STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 01/31/17 through 02/02/17. 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 137 certified bed facility was 122 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 6 closed record reviews (Residents #22 through #27).	F 000	**This plan of correction constitutes our Credible Allegation of Compliance. preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws.**	
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 155	**F 155 483.10 (c)(6)(8)(g)(12) 483.24(a)(3) RIGHT TO REGUSE, FORMULATE ADVANCE DIRECTIVES** Criteria One: Resident #18 has had advanced directives addressed and completed per resident and family current wishes. Criteria Two: Residents with advanced directives will have documentation reviewed for accuracy. Criteria Three: Education regarding the completion of DNR forms will be completed with staff. Audits of random sample of advanced directives will be completed by Social Services Director or designee to assess accuracy of current documentation. A comprehensive audit will be conducted with active residents, then new admissions for 30 days.	

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

Executive Director 2/17/2017

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

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F 155	Continued From page 1	F 155	Criteria Four: Results of Audits and Educational Feedback will be assessed by the facility Quality Assurance Committee. The need for additional education and further review or intervention will be determined as needed. Criteria Five: February 24, 2017	

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

483.24
(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 1 out of 27 Resident's (Resident #18).

The findings included:

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For Resident #18, the facility failed to accurately complete a DDNR (durable do not resuscitate) order form.

Resident #18 was admitted to the facility on 1/21/17. Diagnoses included but were not limited to: edema, muscle weakness, thyroid disorder, gastroesophageal reflux disease, and depression.

A review of Resident #18's MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/28/17, scored the resident to be an 11 in section C for his cognitive pattern.

The clinical record included a DDNR form dated 1/21/17. This form had been signed by the physician and the Resident's responsible party.

This DDNR read in part, "I further certify [must check 1 or 2]:
1. "The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required).
2. "The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision."
Neither box 1 or 2 had been checked to indicate if the resident was capable or incapable to make an informed decision about the DDNR.
Section 2 of the DDNR stated, "If you checked 2 above, check A, B, or C below." The A, B, and C

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F 155	Continued From page 3 boxes had been left blank. The form was incomplete. On 2/2/17, at approximately 9:15 p.m., the RN #3 was shown the DDNR and asked if she could identify what was wrong with the DDNR. She stated, "It's not filled in." On 2/22/17 at approximately 11:05 p.m., a meeting was held with the director of nurses and administrator. The incomplete DDNR was discussed during this meeting. They both agreed it was not complete. Prior to exit no further information was provided related to the incomplete DDNR.	F 155		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 157	**F-157 483.10 (g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** Criteria One: Omission of notification was discussed with Resident #1's provider. Criteria Two: Residents that have recorded FSBS results of "HIGH" will be reviewed to ensure provider notification has been completed. Omitted notifications will be completed upon identification if necessary. Criteria Three: Education of staff regarding notification requirements of "HIGH" FSBS will be completed with staff. Audits of FSBS records will be completed to ensure notification has been completed per regulation 5x/week for 30days. Corrections will be made at time of discovery if necessary.	

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F 157	Continued From page 4 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to notify the physician when blood sugars were "HIGH" for 2 of 27 residents (Resident #1 and Resident #5). The findings included: 1. The facility staff failed to inform the physician when Resident #1's blood sugars were recorded	F 157	Criteria Four: Results of Education and audits will be presented to the facility Quality Assurance Committee for review and further intervention if deemed necessary, as well as the determination of continued monitoring. Criteria Five: February 24, 2017	

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as "High.".

The clinical record of Resident #1 was reviewed 1/31/17 and 2/1/17. Resident #1 was admitted to the facility 8/13/16 with diagnoses that included but not limited to major depressive disorder, anxiety, altered mental status, abnormal weight loss, heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension, gout, dorsalgia, and pain.

Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/7/16 assessed the resident with a cognitive summary score of 9 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors.

The current comprehensive care plan dated 8/22/16 identified a problem of diabetes with approaches to care that included accuchecks as ordered and alert MD (medical doctor) to any significant changes.

The December 2016 physician order sheet (POS) and the January 2017 physician order sheet were reviewed. Each POS had the following order that read "Accuchecks twice daily 630A, 430P and Notify MD if blood sugar < (less than) 60 or > (greater than) 400."

The surveyor reviewed the December 2016 electronic insulin medication administration record (eINSMAR). The blood sugar result for 12/26/16 at 4:30 p.m. and 12/30/16 at 4:30 p.m. read "HIGH." The paper diabetic monitoring record was reviewed. There were no documented recordings for either 12/26/16 or 12/30/16 at 4:30 p.m.

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The surveyor reviewed the user manual for the "Assure Prism Blood Glucose Monitoring System" on 2/1/17. The manual read "HI Message The meter displays results between 20-600 mg/dL (milligrams per deciliter). "HI" appears when the blood glucose level is greater than 600mg/dL and indicates severe hyperglycemia (much higher than normal glucose levels). If "HI" is displayed again upon retesting, please contact the patient's healthcare provider immediately."

The surveyor interviewed the unit manager licensed practical nurse #1 on 2/1/17 at 8:20 a.m. L.P.N. #1 stated the nurses weren't recording the actual result of the blood sugar in the box on the electronic medication record. L.P.N. #1 stated when the blood sugars were recorded, some nurses were just hitting the "HIGH" button. L.P.N. #1 stated for 12/26/16 and 12/30/16, the actual blood sugar was not known and based on the recording of "HIGH" and the physician order, the physician should have been notified. A review of the departmental notes for 12/26/16 and 12/30/16 confirmed that the physician had not been informed of the "HIGH" blood sugar results on 12/26/16 and 12/30/16.

The surveyor informed the administrator and the director of nursing of the above concern in the end of the day meeting on 2/1/17 at 1:25 p.m. and on 2/2/17 at 11:15 a.m. The surveyor requested a copy of the facility policy on physician notification and diabetic management.

The facility policy titled "Diabetes-Clinical Protocol" read in part under "Monitoring and Follow-Up 4. The physician will order desired parameters for monitoring and reporting

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information related to diabetes or blood sugar management."

No further information was provided prior to the exit conference on 2/2/17.
2. For Resident #5, the facility staff failed to notify the physician of a blood sugar (BS) reading of high.

The record review revealed that Resident #5 had been admitted to the facility 04/27/12. Diagnoses included, but were not limited to, diabetes, congestive heart failure, dementia with behavioral disturbances, and anxiety disorder.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/22/16 included a BIMS (brief interview for mental status) summary score of 1 out of a possible 15 points. Section I (active diagnoses) included the diagnosis of diabetes.

The Residents current physician signed orders included the order "NOTIFY MD IF BLOODSUGAR LESS THAN 60 OR GREATER THAN 400."

A review of the eINSMAR (electronic insulin medication administration record) for 01/2017 revealed that on 01/08/17 at 4:30 p.m. the facility nursing staff documented that Resident #5's BS was "High."

On 01/31/17 LPN #1 (licensed practical nurse) and the surveyor reviewed the order and the BS reading. LPN #1 checked the handwritten diabetic flow sheet kept on the unit and was unable to locate an actual number reading for this Resident

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F 157	Continued From page 8 on 01/08/17 at 4:30 p.m. The facility nursing staff provided the surveyor with a copy of the instruction booklet for the glucometer used at the facility. Page 29 of this booklet read in part "HI Message-The meter displays results between 20-600 mg/dL (milligrams per deciliter)."HI" appears when the blood glucose (blood sugar) level is greater than 600 mg/DL and indicates severe hyperglycemia (much higher than normal glucose levels)..." The surveyor was unable to locate any documentation to indicate the physician had been notified of the Residents HI reading on 01/08/17. The Residents CCP (comprehensive care plan) included the problem area of diabetes. Approaches included, but were not limited to, accuchecks as ordered and alert MD (medical doctor) to any significant changes. The administrator and DON (director of nursing) were notified that the facility staff had failed to notify the physician of the Residents high BS reading during a meeting with the survey team on 02/01/17 at approximately 1:25 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 157	**F-241 483.10 (a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY** **Criteria One:** Staff member providing wound care for Resident #10 received education regarding the provision of privacy. **Criteria Two:** Observations of residents receiving wound care were completed prior to survey exit to ensure privacy was being provided. **Criteria Three:** Education of facility staff regarding provision of privacy during wound care will be completed. Privacy rounds will be conducted 3x week/30 day to ensure proper provision of privacy during care will be completed by DON or designee. Issues will be corrected at time of discovery. **Criteria Four:** Results of Education and Observations will be reviewed by facility Quality Assurance Committee for further intervention if deemed necessary as well as the need for continued monitoring. **Criteria Five:** February 24, 2017	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's	F 241		

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individuality. The facility must protect and promote the rights of the resident.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to provide privacy during a wound care observation for 1 of 27 residents (Resident #10).

The findings included:

The facility staff failed to provide privacy during a wound care observation done on Resident #10. L.P.N. #4 failed to close the door to Resident #10's room.

The surveyor reviewed Resident #10's clinical record on 1/31/17 and 2/1/17. Resident #10 was admitted to the facility 6/14/15 with diagnoses that included but not limited to anemia, Alzheimer's disease, depression, insomnia, chronic kidney disease, benign prostatic hypertrophy, fractured femur, hypertension, and Vitamin D deficiency.

Resident #10's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/14/16 assessed the resident with a cognitive summary score of 4 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors.

