STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING _____ B. WING _____	C 03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HEALTHCARE CENTER	508 RISON STREET DANVILLE, VA 24541

(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	F 000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law.	

An unannounced Medicare/Medicaid standard survey was conducted 03/22/16 through 03/24/16. One complaint was investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 60 certified bed facility was 52 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 1 through 12) and 4 closed record reviews (Residents 13 through 16).

F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226	

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This Requirement is not met as evidenced by:
Based on staff interview, employee record review and facility document review it was determined that the facility staff failed to implement policies and procedures to prohibit abuse.
The facility staff failed to obtain criminal background checks, check for licenses and check references for 11 of 20 Employees hired within the past 12 months.
The Findings Included:
On March 24, 2016 at 2 p.m. the surveyor reviewed the facility policy and procedures titled, "Resident Abuse." The policy and procedure read in part ...
"Policy: This facility will not tolerate Mistreatment, Abuse, Involuntary Seclusion or Neglect of its

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	4/13/16

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 226	Continued From page 1 residents or Misappropriation of residents property by anyone. ... Procedure: 1). Screening It is the policy to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. a. The Facility will do the following prior to hiring a new employee; i. Generally attempt to obtain references from prior employers for an applicant; ii. Check with applicable nurse assistant registry, and any other nurse assistant registries that the Facility has reason to believe contain information on the individual, prior to using the individual as a nurse assistant; iii. Check with all applicable licensing and certification status to ensure that the employee hold the requisite license/and/or certification stats to perform their job functions; iv. Conduct criminal background check in accordance with Stat law and facility policy; ..." (sic) On March 24, 2016 at 2:10 p.m. the surveyor reviewed 20 employee records with the Human Resources Director HRD). The surveyor made the following observations: 1. A Housekeeping employee hired on 12/1/15 did not have reference checks. 2. A Dietary employee hired on 11/11/15 did not have reference checks. 3. An Occupational Therapist hired on 4/1/15 did not have a Criminal Background Check (CBD) or reference checks. 4. An Activities employee hired on 2/9/16 did not have reference checks. 5. A Dietary employee hired on 6/5/15 did not have reference checks. 6. An Admission Coordinator employee hired on 6/15/15 did not have reference checks. 7. An Occupational Therapist hired on 12/21/15 did not have Licensure verification and reference checks. 8. A Physical Therapist hired on 4/16/15 did not	F 226	**F226** Employees that did not have background checks have had background checks completed. All potential new hires will have reference checks completed. The Occupational Therapist hired on 12/21/15 has had their licensure verified. All employee files will be reviewed to assure that background checks, licensure verification, and reference checks completed. All potential new hires will have reference checks completed. The Administrator will conduct an audit monthly for three months of all new hires to assure they have competed reference checks, background checks, and licensure verification. The results of the audits will be reviewed at the monthly Quality Assurance Committee Meeting. Completion Date: 5/2/16	

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F 226	Continued From page 2 have reference checks. 9. A dietary employee hired on 7/29/15 did not have reference checks. 10. A Certified Nursing Assistant (C.N.A.) did not have reference checks. 11. An Other Admission employee hired on 6/23/15 did not have reference checks. The surveyor pointed out to the HRM that the employee records were missing License Verifications, CBC and References. The HRM acknowledged that she had not obtained the reference checks. The HRM stated that one of the employees was transferred from a sister facility and that was the reason she did not have the CBC. The surveyor notified the HRM that she, the HRD, should have the CBC on file. No additional information was provided as to why the HRD failed to implement the policy and procedure to prohibit abuse. On March 24, 2016 at 3:05 p.m. the surveyor notified the Administrator (Adm) that the HRD failed to obtain license verification CBC and reference checks on 11 of 20 employees hired within the past 12 months.	F 226		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This Requirement is not met as evidenced by: Based on resident council group interview, staff Interview and resident council group minutes review it was determined the facility staff failed to follow up and communicate a response to	F 244	**F244** The Facility has and will continue to have regular Resident Council meetings. Minutes are taken during the meeting for follow up by the appropriate staff member.	

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F 244	Continued From page 3	F 244		

resident council grievances during subsequent meetings of the council.

