the survey team on 02/10/16 at approximately 3:40 p.m. the DON (director of nursing) and nurse consultant were

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notified of the inaccurate clinical record.

No further information regarding this issue was provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.
2. The facility failed to maintain physician progress notes in the clinical record for Resident # 12.
Resident #12 was admitted to the facility on 8/27/08 and readmitted on 3/12/12. The resident had the following diagnoses of, but not limited to, high blood pressure, dementia, anxiety, seizure disorder, depression, stroke, muscle weakness and difficulty in walking. A quarterly MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/4/16 coded Resident #12 as having a BIMS (Brief Interview for Mental Status) score of 13 out of a total score of 15. The resident was also coded as needing extensive assistance by 1 staff member for dressing, personal hygiene and total dependence for bathing.
During review of the clinical record on 2/9/16, the surveyor noted the following documentation written by the physician in the progress notes for the dates of 6/8/15, 7/20/15, 9/19/15 and 11/29/15 " ... note by phone ... " and signed by the physician. A progress note dated 9/19/15 was in the clinical record. The progress notes dated for 6/8/15, 7/20/15 and 11/29/15 were not in the clinical record and were not scanned into the electronic medical record for Resident #12.
At 3 pm on 2/9/16, the assistant director of nursing (ADON) was notified of the above documented findings in the clinical record of Resident #12. At 3:30 pm in the conference room, the ADON brought the surveyor copies of

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progress notes dated 6/8/15 and 11/29/15. The ADON stated "these came from the doctor's office and the doctor is out of town ...We cannot find the other one".
At 4:15 pm on 2/9/16, the corporate nurse and director of nursing were notified of the above documented findings.
No further information was provided to the surveyor prior to the exit conference on 2/10/16.
3. The facility staff failed to document fluid restrictions on Resident #17.
Resident #17 was admitted to the facility on 1/11/16 with the following diagnoses of, but not limited to, anemia, high blood pressure, diabetes, edema, retention of urine, low sodium levels, difficulty in walking and history of falls. The MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/25/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a total score of 15. Resident #17 was also coded as requiring the extensive assistance of 2 or more staff members for dressing, personal hygiene and bathing.
During the review of Resident #17's clinical record review performed by the surveyor on 2/10/16 at 11:30 am, it was noted that the resident had been discharged from the hospital and was admitted to the facility on 1/11/16 at approximately 4 pm. The following physician order was noted when the resident was admitted to the facility:
"1500 ml (milliliter)/day FLUID RESTRICTIONS every shift: 900 ml/DAY SHIFT, 500 ml/EVENING SHIFT and 100 ml/NIGHT SHIFT".
Upon further review of Resident #17's clinical record, from evening shift on 1/11/16 to evening shift on 1/15/16, there was no intake documented on the resident. Then on 1/20/16, 1/24/16, 2/5/16,

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2/8/16 and 2/9/16 on night shift there were no intake amounts documented for Resident #17.
On 2/10/16 at 12:30 pm, Licensed Practical Nurse (LPN) #2 was interviewed by the surveyor on Unit 2 at the Nurses' Station. LPN #2 was asked what the process was for if you had a resident on fluid restrictions. LPN #2 stated, "The nurse gets the order, puts it in the computer than the nurse alerts the staff that has that resident that they are on fluid restrictions and how much they are to get for that shift. Then the nurses are responsible for documenting how much fluid they received on their shift".
On 2/10/16 at approximately 3:40 pm, the surveyor notified the corporate nurse and director of nursing of the above documented findings in Resident #17's clinical record.
No further information was given to the surveyor prior to the exit conference on 2/10/16.

4. The facility staff failed to document fluid restrictions on Resident #20.
Resident #20 was originally admitted to the facility on 11/25/10 and then readmitted back to the facility on 2/6/16 with the following diagnoses of, but not limited to respiratory distress, congestive heart failure, diabetes, stroke, arthritis, high blood pressure and anxiety. The most recent MDS (Minimum Data Set, an assessment protocol) for Resident #20 was a MDS with an ARD (Assessment Reference Date) of 12/18/15. This MDS coded Resident #20 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. Resident #20 was also coded as needing extensive assistance by 2 staff members for bathing and dressing. The resident was also coded as being occasionally incontinent of bowel and bladder function.
During the review of Resident #20's clinical

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record review performed by the surveyor on 2/10/16 at 1:30 pm, it was noted that the resident returned to the facility on 2/6/16 at approximately 330 pm. The resident had been admitted to the hospital was discharged back to the facility with the following physician order:

"1500ml (milliliter)/day FLUID RESTRICTIONS every shift for CHF (congestive heart failure) 800ml/DAY SHIFT 500ml/EVENING SHIFT and 200ml/NIGHT SHIFT" .

Upon further review of Resident #20's TAR (Treatment Administration Record) for the month of February, 2016, it was noted that on 2/6/16 for evening shift there were an "x" in the column under 'ml" and "evening" . On 2/6/16 for night and 2/7/16 day, evening and night shift, there was an "x" under "ml" with initials under the columns for the day, evening and night shift. It was also noted that on 2/8/16 and 2/9/16 under the column "ml" there were documented amounts with initials under these amounts for each day, evening and night shift columns for these dates.

On 2/10/16 at 1:55 pm, the unit manager for Unit 1 was interviewed and notified of the above documented findings. She stated that the nurses were responsible for keeping the intake on residents that were on fluid restrictions. The surveyor showed the unit manager of the amounts documented for each shift and she stated, "I didn't know we could do that on the computer. I thought we had to go in another way to get it to let us document the ml " .

The corporate nurse and director of nursing were notified of the above documented findings on 2/10/16 at 2:45 pm.

No further information was provided to the surveyor prior to the exit conference on 2/10/16.

Administrator
3/2/16