Resident #10's current comprehensive care plan dated 6/24/15 identified the resident had a potential for skin breakdown (episodes of bowel and bladder incontinence). Approaches included treatments as ordered. Resident #10 also had a care plan for memory recall deficits/dementia with onset date of 12/09/15. Approaches included reorient as needed and encourage self

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F 241	Continued From page 10 participation in all aspects of care. The clinical record contained a physician order dated 1/25/17 that read "Clarification: 1. Cleanse bilateral heels with wound cleanser apply skin prep every night (7P-7A). 2. Float heels while in bed as tolerated by resident." The surveyor observed wound care on 1/31/17 at 10:15 a.m. with licensed practical nurse #4. L.P.N. #4 pulled the curtain between Resident #10 and his roommate (roommate near window). L.P.N. #4 then began wound care while the resident was sitting in the wheelchair at the entrance to his room. The door remained opened during the entire wound care observation. Upon completion of the wound care observation, the surveyor asked L.P.N. #4 if she had provided privacy to Resident #10 during the wound care observation. L.P.N. #4 stated she should have closed the door and then stated "I forgot." The surveyor informed the administrator and the director of nursing of the above concern during an end of the day meeting on 2/2/17 at 11:15 a.m. No further information was provided prior to the exit conference on 2/2/17.	F 241		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 253		

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F 253	Continued From page 11 facility staff failed to maintain resident care equipment clean and sanitary in 1 of 5 shower rooms. A resident shower chair was observed dirty on the Middlebrook unit. The findings include: The facility staff failed to maintain resident care equipment in a clean and sanitary condition in 1 of 5 shower rooms. A resident shower chair was observed dirty in shower room #2 on the Middlebrook unit. The surveyor and maintenance director toured the facility on 2/2/17 beginning around 9:45 a.m. The surveyor and the maintenance director observed shower room #2 on the Middlebrook unit on 2/2/17 at 9:50 a.m. The surveyor looked at the bariatric shower chair. On the front right side of the chair was a red/brown substance. The maintenance director confirmed the presence of the substance but stated he had no idea what the substance might be. The surveyor located the unit manager licensed practical nurse #5 and the unit manager observed the dirty area on the bariatric shower chair. L.P.N. #5 stated "Looks like it's kinda dirty." The surveyor asked how often shower chairs were cleaned. L.P.N. #5 stated "Supposed to be cleaned after each shower. These are adults." The surveyor informed the administrator and the director of nursing of the failure of the facility staff to maintain clean resident care equipment after use on 2/2/17 at 11:15 a.m. No further information was provided prior to the exit conference on 2/2/17.	F 253	F-253 483.10 (i)(2) HOUSEKEEPING AND MAINTENANCE SERVICES Criteria One: The Shower chair in question was cleaned prior to survey exit, upon discovery. Criteria Two: The shower chairs within the facility was reviewed by the Director of Housekeeping prior to survey exit to ensure cleanliness. Criteria Three: Staff education was completed regarding the proper storage and cleanliness of resident care equipment. Equipment observations will be conducted by designated staff 5x/week for 3 weeks to ensure proper cleanliness of equipment. Criteria Four: Educational and Observation results will be presented to the facility Quality Assurance Committee for additional recommendation and intervention if deemed necessary. Criteria Five: February 24, 2017	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 12	F 278	F-278 483.20 (g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	

(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

(h) Coordination
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification
(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment

Criteria One:
Resident #5 MDS was corrected to reflect the weight loss instead of gain.

Criteria Two:
Residents with weight changes will have most recent MDS reviewed for weight accuracy.

Criteria Three:
Education with assessment team regarding accuracy of assessments will be completed. MDS will be reviewed weekly for 30 days to ensure weight accuracy.

Criteria Four:
Results of Education and review will be presented to facility Quality Assurance Committee for additional intervention as deemed necessary.

Criteria Five:
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for 1 of 27 Residents, Resident #5.

The findings included.

For Resident #5, the facility staff inaccurately coded the Resident as being a weight loss.

The record review revealed that Resident #5 had been admitted to the facility 04/27/12. Diagnoses included, but were not limited to, diabetes, congestive heart failure, dementia with behavioral disturbances, and anxiety disorder.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/22/16 included a BIMS (brief interview for mental status) summary score of 1 out of a possible 15 points. Section K (swallowing/nutritional status) included a documented height of 61 inches and a weight of 105 pounds.

Section K of the Residents quarterly MDS assessment with an ARD of 12/29/16 included a documented height of 61 inches and a weight of 158 pounds. This MDS was coded as a weight loss.

The last weight documented in the Residents clinical record that was provided to the surveyor was 145 pounds and was dated 01/26/17.

On 01/31/17 at approximately 10:15 a.m. the surveyor and RN (registered nurse) #2 (MDS nurse) reviewed the Residents MDS and weights. After this review RN #2 verbalized to the surveyor that the MDS should not have been coded as a weight loss. RN #2 then stated she had not

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F 278	Continued From page 14 completed this part of the MDS. On 01/31/17 at approximately 2:40 p.m. the surveyor interviewed the DM (dietary manager) concerning the weight of 158 and the coding of a weight loss on the MDS. The DM verbalized to the surveyor that the MDS had been marked incorrectly and the MDS should not have been coded as a weight loss. During a meeting with the survey team on 02/01/17 at approximately 1:25 p.m. the administrator and DON (director of nursing) were notified of the inaccurate coding of the quarterly MDS assessment. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 278		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related	F 285		

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condition for level II resident review upon a significant change in status assessment.

(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires

Criteria one:
Obtaining PASSRR is not possible for Resident #1 or Resident #10

Criteria Two:
Current Residents will be reviewed to assess the presence of the PASSRR upon admission.

Criteria Three:
Review with staff was conducted prior to survey exit to provide education of the regulation and guidelines regarding PASSRR. Formal contact with referral sources has been completed to provide notice of requirement for future referrals. Audits will be completed upon referrals for 3 weeks for referrals and new admissions to ensure provision of PASSRR prior to admission.

Criteria Four:
Results of education, notice and audits will be reviewed by the facility Quality Assessment Committee for additional recommendation and intervention if necessary.

Criteria Five:
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specialized services for intellectual disability.

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)

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or is a person with a related condition as described in 435.1010 of this chapter.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for level one screening for 2 of 27 residents (Resident #1 and Resident #10).

The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID).

The findings included:
1. The facility staff failed to obtain a level 1 PASRR (pre-admission screening and resident review) for Resident #1.

The clinical record of Resident #1 was reviewed 1/31/17 and 2/1/17. Resident #1 was admitted to the facility 8/13/16 with diagnoses that included but not limited to major depressive disorder, anxiety, altered mental status, abnormal weight loss, heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension, gout, dorsalgia, and pain.

Resident #1's quarterly minimum data set (MDS)

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assessment with an assessment reference date (ARD) of 11/7/16 assessed the resident with a cognitive summary score of 9 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors.

The current comprehensive care plan dated 8/22/16 identified that Resident #1 was at risk for side effects of psychotropic medications and to alert MD (medical doctor) to any significant changes in behaviors, to redirect resident as appropriate for behaviors, and to document resident behaviors. A second care plan dated 10/13/16 identified Resident #1 refused care and approaches included to document behaviors, social services to meet with resident as needed, and alert MD to any significant changes.

The surveyor reviewed the clinical record for a PASRR on 1/31/17 at 10:25 a.m. but was unable to locate one. The surveyor interviewed the social worker other #1 at this time. The social worker stated that he would look for the PASRR and inform the surveyor of his findings.

Social worker informed the surveyor on 1/31/17 at 10:30 a.m. that Resident #1 did not have a PASRR. He stated Resident #1 was admitted under Medicare as the provider but now received Medicaid benefits. The social worker stated the facility had a difficult time getting PASRRs prior to the resident's admissions and when the facility is trying to place residents in the community. He stated getting PASRRs and UAIs (uniform assessment instrument) completed was difficult.

The surveyor informed the administrator and the director of nursing of the above concern on 2/1/17 at 1:25 p.m. and again on 2/2/17 at 11:15 a.m.

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The administrator stated the local department of social services had not been helpful in arranging for PASRRs to be completed.

No further information was provided prior to the exit conference on 2/2/17.

2. The facility staff failed to obtain a level 1 PASRR (pre-admission screening and resident review) for Resident #10.

The surveyor reviewed Resident #10's clinical record on 1/31/17 and 2/1/17. Resident #10 was admitted to the facility 6/14/15 with diagnoses that included but not limited to anemia, Alzheimer's disease, depression, insomnia, chronic kidney disease, benign prostatic hypertrophy, fractured femur, hypertension, and Vitamin D deficiency.

Resident #10's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/14/16 assessed the resident with a cognitive summary score of 4 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors.

Resident #10's current comprehensive care plan dated 10/24/16 identified depression as a problem with approaches that included to notify MD of any decline in status and document, document behaviors, social services to evaluate and visit with resident as needed, encourage out of room activities and socialization. Resident #10 was seen by the physician 10/25/16. Resident #10 was documented to be refusing meals, was more agitated, and had weight loss.

Resident #10's current comprehensive care plan also identified that the resident refused care with

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approaches listed to explain implications/possible consequences of continued resistance to care, document behaviors, social services to meet with resident as needed, and alert MD to any significant changes.

The surveyor reviewed the clinical record on 1/31/17 for the PASRR; however, the surveyor was unable to locate the PASRR. The surveyor interviewed the social worker other #1 on 1/31/17 at 10:25 a.m. about Resident #10's PASRR. Social worker other #1 stated he would check his files in his office for the PASRR. The social worker other #1 informed the surveyor Resident #10 was admitted under skilled services (Medicare) so a PASRR would not have been done. From 9/22/15 to 8/1/16, Resident #10 was private pay. Resident #10 actually received Medicaid on 10/6/16 but the payments were backdated to 8/1/16. The social worker stated the facility had a difficult time getting PASRRs prior to the resident's admissions and when the facility is trying to place residents in the community. He stated getting PASRRs and UAIs (uniform assessment instrument) completed was difficult.

The surveyor informed the administrator and the director of nursing of the above concern on 2/1/17 at 1:25 p.m. and again on 2/2/17 at 11:15 a.m. The administrator stated the local department of social services had not been helpful in arranging for PASRRs to be completed.

No further information was provided prior to the exit conference on 2/2/17.