The Findings Included:
On March 23, 3016 at 10:30 a.m. the surveyor reviewed the Resident Group Council minutes. The surveyor reviewed the Resident Group Council minutes from September 2015 through February 2016. The Administrator (Adm) was leaning over the nurses' station and watching the surveyor review the Resident Group Council minutes. The surveyor did not see Resident Council Group minutes for January 2016. The surveyor did not see attendance/sign in sheets for September, October, November or December 2015. The surveyor also did not see any follow up from Resident Council Group concerns. The Resident Council Group minutes read in part ...
1. A Resident Council Group meeting was held on 2/25/16. The notes read in part ..."Administration: Good job, no concerns. Nursing: No concerns at this time. Dietary: (Resident name withheld) wants wheat bread. Housekeeping: Coming in when sleeping in mornings or trying to get ready. Laundry: Few things missing (Resident name withheld) pink gown missing. Maintenance: Good job (staff member name withheld) is doing a great job, living room too hot. Social Services: No concerns. Activities: Glad (name of staff member withheld) is back. Rehab: (name of resident withheld): Doctor said start therapy? Great job. Business Office: no concerns. New Business: More music programs, Easter Activities planned."
2. A Resident Council Group meeting was held on 2/1/16. The minutes read in part ..."Administration: No concerns. (staff member name withheld) great job. Nursing: Complain about changing guideline. Not wanting certain staff members. Dietary: (name of resident

Administrator attendance will be recorded in the minutes.

All residents are at risk.

The Administrator will continue to attend Resident Council meeting with the invitation of the President of the council's invitation only. The Administrator will review any concerns or grievances with the appropriate Department. Action taken will be reviewed at the following Resident Council meeting. The Administrator will review and track Resident Council meeting minutes and concerns for follow up monthly for three months.

The minutes will be reviewed at the monthly Quality Assurance Committee Meeting.

Completion Date: 5/2/16

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withheld) to talk w/ (with) (name of staff member withheld) Running out of PB (peanut butter), mustard w/ (with) hamburgers + hot dogs. Tired of wings. Housekeeping: (name of staff member withheld) good job, rooms w/ soap in bathroom fitted sheets to fit beds, green spreads too big. Laundry: (name of resident withheld)-missing purple jacket, washcloths too small, (name of resident withheld) requested dry cleaning service. Maintenance: Heating +air conditioning not working. Activities: Coloring pages, shopping, bingo. Rehab: (names of 2 residents withheld) more rehab. Other: Residents missing things, other residents roaming. New Business: Residents request for weekly meal menu." Multiple concern notes were written in the margin of the document regarding food choices, housekeeping and nursing.

3. A Resident Council Group meeting was held on 12/17/15. The notes read in part ... "Social Services: No concerns. Activities: No concerns. New Business: (name of resident withheld) missing gown. Gown ?Red full length nightgown 2 -3 weeks ago. Dietary- fig newton bars, raisons." The surveyor reviewed the Resident Council Group minutes with the Adm. The surveyor pointed out that no follow up to the Group Council Group was provided. The Adm stated that when residents made grievances/concerns in the Resident Council Group meeting the individual resident was directed to go to the Social Worker (SW) to make an individual grievance/concern report. The surveyor asked why the residents' had to go through an additional step/process to make a grievance/concern. The surveyor also asked why there was no follow up to the Resident Council Group when grievances/concerns were made. The Adm stated that once the Resident made an individual grievance/concern to the SW, the SW would then follow up with the resident

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F 244	Continued From page 5 individually. On March 23, 2016 at 1 p.m. the surveyor conducted the Resident Council Group meeting with 15 alert and oriented Resident's. The surveyor asked what happened when the Resident Council Group voiced grievances/concerns during the meeting. The group stated that the Activities Director (AD) sat in on the Resident Council Group meeting and took notes. The group stated that if grievances/concerns were voiced they were directed to go to the facility SW and make an individual grievance/concern report. One of the residents stated that some of the residents could not read or write and that the facility made it hard to voice a grievance/concern. Another resident spoke up and stated that they did not understand why the facility made the residents go through an extra step to voice a grievance/concern. The Resident Council Group stated that the facility staff did not follow up with them regarding voiced group grievances/concerns. On March 23, 2016 at 3:50 p.m. the survey team met with the Adm, Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility did not follow up with voiced Resident Council Group grievances/concerns. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow up with the Resident Council Group meeting grievances/concerns.	F 244		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings	F 252		

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F 252	Continued From page 6	F 252	F252	

to the extent possible.

This Requirement is not met as evidenced by:
Based on observation, and staff interview, it was determined the facility staff failed to provide residents with a safe, clean, comfortable and homelike environment in their rooms and common areas.