F 309 SS=E 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

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F 309	Continued From page 21 483.24 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 (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 staff interview and clinical record review, the facility staff failed to 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 for 4 of 27 residents (Resident #1, Resident #15, Resident #5, and Resident #6). The findings included: 1. (a) The facility staff failed to use	F 309	F-309 483.24, 483.25(K)(L) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Criteria one: Resident #1 will be assessed for non-pharmacological interventions for pain and care plan updated to reflect. Provider was notified prior to survey exit the incorrect amount of potassium doses held. Resident #15's provider was notified of omitted medications. Resident #15 is no longer residing in the facility. Resident #6's provider was notified of the omitted medication. Resident #5's provider was notified of the omitted medication and tubigrip application. Criteria Two: Residents with new medication orders will be reviewed to ensure accurate processing and administration. Residents receiving PRN analgesia will be reviewed for nonpharmacological interventions. Residents that have orders for tubigrips will be reviewed and observed for proper application.	

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non-pharmacological interventions for pain and failed to document the location of pain for Resident #1. (b) The facility staff also failed to follow a physician order to hold Potassium (KCl-potassium chloride) for 3 days. The medication was held for 5 days.

The clinical record of Resident #1 was reviewed 1/31/17 and 2/1/17. Resident #1 was admitted to the facility 8/13/16 with diagnoses that included but not limited to major depressive disorder, anxiety, altered mental status, abnormal weight loss, heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension, gout, dorsalgia, and pain.

Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/7/16 assessed the resident with a cognitive summary score of 9 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors. Section J Health Management and specifically J0100 Pain Management identified Resident #1 had received scheduled pain medication, prn (as needed) pain medication, and non-medication interventions for pain. Resident #1 was assessed to rarely have pain, pain made it hard for her to sleep, pain had limited her activities, and the resident rated pain as a "10."

The current comprehensive care plan dated 8/22/16 identified that Resident #1 was at risk for pain. Approaches: call light within reach, medications as ordered by physician, labs as ordered, report results to MD (medical doctor), document effectiveness of any prns (whenever needed) medications, document and alert MD to any significant changes related to pain, assistive devices as ordered, pain assessment on

Criteria Three:
Medication order audits will be conducted for 30 days to ensure that new orders are processed and administered per provider order. Any omissions will be corrected and processed per facility policy. Residents receiving PRN analgesia will be reviewed 5x/week for 30 days for nonpharmacological intervention documentation. Observations for the use and application of Tubigrips will be completed for residents with applicable order 5xs/week for 30 days. Residents receiving dialysis will have reviews conducted 5x/week for 30 days to ensure documentation of bruit/thrill. Educational sessions regarding medication orders and provision, notification of omissions, use of Tubigrips, and the provision of nonpharmacological interventions.

Criteria Four:
Results of audits, observations, and educational programming will be reviewed by the Quality Assurance Committee for additional intervention as deemed necessary.

Criteria Five:
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admission and as directed by facility, encourage/escort resident to out of room activities.

The December 2016 physician order sheet and the January 2017 physician order sheet included an order that read "Norco Tablet 5-325 mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain."

The December 2016 medication administration records (MARs) were reviewed. Resident #1 received prn (as needed) pain medications twenty-six (26) times in December 2016.

The December 2016 progress notes did not reveal non-pharmacological interventions prior to medication administration on any of the administration days in December 2016. Only two departmental notes written identified the location of the pain (12/14/16 and 12/18/16 abdominal pain). The medication administration record notes identified locations of pain when the pain medication was administered on 12/5/16 at 4:39 p.m., 12/13/16 at 4:59 p.m., 12/14/16 at 8:37 a.m., 12/20/16 at 6:12 p.m., and 12/27/16 at 8:12 a.m.

The January 2017 medication administration records (MARs) were reviewed. Resident #1 received prn (as needed) pain medications thirty-four (34) times in January 2017.

The January 2017 progress notes did not reveal non-pharmacological interventions prior to medication administration on any of the administration days in January 2017. There was no documentation in the January 2017 departmental notes of pain location or use of

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non-pharmacological interventions. The medication administration record notes identified locations of pain when the pain medication was administered on 1/10/17 at 7:44 p.m., 1/19/17 at 7:09 a.m., and 1/30/17 at 8:24 p.m.

(b). The facility staff failed to follow the physician order to hold Potassium for 3 days. Potassium was held for 5 days.

A physician order dated 12/29/16 read "Hold K+ (potassium) x 3 days."

The surveyor reviewed the December 2016 medication administration record (MAR). Klor Con 10 mEq (milliequivalents) Take 1 by mouth every day for supplement-Do Not Crush Order Date: 10/27/16 Start Date: 10/27/16 Discontinue Date: 12/29/16. The boxes for 12/30/16 and 12/31/16 had stars (stars indicated medications were not administered and the order discontinued).

The January 2017 medication administration record was reviewed. Potassium Cl ER 10 mEq Take one by mouth every day for hypokalemia was entered with an order date of 12/31/16 and a start date of 1/4/17. The boxes on the MAR indicated the medication was restarted on 1/4/17.

The order was written on 12/29/16 to hold the potassium for 3 days. However, the potassium was held 5 days (12/30/16, 12/31/16, 1/1/17, 1/2/17, and 1/3/17).

The surveyor could not find an additional order to hold the potassium an extra 2 days.

The surveyor informed the director of nursing and

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the administrator of the above concerns in the end of the day meeting on 2/1/17 at 1:25 p.m. and on 2/2/17 at 11:15 a.m.

No further information was provided prior to the exit conference on 2/2/17.

2. (a) The facility staff failed to administer medications (Calcium Acetate and Vancomycin) as ordered by the physician for Resident #15. (b). The facility staff failed to monitor Resident #15's dialysis access site every shift.

The clinical record of Resident #15 was reviewed 2/1/17 and 2/2/17. Resident #15 was admitted to the facility 1/20/17 with diagnoses that included but not limited to end stage renal disease currently receiving dialysis, abdominal aortic aneurysm, thoracic aortic aneurysm, anemia, chronic obstructive pulmonary disease, left above the knee amputation, and methicillin resistant staphylococcus aureus (MRSA).

Resident #15's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/27/17 assessed the resident with a cognitive summary score of 12 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors.

Resident #15's current comprehensive care plan identified the problem of dialysis identified on 1/31/17. Approaches included medications and treatments as ordered.

The admission physician orders were reviewed 2/1/17 and 2/2/17. One order read "Calcium Acetate 667 mg (milligrams) capsule: Take one by mouth three times a day with meals. Only give

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when Pt (patient) phosphate > (greater than) 5."

The surveyor reviewed the laboratory section of the clinical record but was unable to locate any laboratory tests for phosphate levels. The only phosphorus level found in the clinical record was from the referring hospital and obtained on 12/12/16. The value of phosphorus was 4.5.

The surveyor reviewed both the January 2017 and February 2017 electronic medication administration records (eMAR). The January 2017 eMAR was documented that Calcium Acetate had been administered from 1/21/17 at 9:00 a.m. through 1/31/17 at 5:00 p.m. and on 2/1/17 at 9:00 a.m. and 1:00 p.m. Calcium Acetate was administered thirty-five (35) times without a phosphate level > (greater than) 5.

The surveyor interviewed the unit manager registered nurse #3 on 2/1/17 at 3:30 p.m. R.N. #3 reviewed the physician order and called the dialysis center for clarification. The dialysis center draws labs monthly and R.N. #3 stated labs were planned to be drawn on 2/2/17. R.N. #3 stated the dialysis center gave the order to administer the calcium acetate even though no current order for phosphorus had been obtained.

The January 2017 physician's order sheet (POS) also included an order that read "Vancomycin 500 mg A-V vial: Infuse 100 ml (milliliters) into vein every 24 hrs (hours) for 3 doses."

The surveyor reviewed the January 2017 eMAR. Vancomycin 500 mg A-V Vial: Infuse 100 ml into vein every 3 hrs for 3 doses had been entered into the computer. The first entry was documented on 1/21/17 at 5:00 p.m. with an "N".

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The medication administration record notes were reviewed. The note written for 1/21/17 at 5:00 p.m. read "Vancomycin 500 mg A-V Vial: Infuse 100 ml ....scheduled for 01/21/2017 5:00 p.m. No IV access."

The facility staff failed to follow the physician order for administration of Vancomycin 500 mg IV.

(b) The facility staff failed to assess Resident #15 dialysis shunt for thrill and bruit every shift.

Resident #15's current comprehensive care plan dated 1/31/17 identified the problem of dialysis and approaches included to alert MD (medical doctor) to any abnormal issues with access site for s/s (signs and symptoms) of infection, do not take B/P (blood pressure) in extremity of access site, monitor access site for bleeding, keep access site drsg (dressing) clean dry intact.

An undated physician order read "Dialysis Tues (Tuesday), Thurs (Thursday), Saturday @ 1015. Assess thrill and bruit q shift (every shift)."

The surveyor reviewed the electronic treatment administration record (eTAR) for January 2017 and February 2017. The eTAR had only one documentation that the thrill and bruit had been assessed on 1/31/17 at 6:45 p.m. The surveyor reviewed the developmental notes from 1/20/17 through 2/1/17. Two assessments were documented-one on 1/25/17 at 3:53 a.m. and on 1/31/17 at 1:44 p.m.

The clinical record did not provide evidence the thrill and bruit of Resident #15's dialysis shunt

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had been assessed every shift since admission on 1/20/17.

The surveyor informed the administrator and the director of nursing of the above concern on 2/2/17 at 11:15 a.m. The DON stated she would expect staff to assess the dialysis shunt and document the findings.

No further information was provided prior to the exit conference on 2/2/17.

3. For Resident #5, the facility staff failed to (a) apply tubigrips as ordered by the physician and (b) failed to administer the antibiotic rocephin as ordered by the physician.

Tubigrip tubular bandage is a multi-purpose tubular bandage designed to provide tissue support in treating general edema.