Findings:

Facility staff failed to provide residents with a safe, clean, comfortable and homelike environment in 15 of their 30 rooms and in the common areas. The following observations were made on the initial tour beginning at 12:45 PM on 3/22/16 and continued through the entire survey ending at 4:30 PM on 3/24/16.

The following observations were made:

1. Resident rooms were observed to have dirt and debris build up on the floors and particularly thick behind the doors. The vinyl baseboards were observed to be warping and pulling away from the walls in rooms and bathrooms. Paint was scraped and chipped on the walls of bedrooms and needed repair. The room doors were observed to be scuffed and scarred from equipment damage. The vinyl tiles covering the floors were broken and missing in areas. This was observed in rooms # 216, 214, 212, 209, 210, 207, 208, 205, 114, 109, 103, 105, 102, 101, and 103.

2. In the hallways, vinyl baseboards were observed to be warping and coming away from the walls. The hallway tiles were chipped and broken sporadically throughout the facility. A large

Rooms where build up is present on the floors and behind doors will be cleaned, loose vinyl baseboard will be secured where present including hallways, painting will be performed where needed in rooms and bathrooms, room doors will be sanded or repaired, vinyl tiles will be replaced/repaired in rooms 216, 214, 212, 209, 210, 207, 208, 205, 114, 109, 103, 105, 102, 101, and 103. hallway tiles will be replaced/repaired, handrails repaired, handrail outside the Director of Nursing Office secured, living room carpet cleaned or replaced, furniture in living room repaired/replaced, edges of doors repaired, staff bathrooms cleaned, baseboards secured, painting in bathrooms where needed, carpeting in the Business

Office, MDS Office, and Administrator office will be secured/replaced.

All areas of the facility will be reviewed to ascertain where additional repairs or replacement are necessary.

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slab crack was raising and cracking tiles in a full widthwise projectile in the middle of the two hall. Paint was scuffed and knocked from the walls.

3. The handrails in the hallway were wooden. They were observed scuffed with numerous splintered areas in the resident common hallways. One section of handrail, located outside the DON's (director of nursing) office was not firmly secured to the wall and could be shaken easily with one hand.

4. The living room carpet was observed to be stained and unsightly. The furniture in the living room was observed to have scratched and worn wood in the legs of both chairs and tables. One wooden table, being used as a finger nail polishing station, had been damaged by the polish remover and the finish was completely eroded away in areas.

On 3/24/16 at 2:30 PM, the MD (maintenance director) was interviewed about the condition of the facility. He said he had not long been hired and was trying to catch up on the many conditions that needed attention in this facility, "It's a very old facility. It requires a lot of attention."

On 3/24/16 at 2:45 PM, during a tour of the facility with the MD (maintenance director) the surveyor pointed out the wooden handrails were very worn and splintering in places. The MD said he kept them smoothed as well as he could--but they were old and any equipment (wheelchairs, gurneys) scratching the service would cause splinters.

The MD said he would like to get new handrails for the facility made of a material that didn't

All areas cited during the survey will be reviewed monthly for three months by the Administrator to assure they are maintained/repaired and inspect entire facility for cleanliness and repairs.

The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting.

Completion Date 5/2/16

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splinter the way wood does. The MD noted anyone getting a splinter like that could end up with an infection caused by whatever organism was contained on the surface.

The surveyor also pointed out the edges of several doors that were worn or had been gauged on the edges by equipment. These rough edges had a potential for harm if any resident scraped a hand or arm against them.

The surveyor also pointed out a loose section of handrail clinging loosely to the wall across the hall from the DON's (director of nursing) office. It shook easily with one hand and could easily come off the wall if a great deal of weight were applied to it.

5. Two staff bathrooms were dirty with dark debris and trash behind the doors. A build up of debris was noted behind the toilets and on the baseboards which were warped and falling a away from the walls.
The paint was scuffed and dingy and the tiles were wearing on the edges. The staff bathroom on unit II was full of water from a toilet overflowing. No one was aware of attending the issue during this observation.

6. The three administrative offices up front (Business office, MDS (minimum data set) office and the administrator's office) were all observed to need new carpet. The carpet in the offices was rolled up and loose. This was not in a single area or two--but the ripples and rolls were prevalent all throughout all three offices. This surveyor actually tripped over one of the "rolled up areas" when entering the Business office for information.

On 3/24/16 at 4:00 PM the DON (director of

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F 252	Continued From page 9 nursing) and administrator were informed of these findings. The administrator was informed of the surveyor's observations on 3/24/16.	F 252		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**F272** The MDS Coordinator and MDS nurse will be in-serviced by the Regional Reimbursement Nurse on how to complete accurate CAAs on an MDS. MDS for residents 1, 2, 5, 6, 7, 8 will be updated and accurate. All residents have the potential to be affected. All future CAAs will include the location and date of supporting documentation. Audits of CAAs will be done for MDS completed that week by DON or designee weekly x 4 then monthly to ensure the date and location of supporting documentation is documented. The results of the audits will be reviewed at the monthly QA committee meeting. Completion date 5/2/16	

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This Requirement is not met as evidenced by:
Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate Care Area Assessment Summary (CAA'S) for 6 of 16 Residents in the sample survey, Resident #1, Resident #2, Resident #6, Resident #5, Resident #7 and Resident #8.
The Findings Included:
1. For Resident #1 the facility staff failed to ensure a complete and accurate Section V. Care Area Assessment Summary (CAA's) on an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/16. Resident #1 was a 66 year old male who was admitted on 2/2/16. Admitting diagnoses included, but were not limited to: spinal stenosis in the lumbar region, degeneration disc disease, diabetes mellitus, hypertension, and high cholesterol.
The most current MDS located in the clinical record was a 30 Day MDS assessment with an ARD of 3/1/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #1 required set up assistance (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL's).
On March 22, 2016 at 3:10 p.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced an Admission MDS assessment with an ARD of 2/9/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 15. The facility staff also

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coded that Resident #1 required extensive assistance (3/3) with ADL's. In Section V. CAA'S in the column titled, "Location and Date of CAA documentation" the facility staff coded ... "CAA WS (work sheet) dated 2/15/16 ....CAA WS dated 2/10/16." (sic) Continued review of the MDS produced CAA worksheet. The CAA worksheet documented what "triggered" from the MDS. The CAA'S did not document the location or date of supporting documentation for the CAA's care plan making decision.

On March 22, 2016 at 3:50 p.m. the surveyor notified the Director of Nursing (DON) that Resident #1's Admission MDS assessment with the ARD of 2/09/16 did not have complete and accurate CAA'S. The surveyor reviewed Resident #1's clinical record with the DON. The surveyor pointed out that the CAA'S were not complete and accurate. The surveyor pointed out that the facility staff documented, "CAA WS (work sheet) dated 2/15/16 ...CAA WS dated 2/10/16." (sic) The surveyor notified the DON that the specific location and date of the supporting documentation had to be documented in Section V. CAA'S.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #1's Admission MDS assessment with the ARD of 2/09/16 CAA'S were not completed.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate CAA'S for Resident #1.

2. For Resident #2 the facility staff failed to ensure complete and accurate Section V. Care Area Assessment Summary (CAA'S) on an Annual Minimum Date Set (MDS) assessment

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with an Assessment Reference Date (ARD) of 9/15/15.
Resident #2 was an 85 year old female who was originally admitted on 1/1/11 and readmitted on 2/28/14. Admitting diagnoses included, but were not limited to the following: fall, diabetes mellitus, cerebrovascular accident, hypertension, osteoarthritis, morbid obesity, urinary tract infection, cardiomyopathy, anxiety, depression, asthma and bipolar.
The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 2/3/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #2 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's).
On March 23, 2016 at 2:30 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced an Annual MDS assessment with an ARD of 9/15/15. The facility staff coded that Resident #2 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #2 required extensive assistance (3/3) to total nursing care (4/2) with ADL's. In Section V. CAA'S in the column titled, "Location and Date of CAA documentation" the facility staff coded ... "CAA WS (work sheet) dated 9/21/15 ....CAA WS dated 9/18/15 ...CAA WS dated 9/16/15." (sic) Continued review of the MDS produced CAA worksheet. The CAA worksheet documented what "triggered" from the MDS. The CAA'S did not document the location or date of supporting documentation for the CAA's care plan making decision.
On March 24, 2016 at 9 a.m. the surveyor notified the MDS Nurse that Resident #2's Annual MDS with the ARD of 9/15/15 CAA'S were not accurate/complete. The surveyor reviewed the MDS with the MDS Nurse. The surveyor

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reviewed Section V. CAA'S and the CAA'S worksheet with the MDS Nurse. The surveyor pointed out that specific location and date of supporting documentation for the care plan decision making was not documented on the CAA'S or CAA'S worksheet. The surveyor notified the MDS Nurse that specific location and dates of supporting documentation regarding the care plan making decision had to be documented.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #2's Annual MDS assessment with the ARD of 9/15/15 CAA'S were not completed.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate CAA'S for Resident #2.