The record review revealed that Resident #5 had been admitted to the facility 04/27/12. Diagnoses included, but were not limited to, diabetes, congestive heart failure, dementia with behavioral disturbances, and anxiety disorder.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/22/16 included a BIMS (brief interview for mental status) summary score of 1 out of a possible 15 points

The Clinical Record included orders for the following.

(a) Order date 12/19/16 "Apply tubigrips q (every) am (morning), remove qhs (bedtime/hour of sleep)-edema..."

(b) Order date 01/09/17 "Rocephin 1 g (gram) IM

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(intramuscular) stat + qd (everyday) X 7 d (days)-UTI (urinary tract infection)."

(a) A review of the eTAR's (electronic treatment administration records) for January revealed that the nursing staff had documented they had applied the tubigrips every day beginning at 3:00 p.m. not in the am as ordered by the physician and removed them at 11:00 p.m. The nursing staff had not documented that they had applied the tubigrips on 01/31/17. However, they had documented they had been removed at 11:00 p.m.

The Residents CCP (comprehensive care plan) included the problem area "Resident has edema of feet and legs." On 12/19/16 the facility staff had handwritten on the CCP "Tubigrips to legs q am + off qHS or as tol (tolerated) by resident."

Resident #5 was observed on 01/31/17 at various times during the day and the tubigrips were never observed by the surveyor to be in place.

On 02/01/17 at approximately 8:10 a.m. the surveyor observed Resident #5 up in their chair at the nurse's station. LPN (licensed practical nurse) #1 was asked about the tubigrips and after observing the Resident LPN #1 verbalized to the surveyor that the Resident did not have the tubigrips in place and she would put them on. A few minutes later LPN #1 approached the surveyor and stated she was unable to locate any on the unit and she would have to go downstairs and obtain the tubigrips.

Upon returning to the unit LPN #1 showed the surveyor a box of tubigrip and stated she would have to cut them to fit the Resident.

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(b) A review of the Resident's clinical record revealed that LPN #2 had documented in the nursing notes that they had administered the stat order of rocephin on 01/09/17. A review of the Resident's eMAR's (electronic medication administration records) for January 2017 revealed that the nursing staff had documented they had administered 6 doses of the rocephin (01/10-01/15/17).

On 02/01/17 at approximately 10:10 a.m. the surveyor interviewed the physician at the facility. After reviewing the rocephin order the physician verbalized to the surveyor that the order was actually 2 separate orders and the Resident should have received a total of 8 doses. The Resident had only received 7 doses.

During a meeting with the survey team on 02/01/17 at 1:25 p.m. the administrator and DON (director of nursing) were notified that Resident #5 did not have her tubigrips in place during observations by the surveyor on 01/31/17 and 02/01/17 and that the Resident had only received 7 doses of rocephin when the physician had ordered 8 doses.

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

4. For Resident #6, the facility staff failed to administer the antibiotic cipro as ordered by the physician.

The record review revealed that Resident #6 had been admitted to the facility 02/12/16. Diagnoses included, but were not limited to, acute kidney

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failure, chronic kidney disease, hypertension, and diabetes.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/28/16 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points.

The clinical record included a physician's telephone order dated 01/14/17 for "Cipro 500 mg PO (by mouth) BID (twice a day) X 7 days..." For a total of 14 doses.

A review of the eMAR's (electronic medication administration records) indicated that this medication had been started on 01/15/17 at 8:00 a.m. and ended on 01/01/21/17 at 8:00 a.m. for a total of 13 doses.

During a meeting with the survey team on 02/01/17 at 1:25 p.m. the administrator and DON (director of nursing) were notified of the missing dose of cipro.

On 02/01/17 the DON provided the surveyor with a copy of delivery slip from their pharmacy. This delivery slip indicated that 14 doses of cipro had been dispensed for Resident #6 on 01/14/17.

On 02/01/17 at approximately 3:45 p.m. the surveyor spoke with pharmacist #1 via phone regarding the cipro. Pharmacist #1 verbalized to the surveyor that as of 02/01/17 no cipro had been returned to the pharmacy.

On 02/02/17 at approximately 9:15 a.m. the surveyor and LPN (licensed practical nurse) #3

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F 309	Continued From page 32 checked the medication room for any medication to be returned to the pharmacy for Resident #6. This medication room included a medication card with Resident #6's name that included 1 cipro tablet to be returned to the pharmacy. During a meeting with the survey team on 02/02/17 at approximately 11:10 a.m. the administrator and DON were notified of the above. The DON verbalized to the survey team that she was unable to locate any information to indicate a dose had been removed from their cubex (back up). No further information regarding this issue was provided to the survey team prior to the exit conference.	F 309	F-314 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Criteria One: Residents heels were being floated prior to survey exit. Criteria Two: Residents with orders to have heels floated were reviewed to ensure compliance. Criteria Three: Audits of residents with orders for heel floating will be completed, observation of residents will be completed 5x/week for 30 days to ensure provision of care per order. Noncompliance will be addressed at time of observation. Education regarding floating heels will be completed with facility clinical staff. Criteria Four: Results of education, audits, review and observation will be presented to facility Quality Assurance Committee for additional recommendation and intervention if deemed necessary. Criteria Five: February 24, 2017	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 314		

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by:
Based on observation, staff interview, and clinical record review, the facility staff failed to follow the physician orders to float the heels for 1 of 27 residents (Resident #10).

The findings included:

The facility staff failed to float the heels of Resident #10 while in bed.

The surveyor reviewed Resident #10's clinical record on 1/31/17 and 2/1/17. Resident #10 was admitted to the facility 6/14/15 with diagnoses that included but not limited to anemia, Alzheimer's disease, depression, insomnia, chronic kidney disease, benign prostatic hypertrophy, fractured femur, hypertension, and Vitamin D deficiency.

Resident #10's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/14/16 assessed the resident with a cognitive summary score of 4 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors. Section G coded the resident as totally dependent on one person for bathing. Resident #10 was assessed to be at risk for the development of pressure ulcers. The last pressure ulcer risk assessment dated 11/17/16 identified Resident #10 to be a "13" and to follow pressure sore protocol. The surveyor asked the unit manager licensed practical nurse #1 what the protocol was for pressure ulcers. L.P.N. #1 stated she did not know but did not offer to find out for the surveyor.

Resident #10's current comprehensive care plan dated 6/24/15 identified the resident had a potential for skin breakdown (episodes of bowel

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and bladder incontinence). Approaches included treatments as ordered.

The clinical record contained a physician order dated 1/25/17 that read "Clarification: 1. Cleanse bilateral heels with wound cleanser apply skin prep every night (7P-7A). 2. Float heels while in bed as tolerated by resident."

The surveyor observed the resident on 1/31/17 at 9:25 a.m. Resident #10 was observed in bed. The surveyor did not observe that Resident #10's heels were floated. There was no pillow under the feet or a heels up device observed.

Two surveyors observed Resident #10 on 1/31/17 at 1:25 p.m. Neither surveyor observed that Resident #10's heels were floated.

The surveyor interviewed licensed practical nurse #4 on 1/31/17 at 2:00 p.m. The surveyor asked L.P.N. #4 if Resident #10's heels were to be floated. L.P.N. #4 stated that's what the order said. Resident #10 was observed in bed on 1/31/17 at 2:00 p.m. L.P.N. #4 stated Resident #10's heels were not floated.

The surveyor informed the administrator and the director of nursing of the above concern during an end of the day meeting on 2/2/17 at 11:15 a.m.

No further information was provided prior to the exit conference on 2/2/17.

F 323 SS=D 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES F 323

(d) Accidents.
The facility must ensure that -

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F 323	Continued From page 35 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a hazard free environment for 1 of 27 Residents, Resident #6. The findings included. Resident #6's clinical record included a physicians order for a wanderguard. This wanderguard was placed on the Resident's merrywalker and not the Resident. The Resident was able to exit the merrywalker at times without assistance making them an elopement risk.	F 323	F-323 483.25 (d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT/HAZARDS/SUPERVISION/ DEVICES Criteria One: Resident #6 has wander guard on person. Criteria Two: Residents with wander guard orders were reviewed to ensure proper application. Criteria Three: Residents with Wander Guards will be observed 5x/week for 30 days to ensure proper application. Education for staff will be conducted regarding the application of Wander Guard. Criteria Four: Results of Observation and Education will be presented to the Quality Assurance Committee for further recommendation and intervention if deemed necessary. Criteria Five: February 24, 2017	

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A merrywalker is an ambulation device that is a walker/chair combination.

The record review revealed that Resident #6 had been admitted to the facility 02/12/16. Diagnoses included, but were not limited to, acute kidney failure, chronic kidney disease, hypertension, and diabetes.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/28/16 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. Section E (behavior) was coded with a 0 to indicate the Resident had not exhibited any wandering behaviors in the look back period. Section P (restraints) was coded with a 1 to indicate the Resident used a chair to prevent rising and that it was used less than daily.

The clinical record included an "Elopement/Wander Risk Assessment" dated 11/18/16. This assessment scored the Resident 20. Per the preprinted code on this form for a score of 0-9 no action is required. A score of 10 or better requires the facility to address it on the care plan, picture in elopement book, interventions as applicable, and notify designated personal.

The Resident's CCP (comprehensive care plan) included the following.
Falls-ambulates with merrywalker. The staff had transcribed the following comments on the CCP 12/03/16 "OBS (observed) X4 on dayshift stepping out of Merry Walker + attempting to ambulate Unassisted down hallway."

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At risk for elopement (wanders on unit and has to be redirected at times). The facility staff had transcribed the following onto the Resident's CCP-11/07/16-"Rec'd (received) call from husband, tearful after call. Opened exit door @ end of hallway and went through-redirected." 11/10/16-"Attempted to open exit door-redirected." 12/10/16" OBS walking onto elevated-redirected." Approaches included-Redirection when exit seeking.