3. For Resident #6 the facility staff failed to ensure complete and accurate Section V. Care Area Assessment Summary (CAA'S) on an Admission and 5 Day Medicare Minimum Data Set (MDS) assessment with an Assessment Reference Date of 2/20/16.

Resident #6 was a 92 year old female who was admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection, encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease.

The most current MDS located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 required limited (2/2)

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to extensive assistance (3/2) with Activities of Daily Living (ADL's).
On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced an Admission and 5 Day Medicare MDS assessment with an ARD of 2/20/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section V. Care Area Assessment Summary (CAA's) column titled, "Location and Date of CAA documentation" the facility staff documented, "CAA WS (work sheet) dated 2/22/16" for each CAA triggered. (sic) Continued review of the MDS produced CAA worksheet. The CAA worksheet documented what "triggered" from the MDS. The CAA'S did not document the location or date of supporting documentation for the CA s care plan making decision.
On March 22, 2016 at 4:55 p.m. the surveyor notified the Director of Nursing (DON) that Resident #6 's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 did not have complete and accurate CAA'S. The surveyor reviewed Resident #6's clinical record/MDS with the DON. The surveyor pointed out that the CAA'S were not complete and accurate. The surveyor pointed out that the facility staff documented, "CAA WS (work sheet) dated 2/22/16." (sic) The surveyor notified the DON that the specific location and date of the supporting documentation had to be documented in Section V. CAA's for the decision making process.
On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified

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the Administrative Team (AT) that Resident #6's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 CAA'S were not completed.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate CAA'S for Resident #6.
4. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident #5. The resident's clinical record was reviewed on 3/23/16 at 9:00 AM.

Resident # 5 was admitted to the facility on 10/6/15. The diagnoses included Bipolar disorder, diabetes, coronary artery disease and cerebral vascular accident with hemi-plegia.

The resident's significant change MDS (minimum data set) assessment dated 10/13/15 coded the resident with unimpaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of daily living.)

The MDS contained CAA's signed and dated 10/19/15. The location and date section (Section V) of the CAA documentation was observed to be incomplete for location and dates of the summarized material.

This information was shared with the DON and administrator on 3/23/16 at 3:30 PM. No additional info was provided.

5. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident #7. Resident #7's clinical record was reviewed on 3/23/16 at 11:30 AM.

Resident #7 was admitted to the facility on 2/2/16.

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The diagnoses included hypertension, congestive pulmonary disease, end-stage renal disease and Hepatitis C.

The resident's annual MDS (minimum data set) assessment dated 2/9/16 coded the resident with slightly impaired cognitive impairment. Resident #7 required staff assistance for all ADL (activities of daily living.)

The MDS contained CAA's signed and dated 2/11/16. The location and date of the CAA documentation (Section V) was observed to be incomplete for dates and location of the information upon which this summary was based.

This information was shared with the DON and administrator On 3/23/16 at 3:30 PM.

7. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident # 8. The resident's clinical record was reviewed on 3/23/16 at 9:30 AM.

Resident # 8 was admitted to the facility on 10/1/10. The diagnoses included psychosis, depression, hypertension, diabetes, and cancer.

The resident's annual MDS (minimum data set) assessment dated 10/6/15 coded the resident with unimpaired cognitive ability. Resident #8 required staff assistance for all ADL (activities of daily living.)

The MDS contained CAA's signed and dated 10/13/15. The location and date section (Section V) of the CAA documentation was observed to be incomplete for location and dates of the summarized material.

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F 272	Continued From page 17 This information was shared with the DON and administrator on 3/23/16 at 3:30 PM. No additional info was provided.	F 272	**F278** Resident #6's MDS with ARD of 2/20/16 was amended to reflect coding of a UTI and Psychotropic drug use. All residents have potential to be affected. Resident #5's Significant Change MDS dated 10/13/15 was amended to reflect use of antipsychotics during the look back period. All residents have the potential to be affected. The MDS Coordinator and MDS nurse will be educated by the Regional Reimbursement Nurse on accurate coding of UTIs and psychotropic drug use including but not limited to antipsychotics. An audit of completed MDS will be done weekly x 4 weeks by DON or designee then monthly to ensure proper coding of UTIs and psychotropics. The results of the audits will be reviewed at the monthly QA committee meeting. Completion date 5/2/16	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. 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 it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 2 of 16 Residents in	F 278		