The current physician signed (01/03/17) POS (physician order sheet) included the order "WANDERGUARD-CHECK PLACEMENT EVERY SHIFT."

The clinical record included the following nursing notes.
12/03/16-Resident has been observed stepping out of her merri-walker 4 times today and attempting to ambulate down the hall unassisted. Staff has attempted to redirect resident each time.
12/11/16-"Late entry-At 2120 Resident was noted to be walking onto elevator. Resident assisted back to Unit ___. Resident placed on "Close Observation Q (every) 15 minutes checks". Wonderguard noted to not be working at this time. this nurse communicated this incident to oncoming night shift staff. New wonderguard will be placed on resident as soon as one is located within the facility." (sic)

On 02/01/17 at approximately 8:00 a.m. the Resident was observed to be up in the merrywalker in the dining area. The wanderguard was observed to be attached to the merrywalker and not the Resident. During this observation LPN (licensed practical nurse) #1 was asked if

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the Resident could get out of her merrywalker independently. LPN #1 verbalized to the surveyor that the Resident could exit her merrywalker at times but not consistently so it was coded as a restraint.

On 02/01/17 at approximately 8:30 a.m. Resident #6 was observed sitting next to the elevator. The wanderguard remained on the merrywalker and when the surveyor attempted to exit the floor via the elevator an alarm sounded indicating the wanderguard was in working order.

During a meeting with the survey team on 02/01/17 at approximately 1:25 p.m. the administrator and DON (director of nursing) were notified that Resident #6's wanderguard was attached to their merrywalker and not the Resident and the clinical record as well staff interview indicated the Resident was able to exit the merrywalker independently at times.

The DON provided the surveyor with a copy of a document titled "Q2 Hour Check" that included the Resident's name indicating the Resident was checked at least every 2 hours by staff.

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

F 329 SS=E 483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS — F 329

(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

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F 329	Continued From page 39 (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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 4 of 27 Residents were free from unnecessary medications, Residents #5, #20, #21, and #1. The findings included. 1. For Resident #5, the facility staff failed to provide behavioral interventions and non-pharmacological approaches prior to administering the prn (as needed) medication ativan (lorazepam) and failed to document the clinical rationale or reason for administering this medication. According to the National Institute of Health ativan (lorazepam) is an antianxiety, anticonvulsant, and skeletal muscle relaxant. It is used to treat anxiety disorders. The record review revealed that Resident #5 had been admitted to the facility 04/27/12. Diagnoses	F 329	F-329 483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Criteria One: Resident #5, #20, #21, and #1, has been assessed for the use of nonpharmacological behavioral management. Treatment plans will be updated to reflect the type and appropriateness of the intervention. Criteria Two: Residents receiving PRN meds for anxiety or other behavioral issues, were reviewed to assess the appropriateness of nonpharmacological interventions and appropriate treatment plans initiated as deemed necessary. Criteria Three: Audits of PRN Behavioral Medications will be conducted 5x/week for 30 days by designee to review the use and documentation of Non pharmacological medications. Education of staff to include the use and documentation of nonpharmacological treatments will be completed. Criteria Four: Results of Education and Audits will be presented to the facility Quality Assurance committee for further recommendation and intervention as deemed necessary.	

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included, but were not limited to, diabetes, congestive heart failure, dementia with behavioral disturbances, and anxiety disorder.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/22/16 included a BIMS (brief interview for mental status) summary score of 1 out of a possible 15 points. Section E (behavior) was coded to indicate the Resident did not have any potential indicators of psychosis and no behavioral symptoms directed toward others. Section I (active diagnoses) was coded to indicate the Resident had active diagnoses of Alzheimer's disease and an anxiety disorder.

The current physician signed (01/03/17) POS (physician order sheet) included the order "ATIVAN 0.5 MG TABLET BY MOUTH AS NEEDED FOR ANXIETY."

The current CCP (comprehensive care plan) included the problem area "DX (diagnosis) Alzhemer's (sic) Dementia with behavioral disturbances/psychosis Impaired memory thought processes/agitated @ times. Verbally and physically aggressive (sic) with fellow residents at times. 12/2-SIG (significant) CHANGE: Increased lethargy and decreased responsiveness with increased dependence on staff to meet care needs secondary to acute physical decline...AT RISK FOR SIDE EFFECTS OF PSYCHOTROPIC MEDICATION(S) (receives antianxiety meds). Approaches included document resident behavior. ANXIETY-Document behaviors.

A review of the eMAR (electronic medication

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administration record) for 01/2017 revealed that the facility nursing staff had documented they had administered the prn (as needed) ativan 11 times in January.

During the record review the surveyor was unable to find any information to indicate why the prn ativan was administered or if any nonpharmalogical interventions were attempted prior to administering the prn ativan.

The administrator and DON (director of nursing) were notified of the missing information regarding the prn ativan during a meeting with the survey team on 02/01/17 at approximately 1:25 p.m.

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

2. For Resident #20, the facility staff failed to provide behavioral interventions and non-pharmacological approaches prior to administering the prn (as needed) medication ativan (lorazepam) and failed to document the clinical rationale or reason for administering this medication.

According to the National Institute of Health ativan (lorazepam) is an antianxiety, anticonvulsant, and skeletal muscle relaxant. It is used to treat anxiety disorders.

The record review revealed that Resident #20 had been admitted to the facility 12/15/16 and readmitted on 01/18/17. Diagnoses included, but were not limited to, chronic insomnia, rhabdomyolysis, glaucoma, anxiety disorder, and atrial fibrillation.

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Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with an ARD (assessment reference) date of 12/22/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section E (behaviors) was coded to indicate the Resident had no indicators of psychosis and no behavioral symptoms directed toward others. Section I (active diagnoses) was coded to indicate the Resident has an active diagnosis of non Alzheimer's Dementia.

The Residents current POS (physician order sheet) included the order "ATIVAN 0.5 MG TAKE ONE TABLET BY MOUTH TWICE A DAY AS NEEDED FOR AGITATION OR ANXIETY."

A review of the Resident's eMAR's (electronic medication administration record) revealed that this medication had been administered 20 times in January and 1 time in February.

During the record review the surveyor was unable to find any information to indicate why the prn ativan was administered or if any nonpharmalogical interventions were attempted prior to administering the prn ativan.

The administrator and DON (director of nursing) were notified of the missing information regarding the prn ativan during a meeting with the survey team on 02/02/17 at approximately 11:10 a.m.

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

3. For Resident #21, the facility staff failed to

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provide behavioral interventions and non-pharmacological approaches prior to administering the prn (as needed) medication xanax (alprazolam) and failed to document the clinical rationale or reason for administering this medication.

According to the national institute of health xanax is an antianxiety and is used to relieve symptoms of anxiety, including anxiety caused by depression. It is also used to treat panic disorders in some people.

The record review revealed that Resident #21 had been admitted to the facility 06/02/16 and had been readmitted on 01/25/17. Diagnoses included, but were not limited to, dementia, diastolic congestive heart failure, hypertension, hypothyroidism, and dysphagia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/16/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section E (behavior) was coded to indicate the Resident had no potential indicators of psychosis and had no behavioral symptoms directed toward others. Section I (active diagnoses) included non-Alzheimer's dementia, anxiety disorder, and depression.

The Resident's current CCP (comprehensive care plan) included the problem area of anxiety and depression. Approaches included encourage out of room activities and socialization and document behaviors. At risk for side effects of psychotropic medication-approaches included will try to redirect resident as appropriate for behaviors,

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administer medication as ordered by physician, and document resident behavior.

The Residents clinical record included a physician signed (01/27/17) POS (physician order sheet) that included an order for "XANAX 0.25 MG 1 BY MOUTH EVERY 6 HOURS AS NEEDED FOR ANXIETY."

A review of the Resident's eMAR (electronic medication administration record) revealed that this medication had been administered 11 times in January.

During the record review the surveyor was only able to find where the nursing staff had documented twice (01/06 and 01/05) as to why they had administered the xanax. The surveyor was unable to find any information to indicate any nonpharmalogical interventions were attempted prior to administering the prn xanax.

The administrator and DON (director of nursing) were notified of the missing information regarding the prn xanax during a meeting with the survey team on 02/02/17 at approximately 11:10 a.m.

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

4. The facility staff failed to monitor Resident #1's behavior prior to the administration of an anxiolytic medication Ativan. Resident #1 was administered PRN (as needed) Ativan without any indication of the attempt to use non-pharmacological interventions prior to the administration. The facility staff failed to identify the targeted behavior for the use of the prn Ativan and failed to provide evidence of monitoring when

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the anxiolytic was administered.

The clinical record of Resident #1 was reviewed 1/31/17 and 2/1/17. Resident #1 was admitted to the facility 8/13/16 with diagnoses that included but not limited to major depressive disorder, anxiety, altered mental status, abnormal weight loss, heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension, gout, dorsalgia, and pain.

Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/7/16 assessed the resident with a cognitive summary score of 9 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors. Section E Behaviors was not coded for any behaviors during the look back period.

The current comprehensive care plan dated 8/22/16 identified that Resident #1was at risk for side effects of psychotropic medications and to alert MD (medical doctor) to any significant changes in behaviors, to redirect resident as appropriate for behaviors, and to document resident behaviors. A second care plan dated 10/13/16 identified Resident #1 refused care and approaches included to document behaviors, social services to meet with resident as needed, and alert MD to any significant changes.

A telephone order dated 12 12/16 read to discontinue Valium 5 milligrams and to start Ativan 0.5 mg bid (twice per day) prn (whenever needed). On 12/19/16, the order for Ativan was changed to Ativan 0.5 mg tid (three times a day) and every 6 hours as needed.

The January 2017 physician order sheet read in

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part "Ativan tablet 0.5 mg (milligrams) by mouth every six (6) hours as needed for anxiety."

The December 2016 medication administration records were reviewed. Resident #1 was administered Ativan 0.5 mg (milligrams) three (3) times in December on the following days: 12/14/16, 12/15/16, and 12/18/16. The January 2017 medication administration records were reviewed. Resident #1 received Ativan 0.5 mg fifteen (15) times.