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the sample survey, Resident #6 and Resident #5.
The Findings Included:
1. For Resident #6 the facility staff failed to code/capture a Urinary Tract Infection and Psychotropic Drug use on an Admission and 5 Day Medicare Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/20/16.
Resident #6 was a 92 year old female who was admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection, encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease.
The most current MDS located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's).
On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced a hospital History and Physical dated 2/11/16. The History and Physical documented that Resident #6 was seen in the emergency room after Resident #6 had a change in mental status. The History and Physical also documented that Resident #6 had urinary frequency and painful urination. The History and Physical documented that Resident #6's urinalysis showed a small amount of blood, small leukoctye esterase with WBC's (white blood cells) between 5-10. The History and Physical documented "Metabolic encephalopathy secondary to urinary tract infection complicated by advanced dementia." (sic) Lastly the History and Physical documented that the physician

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ordered ceftriaxone (an antibiotic) 1 gram every 24 hours.
Further review of the clinical record produced admission orders for Resident #6. Review of the physician signed admission orders included, but were not limited to: "Risperidone (a psychotropic drug) 0.25 mg 1 po (by mouth) BID (twice a day)." (sic)
Continued review of the clinical record produced the February 2016 Medication Administration Records (MAR's). The February 2016 MAR's documented that Resident #6 received the Risperidone 0.25mg BID as ordered by the physician.
Additional review of the clinical record produced an Admission and 5 Day Medicare MDS assessment with an ARD of 2/20/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section I. Active Diagnoses I2300 Urinary Tract Infection (UTI) (last 30 Days) was not coded/captured. In Section N. Medications A. Antipsychotic the facility staff documented "0" indicating that Resident #6 did not receive any psychotropic medications within the past 7 days.
On March 22, 2016 at 4:55 p.m. the surveyor notified the Director of Nursing (DON) that Resident #6's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 was inaccurate. The surveyor reviewed Resident #6's clinical record with the DON. The surveyor pointed out that Resident #6 History and Physical documented that Resident #6 was admitted into the hospital with a UTI. The surveyor also pointed out that Resident #6 was admitted into the facility with orders for Risperidone and that the MAR's documented that Resident #6 received the

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Risperidone. The surveyor then reviewed the Admission and 5 Day Medicare MDS with the DON. The surveyor pointed out that the UTI and the psychotropic drug use (Risperidone) was not captured/coded on the MDS.
On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #6's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 was inaccurate. The surveyor notified the AT that the MDS did not capture/code Resident #6's UTI or psychotropic drug use.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #6.
2. Facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for Resident #5. The resident's antipsychotic medication (Fluoperazine) was not recorded as part of her drug regimen. The clinical record was reviewed 3/23/16 at 9:00 AM.

Resident # 5 was admitted to the facility on 10/6/15. The diagnoses included Bipolar disorder, diabetes, coronary artery disease and cerebral vascular accident with hemi-plegia.

The resident's significant change MDS (minimum data set) assessment dated 10/13/15 coded the resident with unimpaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of daily living.) The resident was not coded during the MDS look-back period for the use of antipsychotics

The CCP (comprehensive care plan) reviewed

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F 278	Continued From page 21 and revised 1/19/16 included the resident's potential for adverse drug related complications due to psychotropic med use: Diagnosis, Major depression and psychotic bipolar disorder. The interventions included: 1. Assess the resident's mood state and behavior 2. Meds per order 3. Monitor the actions of the resident for inappropriateness 4. Monitor the resident's mental status functioning on on-going basis. Resident #5's physician's orders, signed and dated 2/27/16, included "Trifluoperazine HcL 2 mg (milligram) ....take 1 tab by mouth every day for Bipolar." The order was implemented by staff and observed daily on the medication records beginning on 10/6/15 and continued until present. On 9/23/16 at 9:00 AM MDS I (minimum data set staffer) was asked why the antipsychotics did not appear on Resident #5's significant change MDS--even though she had been provided with the medication throughout the entire look-back period. MDS I said they must have overlooked it. This information was shared with the DON and administrator on 3/23/16 at 3:30 PM. No additional info was provided.	F 278	F279 Resident #2's Comprehensive Care Plan has been updated to include communication deficit. Resident #3's Comprehensive Care Plan has been updated to include ADL deficit.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	Resident #6's Comprehensive Care Plan has been updated to include Nutritional Status. The MDS Coordinator and MDS nurse will be educated by the DON on including communication deficits and ADL deficits. The Registered Dietician	