The current comprehensive care plan did not include any non-pharmacological interventions prior to the use of Ativan or what specific behaviors were to be targeted.

The December 2016 and January 2017 developmental notes had no documentation why Ativan was administered the three times in December 2016 and the fifteen times in January 2017. There were no non-pharmacological interventions prior to the administration of the Ativan.

The surveyor found no monitoring for the use of the prn medication Ativan-an antianxiety medication.

The facility staff failed to identify the targeted behavior for Resident #1's Ativan use, failed to monitor the behavior and failed to incorporate non-pharmacological interventions prior to the administration of Ativan.

The surveyor informed the administrative staff of the above finding on 2/1/17 at 1:25 p.m. and on 2/2/17 at 11:15 a.m.

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F 329	Continued From page 47 No further information was provided prior to the exit conference on 2/2/17.	F 329	F-425 483.45(a)(b)(1) PHARMACEUTICAL SCVS ACCURATE PROCEDURES, RPH	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) 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 clinical record review, the facility staff failed to ensure medication was available for administration for 1 of 27 residents (Resident #17). The findings included: On 2/1/17 at 8:30 am, the scheduled medication Tylenol was not available for administration during medication pass observation to Resident #17. Resident #17 was admitted to the facility with diagnoses that included but were not limited to: pneumonia, thyroid disorder, urinary tract infection, arthritis, depression, bipolar disease, hypertension, and diabetes. Resident #17's quarterly minimum data set (MDS) assessment with an assessment	F 425	Criteria One: Resident has been discharged from the facility Criteria Two: MARs were reviewed to ensure ordered medications were available for residents prior to survey exit. Criteria Three: Residents with new med orders will be reviewed 5x/week for 30 days to ensure timely receipt of meds from pharmacy. Education of staff regarding timely receipt of medications and what to do when meds do not arrive will be conducted. Criteria Four: Results of education and audits will be reviewed by the Quality Assurance Committee for further recommendation and intervention as deemed necessary. Criteria Five: February 24, 2017	

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reference date (ARD) of 1/12/17 assessed the resident with a cognitive summary score of 15 out of 15.

The physician order sheet dated 1/5/17 contained an order for: "acetaminophen (Tylenol) 500mg. Take one by mouth two times a day for pain."

Resident #17's electronic medication administration record (eMARs) was reviewed. The eMAR also contained the order: "Acetaminophen (Tylenol) 500mg. Take one by mouth two times a day for pain."

The medication acetaminophen was not available for administration by the staff on 2/1/17 during the medication pass observation. The Cubex (the facility medication dispensing system), was checked for the acetaminophen; however the medication was not available.

The surveyor interviewed licensed practical nurse #6, she stated, "When a medication isn't in Cubex, we place the medication on hold and inform the physician; it will not be available until tomorrow." The surveyor was also informed that the pharmacy would have to contact the backup pharmacy to provide needed medications.

After the medication acetaminophen was identified as not being available for administration, the unit manager contacted the physician obtaining the following order: "2/1/17 9:29 AM, NO (new order) d/c (discontinue) Tylenol 500mg po bid and change to start Tylenol prn (as needed) for pain."

The surveyor spoke with Resident #17's physician at 9:55am on 2/1/17. She confirmed

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F 425	Continued From page 49 she had changed the acetaminophen order when it was not available for administration. She also told the surveyor she did not think it should be left up to the provider to make the decision for a change when it is a common drug. The surveyor also spoke to the pharmacy that provides the medications to the facility on 2/1/17 and again 2/2/17. The pharmacist was questioned regarding the acetaminophen not being available. She stated, "If it is a scheduled drug, they need to reorder it. I would have to look at the stock list. It is the facility's decision what is on the stock list. If they don't have a stock list, then that is their decision. They have control of what is on that list." During the end of the day meeting on 2/1/17, the administrator and the director of nurses were informed of the medication not being available. Prior to exit on 2/2/17, no further information was provided by the facility related to the acetaminophen being unavailable for administration.	F 425		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 441		

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F 441	Continued From page 50 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 441	F-441 483.80 (a)(1)(2)(4)€(f) INFECTION CONTROL, PREVENT SPREAD LINENS Criteria One: Staff member performing wound care for Resident #10 was educated to wash hands before and after providing wound care. Criteria Two: No other resident was impacted by alleged deficient practice Criteria Three: Education regarding Handwashing, Infection control and Handwashing requirements with wound care is being completed with facility staff. Wound care observations are being conducted 3x/week for 30 days to ensure proper handwashing techniques before and after wound care. Criteria Four: Results of education and observation will be presented to the Quality Assurance committee for further recommendation and intervention as deemed necessary. Criteria Five: February 24, 2017	

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

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

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

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control guidelines during wound care for 1 of 27 residents (Resident #10). The facility staff failed to wash hands before wound care and after wound care.

The findings included:

The facility staff failed to wash hands prior to wound care and after wound care for Resident #10.

The surveyor reviewed Resident #10's clinical record on 1/31/17 and 2/1/17. Resident #10 was admitted to the facility 6/14/15 with diagnoses that included but not limited to anemia, Alzheimer's disease, depression, insomnia, chronic kidney disease, benign prostatic hypertrophy, fractured femur, hypertension, and Vitamin D deficiency.

Resident #10's quarterly minimum data set

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(MDS) assessment with an assessment reference date (ARD) of 11/14/16 assessed the resident with a cognitive summary score of 4 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors. Section G coded the resident as totally dependent on one person for bathing. Resident #10 was assessed to be at risk for the development of pressure ulcers. The last pressure ulcer risk assessment dated 11/17/16 identified Resident #10 to be a "13" and to follow pressure sore protocol. The surveyor asked the unit manager licensed practical nurse #1 what the protocol was for pressure ulcers. L.P.N. #1 stated she did not know but did not offer to find out for the surveyor.

Resident #10's current comprehensive care plan dated 6/24/15 identified the resident had a potential for skin breakdown (episodes of bowel and bladder incontinence). Approaches included treatments as ordered.

The clinical record contained a physician order dated 1/25/17 that read "Clarification: 1. Cleanse bilateral heels with wound cleanser apply skin prep every night (7P-7A). 2. Float heels while in bed as tolerated by resident."

The surveyor observed wound care on 1/31/17 at 10:15 a.m. with licensed practical nurse #4. L.P.N. #4 gathered the supplies for wound care at the treatment cart and applied disposable gloves at the treatment cart. L.P.N. #4 then met the resident at the entrance to his room. Resident #10 was seated in a wheelchair, both feet flat on the floor. Resident #10 was observed to have socks on both feet but no shoes. L.P.N. #4 removed the sock from Resident #10's left foot and cleaned the heel with wound cleanser. Then

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L.P.N. #4 patted the left heel dry. Skin prep was applied. L.P.N. #4 then reapplied the sock back to Resident #10's left foot. L.P.N. #4 then removed the sock from Resident #10's right foot, cleaned the right heel with wound cleanser, patted the right heel dry, and applied skin prep. L.P.N. #4 then reapplied the sock to Resident #10's right foot.

L.P.N. #4 then left Resident #10's room and proceeded to the treatment cart and disposed of the soiled dressing. L.P.N. #4 was not observed to wash her hands before the treatment began or upon completion.

Upon completion of the wound care observation, the surveyor interviewed L.P.N. #4 about handwashing. L.P.N. #4 was asked if she washed her hands before wound care began. L.P.N. #4 stated she had washed them. The surveyor did not observe L.P.N. #4 wash her hands. L.P.N. #4 was asked if she washed her hands when she completed wound care. L.P.N. #4 stated she had forgotten to wash her hands.

The surveyor informed the administrator and the director of nursing of the failure of the facility staff to wash hands before and after wound care in the end of the day meeting on 1/31/17 at 5:00 p.m. and requested the facility policy on handwashing/wound care.

The facility policy titled "Wound Care" was reviewed 2/1/17 at 9:20 a.m. The policy read in part "Steps in the Procedure 1. Use disposable cloth to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash

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and dry your hands thoroughly. 22. Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart. 23. Wash and dry your hands thoroughly."

No further information was provided prior to the exit conference on 2/2/17.

F 502 SS=D 483.50(a)(1) ADMINISTRATION — F 502

(a) Laboratory Services

(1) 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 physician ordered laboratory tests for 1 of 27 residents (Resident #3).

The findings included:

The facility staff failed to obtain a complete blood count (CBC), a comprehensive metabolic panel (CMP) and a hemoglobin A1C (A1C) for Resident #3.

The clinical record of Resident #3 was reviewed 1/31/17 and 2/1/17. Resident #3 was admitted to the facility 5/21/16 with diagnoses that included but not limited to metabolic syndrome, insulin dependent diabetes, gastroesophageal reflux disease, major depressive disorder, constipation, cerebrovascular accident, asthma, chronic obstructed pulmonary disease, urinary tract

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F 502	Continued From page 55 infection, and hypertension. Resident #3's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/20/16 coded the resident with a cognitive summary score of 7 out of 15 in Section C and without signs or symptoms of delirium, psychosis, or behaviors. Resident #3's current comprehensive care plan dated 6/1/16 identified hyperlipidemia and diabetes as two problems/needs with approaches to obtain labs (laboratory tests) as ordered with results to MD (medical doctor). Physician order dated 8/12/16 read in part "7. CMP, CBC, A1C next lab day-DM, HTN (diabetes mellitus, hypertension)." The surveyor reviewed the laboratory section of the clinical record but was unable to locate the laboratory results ordered on 8/12/16. The surveyor spoke with registered nurse #1 on 2/1/17 at 8:55 a.m. and requested assistance with finding the results of the ordered laboratory tests. R.N. #1 informed the surveyor 2/1/17 at 9:15 a.m. that a call had been made to the contracting laboratory and the tests had not been done. The surveyor informed the director of nursing and the administrator of the above issue on 2/1/17 at 1:25 p.m. and again on 2/2/17 at 11:15 a.m. No further information was provided prior to the exit conference on 2/2/17.	F 502	F-502 483.50(a)(1) ADMINISTRATION Criteria One: Notifications were completed related to the Omitted labs for Resident #3 Criteria Two: Lab orders were reviewed to ensure obtained per order. Criteria Three: Audit of Lab orders will be completed on a random sample of resident chart to ensure compliance with Provider order 5x/week for 30 days. Education regard lab services and lab orders will be completed with clinical staff. Criteria Four: Results of Audits and education will be presented to the facility Quality Assurance committee for further recommendation and intervention as deemed necessary. Criteria Five: February 24, 2017	
F 504	483.50(a)(2)(i) LAB SVCS ONLY WHEN	F 504		

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F 504 SS=D	Continued From page 56 ORDERED BY PHYSICIAN	F 504		

(a) Laboratory Services

(2) The facility must-

(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff obtained a laboratory test without a physician order for 1 of 27 residents (Resident #1). A comprehensive metabolic panel was done 10/30/16 without a physician order.