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needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This Requirement is not met as evidenced by:
Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to develop a Comprehensive Care Plan (CCP) for 3 of 16 Residents in the sample survey, Resident #2, Resident #3 and Resident #6.
The Findings Included:
1. For Resident #2 the facility staff failed to develop a Comprehensive Care Plan (CCP) to include a care plan for Communication as triggered and identified on an Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/15/15.
Resident #2 was an 85 year old female who was originally admitted on 1/1/11 and readmitted on 2/28/14. Admitting diagnoses included, but were not limited to the following: fall, diabetes mellitus, cerebrovascular accident, hypertension, osteoarthritis, morbid obesity, urinary tract infection, cardiomyopathy, anxiety, depression, asthma and bipolar.
The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 2/3/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of

and Dietary Manager will be educated by the DON on including Nutritional Status in the Comprehensive Care Plans.

All current Care Plans reviewed for accuracy to include communication deficit if applicable, ADLs and nutritional status to identify other residents at risk.

A care plan audit will be done weekly x 4 weeks of care plans due that week by DON or designee then monthly on all new admits going forward to ensure accuracy to include communication deficit, ADL deficit and nutritional status.

The audit results will be reviewed at the monthly QA Committee meeting.

Completion Date 5/2/16

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14. In Section B. Hearing, Speech, and Vision the facility staff coded that Resident #2 was "1.Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time." (sic) The facility staff also coded that Resident #2 was "1. Usually understands-misses some part/intent of message but comprehends most conversation." (sic) The facility staff also coded that Resident #2 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's).
On March 23, 2016 at 2:30 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced an Annual MDS assessment with an ARD of 9/15/15. The facility staff coded that Resident #2 had a Cognitive Summary Score of 15. The facility staff coded in Section B. Hearing, Speech, and Vision the facility staff coded that Resident #2 was "1.Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time." The facility staff also coded that Resident #2 was "1. Usually understands-misses some part/intent of message but comprehends most conversation." (sic)The facility staff also coded that Resident #2 required extensive assistance (3/3) to total nursing care (4/2) with ADL's. In Section V. Care Area Assessment Summary (CAA'S) Resident #2 "triggered" for Communication. The facility staff documented that a care plan would be developed to address Resident #2's Communication deficit. Continued review of the clinical record produced the CCP. Review of the CCP failed to include a care plan for Resident #2's Communication deficit.
On March 23, 2015 at 3 p.m. and on March 24, 2015 at 9:30 a.m. the surveyor interviewed Resident #2. The surveyor noted that Resident #2's speech was garbled due to being

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edentulous. The surveyor also had to repeat herself several times to ensure that Resident #2 understood the surveyor.
On March 24, 2016 at 9 a.m. the surveyor notified the MDS Nurse that Resident #2's "triggered" for Communication on the Annual MDS with the ARD of 9/15/15. The surveyor notified the MDS Nurse that the facility staff documented that a care plan would be developed to address Resident #2's Communication deficit. The surveyor notified the MDS Nurse that review of the CCP failed to produce a care plan that addressed Resident #2's Communication deficit. The MDS Nurse reviewed the CCP and was unable to locate a care plan that addressed Resident #2's Communication deficit.
On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to develop a CCP for Resident #2 to include Communication deficit as "triggered" on the Annual MDS with the ARD of 9/15/15.
No additional information was provided prior to exiting the facility as to why the facility staff failed to develop a CCP for Resident #2.

2. Resident #3 was an 85 year old female who was admitted on 11/12/11. Admitting diagnoses included, but were not limited to: ischemic heart disease, restless leg syndrome, dementia, urinary tract infection, hypertension, vitamin D deficiency and paralysis agitans.
The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 3/16/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #3

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required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section V. Care Area Assessment Summary (CAA's) Resident #3 "triggered" for ADL's. The facility staff documented that a care plan would be developed to address Resident #3's ADL deficit.

On March 24, 2016 at 9 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP failed to include a care plan that addressed Resident #3's ADL deficit.

Continued review of the clinical record produced a Social Worker (SW) note stating that Resident #3 was taken to care conference on 3/22/16.