The findings included:

The facility staff obtained a comprehensive metabolic panel (CMP) without a physician order for Resident #1. The physician ordered a CMP. The facility staff obtained a basic metabolic panel (BMP) instead.

The clinical record of Resident #1 was reviewed 1/31/17 and 2/1/17. Resident #1 was admitted to the facility 8/13/16 with diagnoses that included but not limited to major depressive disorder, anxiety, altered mental status, abnormal weight loss, heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension, gout, dorsalgia, and pain.

Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/7/16 assessed the resident with a

F-504 483.50 (a)(2)(i) LAB SVCS ONLY
WHEN ORDERED BY PHYSICIAN

Criteria One:
The provider of resident #1 was notified of the obtaining of incorrect lab prior to survey exit.

Criteria Two:
Residents with CMP orders were reviewed to ensure compliance with provider order prior to survey exit.

Criteria Three:
Lab order audits will be conducted 5x/week for 30 days to ensure proper processing. Education of staff to include proper lab order processing will be completed.

Criteria Four:
Results of education and audits will be reviewed by facility Quality Assurance committee for additional intervention and recommendation if deemed necessary.

Criteria Five:
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cognitive summary score of 9 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors.

Resident #1's current comprehensive care plan dated 8/22/16 identified the resident was at risk for pain and approaches included labs (laboratory tests) as ordered, report results to MD (medical doctor).

Physician order dated 10/30/16 read in part "2. Stat CBC (complete blood count), BMP (basic metabolic panel) (abdominal pain)."

The surveyor reviewed the laboratory section of the clinical record but was unable to locate the results of the BMP. The results of a complete metabolic panel were obtained on 10/30/16 not a BMP as ordered.

The surveyor interviewed the unit manager licensed practical nurse #1 on 1/31/17 at 2:30 p.m. After reviewing the physician order and the laboratory results, L.P.N. #1 stated "Looks like it was done incorrectly. The BMP was ordered but the lab did a CMP." The surveyor requested the laboratory request form for the physician ordered BMP. L.P.N. #1 stated she turned those in to the director of nursing.

The surveyor informed the administrator and the director of nursing of the above issue on 2/1/17 at 1:25 p.m. and on 2/2/17 at 11:15 a.m.

No further information was provided prior to the exit conference on 2/2/17.

F 514 SS=E 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB — F 514

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F 514	Continued From page 58 LE	F 514	F-514 483.70 (I)(1)(5) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE	

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview the facility staff failed to ensure a complete and accurate clinical record for 10 of 27

Criteria One:
Ad Hoc QA meeting was held prior to survey exit. Providers and RPs for residents #19, #4, #11, #15, #3, #5, #6, #7, were notified of omissions of medication documentation. Provider and RP was notified of omission of bath/shower/BM record for Resident #1 and #9.

Criteria Two:
Internal Review of active residents bathing record, BM, Insulin MAR, and MAR was reviewed to ensure complete and accurate documentation prior to survey exit.

Criteria Three:
Education for staff related to facility policy and procedure for accurate and completed documentation, will be completed to include: 1. Medication Documentation, 2. Bathing Documentation, 3. Mental Health Status Documentation, 4. BM documentation, 5. Insulin MAR. Audits will be completed 5x/week for 30 days to ensure complete and accurate documentation.

Criteria Four:
Results of audits and education will be presented to the facility Quality Assurance committee for further recommendation and intervention if necessary.

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Residents, Residents #19, #4, #9, #1, #3, #11, #15, #5, #6, and #7.

The findings included:

1. For Resident #19 the facility staff failed to document that a physician ordered medication had been administered.

Resident #19 was admitted to the facility on 09/23/13 and readmitted on 12/11/15. Diagnoses included but not limited to cerebral palsy, hemiplegia, Parkinson's disease, seizure disorder, gastroesophageal reflux disease, malnutrition, depression and hypokalemia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/04/17 coded the Resident as 12 of 15 in section C, cognitive patterns.

Resident #19's clinical record was reviewed on 02/01/17. It contained a signed physician's order dated 01/05/17 which read in part "1L (liter) NS (normal saline) @ 75ml/hr now > ^ (for increased) phenytoin level". Resident #19's eMAR (electronic medication administration record) for January was reviewed on 02/01/17. Surveyor could not locate any entry which indicated that the physician's order for NS had been completed.

The concern of not following the physician's order was discussed with the administrative staff during a meeting on 02/01/17 at approximately 1325.

The DON (director of nursing) provided the surveyor with a copy of a pharmacy receipt showing that the NS had been delivered to the facility on 01/05/17. DON also provided copies of

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the Resident's phenytoin level on 01/05/17 which read in part "Phenytoin 24.2 (normal range 10-20)", and phenytoin level on 01/06/17 which read in part "Phenytoin 16.1".

The concern of not documenting that the NS had been administered as ordered was discussed during a meeting with the administrative staff on 02/02/17 at approximately 1110.

No further information was provided prior to exit.
2. For Resident #4, the facility staff failed to maintain an accurate January 2017 medication administration record.

The clinical record of Resident #4 was reviewed 1/31/17 and 2/1/17. Resident #4 was admitted to the facility 9/15/15 and readmitted on 12/2/16 with diagnoses that included, but were not limited to depression, gastroesophageal reflux disease, heart failure, anemia, anxiety, diabetes mellitus, anxiety, atrial fibrillation, and thyroid disorder.

Resident #4's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/06/16 revealed that Resident #4 was able to understand others and could make themselves understood to others. In Section C for Cognitive Patterns, Resident #2 was assessed as 12 out of 15 for cognitive summary score.

The clinical record revealed a physician's order Novolog 100unit/ml vial sliding scale insulin order dated 12/14/17. The scale read: 140-199=2 units; 200-249=4 units; 250-259=6 units; 300-349=8 units; 350=10 units.

The surveyor reviewed the January 2017 electronic medication administration record. On

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1/8/17 at 4:30pm, Resident #4's glucometer reading read high and there was no recorded amount of insulin administered to the resident.

The unit manager was asked to assist in locating information related to the high recording. She provided the surveyor with the diabetic monitoring record for Resident #9. On 1/8/17 at 4:30pm, the record revealed his blood sugar was 148. According to the sliding scale the resident should have received 2 units of Novolog insulin. However, there was no documented amount of insulin administered.

An interview was conducted with LPN #4 who was working on 1/8/17, who informed the surveyor she had given Resident #4 2 units of Novolog, but failed to document it.

The surveyor informed the administrator and the director of nursing of the above finding on 2/1/17 at 3:00pm.

No further information was provided prior to the exit conference on 2/2/17.

3. The facility staff failed to accurately document Resident #9's baths/showers for January 2017.

Resident #9 was admitted to the facility on 10/12/16, with diagnoses of fracture of femur, Alzheimer's disease, and high blood pressure.

Resident #9's MDS was a significant change assessment with an ARD (assessment reference date) of 8/24/16. Section C (cognitive patterns), this assessment scored the resident a 08 out of 15. Section B coded the resident to understand and to be understood. She was also coded

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requiring assistance of 1-2 persons for bed mobility, dressing, toileting, bathing, and hygiene.

The comprehensive care plan was reviewed. The care plan indicated the resident was incontinent and requires assistance with all activities of daily living.

Resident #9 was observed in her bed on 1/31/17; she was clean and did not have an odor. The surveyor spoke with her and she told the surveyor she was waiting to get a shower.

Resident #9's clinical record was reviewed on 1/31/7 through 2/2/17. The surveyor had difficulty locating the bathing record. The facility staff printed the December 2016 and the January 2017 bathing record for the surveyor to review.

The January 2017 record revealed the resident did not have a recorded shower from 1/6/17 through 1/18/17.

The director of nurses reviewed the record with the surveyor on 2/2/17, and agreed there was no documented shower during this time frame.

On 2/2/17, the administrator and the director of nurses were informed of the above issue.

Prior to exit on 2/2/17, no further information was provided to the surveyor.
4. For Resident #1, the facility staff failed to document December 2016 baths and December 2016 bowel movements in the clinical record.

The clinical record of Resident #1 was reviewed 1/31/17 and 2/1/17. Resident #1 was admitted to the facility 8/13/16 with diagnoses that included

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but not limited to major depressive disorder, anxiety, altered mental status, abnormal weight loss, heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension, gout, dorsalgia, and pain.

Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/7/16 assessed the resident with a cognitive summary score of 9 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors.

The surveyor reviewed the electronic record for bathing and bowel movements roster on 1/31/17 and 2/1/17. The surveyor was unable to locate any December 2016 documentation for baths or for bowel movements.

The surveyor informed the director of nursing of the above concern on 2/1/17 at 9:05 a.m. The director of nursing stated bowel movements weren't always seen because Resident #1 takes herself to the bathroom. The DON also stated Resident #1 did refuse baths. The DON did provide the surveyor with skin assessments done 12/22/16 and 12/29/16. The DON stated she was unsure why baths and bowel movements failed to show up on the computer.

The surveyor informed the administrator and the director of nursing of the above lack of documentation of baths and bowel movements for Resident #1 during an end of the day meeting on 2/1/17 at 1:25 p.m. and again on 2/2/17 at 11:15 a.m.

5. The facility staff failed to accurately document Resident #3's accurate medical status on the

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electronic insulin medication administration record.

The clinical record of Resident #3 was reviewed 1/31/17 and 2/1/17. Resident #3 was admitted to the facility 5/21/16 with diagnoses that included but not limited to metabolic syndrome, insulin dependent diabetes, gastroesophageal reflux disease, major depressive disorder, constipation, cerebrovascular accident, asthma, chronic obstructed pulmonary disease, urinary tract infection, and hypertension.

Resident #3's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/20/16 coded the resident with a cognitive summary score of 7 out of 15 in Section C and without signs or symptoms of delirium, psychosis, or behaviors.

The December 2016 electronic insulin administration documentation for 12/25/16 at 4:30 p.m. documented Resident #3's accucheck was high. The paper diabetic monitoring sheet documented that Resident #3 was out of the facility. The developmental note for 12/25/16 at 6:14 p.m. read "Resd (resident) returned to facility accompanied by his siter and brother. No skin impairment noted."

The surveyor discussed the inaccurate documentation with registered nurse #1 on 2/1/17 at 9:15 a.m. R.N. #1 reviewed the electronic record and the paper documentation and stated one was inaccurate.

The surveyor informed the administrator and the director of nursing of the above concern during a

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meeting on 2/1/17 at 1:25 p.m. and again on 2/2/17 at 11:15 a.m.

No further information was provided prior to the exit survey on 2/2/17.

6. The facility staff failed to document accurately on the December 2016 medication administration records (MARs) for Resident #11.

The clinical record of Resident #11 was reviewed 2/1/17. Resident #11 was admitted to the facility 2/3/14 and readmitted 6/19/15 with diagnoses that included but not limited to dementia without behavioral disturbances, hypertension, depression, chronic obstructive pulmonary disease, iron deficiency anemia, constipation, obsessive compulsive disorder, edema, pain, age related osteoporosis, and allergic rhinitis.

Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/16/16 assessed the resident with a cognitive summary score of 10 out of 15 and without signs/symptoms of delirium, psychosis, and behaviors.

The surveyor reviewed the physician order dated 12/9/16. The physician order read "Extend Rocephin for 7 days. Duoneb tid (three times a day) x 7 days. ST (speech therapy) consult due to possible aspiration pneumonia. Lactobacillus 1 po (by mouth) bid (twice a day) for 7 days."

The surveyor reviewed the December 2016 electronic medication administration record (eMAR). The entry for Duoneb had documentation that Resident #11 received fifteen (15) doses of Duoneb. The clinical record had

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one more documented administration of Duoneb than physician ordered. The entry for Lactobacillus had documentation that Resident #11 had been administered eight (8) doses of Lactobacillus. Resident #11 had documentation that she had received one extra dose of Lactobacillus.

The surveyor requested assistance from registered nurse #1 on 2/1/17 at 10:30 a.m. R.N. #1 reviewed the entries on the eMAR for Duonebs and Lactobacillus. The surveyor requested the pharmacy manifests for Lactobacillus and Duonebs.

The first Duoneb entry was entered on 12/9/16 at 5:00 p.m. The first entry for Lactobacillus was entered on 12/9/16 at 5:00 p.m. The surveyor and registered nurse #1 reviewed the delivery times of the medications from the pharmacy manifest. Both had the delivery time as 8:30 p.m. and actually completed 12/9/16 at 10:23:32 p.m. R.N. #1 stated the medication was not available for administration until 12/10/16. R.N. #1 "That's an error in documentation."

The surveyor informed the administrator and the director of nursing of the above documentation error in medication administration on 2/1/17 at 1:25 p.m. and again on 2/2/17 at 11:25 a.m.

No further information was provided prior to the exit conference on 2/2/17.

7. The facility staff failed to document medications administered to Resident #15 on the electronic medication administration record.

The clinical record of Resident #15 was reviewed

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2/1/17 and 2/2/17. Resident #15 was admitted to the facility 1/20/17 with diagnoses that included but not limited to end stage renal disease currently receiving dialysis, abdominal aortic aneurysm, thoracic aortic aneurysm, anemia, chronic obstructive pulmonary disease, left above the knee amputation, and methicillin resistant staphylococcus aureus (MRSA).

Resident #5's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/27/17 assessed the resident with a cognitive summary score of 12 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors.

The January 2017 physician's order sheet (POS) included an order that read "Vancomycin 500 mg A-V vial: Infuse 100 ml (milliliters) into vein every 24 hrs (hours) for 3 doses."

The surveyor reviewed the January 2017 eMAR. Vancomycin 500 mg A-V Vial: Infuse 100 ml into vein every 3 hrs for 3 doses had been entered into the computer. The first entry was documented on 1/21/17 at 5:00 p.m. with an "N".

The medication administration record notes were reviewed. The note written for 1/21/17 at 5:00 p.m. read "Vancomycin 500 mg A-V Vial: Infuse 100 ml ....scheduled for 01/21/2017 5:00 p.m. No IV access."

The surveyor was unable to locate documentation that the remaining two doses of physician order vancomycin had been administered. There was no documentation on the January 2017 eMAR of Vancomycin administration.

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The surveyor discussed the concern with the director of nursing on 2/2/17 at 8:30 a.m. The DON stated all she knew was the medication had been delivered on 1/21/17 at 12:00:40 a.m.

The surveyor informed the administrator and the director of nursing of the above concern during an end of the day meeting on 2/2/17 at 11:15 a.m.

No further information was provided prior to the exit conference on 2/2/17.

8. For Resident #5, the facility staff failed to accurately document for the administration of the probiotic lactobacillus and the medication duonebs.

The record review revealed that Resident #5 had been admitted to the facility 04/27/12. Diagnoses included, but were not limited to, diabetes, congestive heart failure, dementia with behavioral disturbances, and anxiety disorder.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/22/16 included a BIMS (brief interview for mental status) summary score of 1 out of a possible 15 points.

The Resident's clinical record included a physician's telephone orders dated 01/09/17 that included orders for duonebs three times a day for 7 days (21 doses) and lactobacillus twice a day for 7 days (14 doses).

A review of the Residents eMAR's (electronic medication administration records) for January revealed that the facility nursing staff had documented that they had administered 24 doses

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of duonebs when they should have only administered 21 doses and for the lactobacillus the nursing staff had documented they administered the medication for a total of 8 days (16 doses) vs 14 doses/7 days as ordered by the physician.

On 02/01/17 the DON (director of nursing) provided the surveyor with a copy of invoice from the pharmacy indicating that the pharmacy had dispensed 14 lactobacillus tablets and 7 days of duonebs for Resident #5.

The administrator and DON were notified of the inaccurate documentation regarding the above medications during a meeting with the survey team on 02/01/17 at 1:25 p.m.

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

9. For Resident #6, the facility staff failed to document they had administered the Resident's insulin and the results of the Residents BS (blood sugars).

The record review revealed that Resident #6 had been admitted to the facility 02/12/16. Diagnoses included, but were not limited to, acute kidney failure, chronic kidney disease, hypertension, and diabetes.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/28/16 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points.

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The Residents clinical record included a physician signed (01/03/17) POS (physician order sheet) that included orders for the following-Accuchecks twice daily for diabetes mellitus, levemir insulin 12 units every night, and levemir 20 units everyday. The 20 units of levemir had been decreased to 18 units beginning on 01/20/17.

When reviewing the eINSMAR (electronic insulin medication administration record) for January 2017 the surveyor was unable to locate any documentation to indicate the accuchecks had been completed on 01/05 and 01/08/17 at 4:30 p.m. and the facility nursing staff had not documented that they had administered the levemir insulin at 8:00 a.m. on 01/05, 01/07, and 01/08 and at 9:00 p.m. on 01/17. A review of the blood sugars that would have been obtained after these timeframe's did not reveal any abnormal blood sugar levels for this Resident.

The administrator and DON (director of nursing) were notified of the inaccurate documentation regarding the Resident's insulin and accuchecks during a meeting with the survey team on 02/01/17 at 1:25 p.m.

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

10. The facility staff failed to document the administration of a flu vaccine on Resident #7's vaccination record.

Resident #7 was admitted to the facility on 9/25/15 with the following diagnoses of, but not limited to Bipolar Disorder, anemia, high blood

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pressure, Alzheimer's disease, aphasia, dementia, anxiety disorder and depressive disorder.

Resident #7 was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/22/16 as having short term and long term memory problems with being moderately impaired with daily decision making. The resident was also coded as requiring extensive assistance of 1 staff member for dressing, eating and personal hygiene.

The surveyor conducted a clinical record review of Resident #7's record on 1/31/17. During the review, the surveyor noted that a Flu Vaccination Consent had been signed by the responsible party of Resident #7 on 11/10/16. The following documentation was noted in the nurses' notes dated for 11/10/17 at 12:41 pm: "RP (responsible party was contacted in ref (reference) to admin (administration) flu vaccine. Approved by RP and verified by 2 nurses. Flu vaccine was admin in lt (left) arm ..." The Resident Vaccine Record did not contain this documentation.

The director of nursing was notified of the above. The surveyor asked the director of nursing where the documentation should be documented. The director of nursing stated "The nurses are to document this in the nurses' notes and also fill out the Resident Vaccine Record." The surveyor showed the director of nursing the vaccine record for Resident #7 and she stated "There's no documentation of the flu vaccine given."

The administrator and director of nursing was notified of the above documented findings by the surveyor team on 2/2/17 at 11:10 am.

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