On March 23, 2016 at 10:15 a.m. the surveyor notified The Director of Nursing (DON) that Resident #3 "triggered" for ADL's on the Annual MDS with the ARD of 3/16/16. The surveyor notified the DON that the facility staff documented that a care plan would be developed to address Resident #3's ADL deficit. The surveyor notified the DON that a care plan that addressed Resident #3's ADL deficit could not be located in the CCP. The surveyor reviewed the Annual MDS with the ARD of 3/16/16 and the CCP with the DON. The DON was unable to locate a care plan that addressed Resident #3's ADL deficit.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to develop a CCP, to include ADL status/deficit, as "triggered/identified" on the Annual MDS assessment with the ARD of 3/16/16.

No additional information was provided prior to exiting the facility as to why the facility staff failed

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to develop a CCP for Resident #3.
3. For Resident #6 the facility staff failed to develop a Comprehensive Care Plan as "triggered/identified" on an Admission and 5 Day Medicare Minimum Data Set (MDS) assessment with an Assessment Reference Date of 2/20/16. The facility staff failed to develop a care plan that addressed Resident #6's Nutritional Status. Resident #6 was a 92 year old female who was admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection, encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease.
The most current MDS located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section K. Swallowing/Nutritional Status Resident the facility staff coded that Resident #6 was receiving a therapeutic diet.
On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced an Admission and 5 Day Medicare MDS assessment with an ARD of 2/20/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section K. Swallowing/Nutritional Status the facility staff coded that Resident #6 was receiving a therapeutic diet. In Section V. Care Area Assessment Summary (CAA's) Resident #6 "triggered/identified" for Nutritional Status. The

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F 279	Continued From page 27 facility staff documented that a care plan would be developed to address Resident #6's Nutritional Status. Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP failed to include a care plan that addressed Resident #6's Nutritional Status. On March 22, 2016 at 4:55 p.m. the surveyor notified the Director of Nursing (DON) that Resident #6's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 "triggered" for Nutritional Status. The surveyor notified the DON that review of the CCP failed to include a care plan that addressed Resident #6's Nutritional Status. The surveyor reviewed the MDS and CCP with the DON. The DON was unable to locate a care plan that addressed Resident #6's Nutritional Status. On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to develop a CCP, to include Nutritional Status, as "triggered/identified" on Resident #6's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 No additional information was provided prior to exiting the facility as to why the facility staff failed to develop a CCP, to include Nutritional Status, for Resident #6.	F 279	**F309** The facility has a signed contract with the Dialysis provider and a dialysis policy. All residents are at risk who are receiving dialysis. The Administrator will review all contracted resident services to assure contracts and policies are present and current. The Administrator will review the Dialysis contract and policy monthly for three months. Results will be reviewed at the monthly Quality Assurance Committee meeting. Completion Date: 5/2/16	
F [redacted] SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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This Requirement is not met as evidenced by:
Based on observation, staff interview and clinical record review it was determined the facility staff failed to maintain a contractual agreement with a dialysis service for 1 of 16 residents (Resident #7) to ensure the resident received and the facility provided the necessary care and services in accordance with the comprehensive assessment and plan of care. Resident #7's clinical record was reviewed on 3/23/16 at 11:30 AM.

Resident #7 was admitted to the facility on 2/2/16. The diagnoses included hypertension, congestive pulmonary disease, end-stage renal disease and Hepatitis C.

The resident's annual MDS(minimum data set assessment dated 2/9/16 coded the resident with slightly impaired cognitive impairment. Resident #7 required staff assistance for all ADL activities of daily living). The resident was coded with receiving dialysis services.

Resident #7 had a physician's order, signed and dated 2/4/16, for dialysis Monday, Wednesday and Friday.

The resident's CCP (comprehensive care plan) reviewed and revised on 2/9/16 gave the problems:
1. Resident receives dialysis treatments three times weekly. ESRD (end stage renal disease)

The CCP interventions included:
1. Monitor shunt/cath site for bleeding or signs of infection.
2. No labs B/P on shunt arm.

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F 309	Continued From page 29 3. Monitor thrill and bruit per routine or specific orders. 4. Assess/monitor for signs of bleeding 5. Assist with transfer needs when going to dialysis. 6. Maintain communication with dialysis staff and physician per routine. 7. Dialysis per orders. Tuesday, Thursday, Saturday. The resident was observed on 3/23/16 at 11:30 AM. He was lying quietly in his bed. The resident was observed to have long ragged fingernails with dark debris embedded under all ten nails. CNA I agreed it was time to trim his nails. On 3/23/16 at 2:00 PM the surveyor asked the DON for the dialysis communication sheets, policy and procedure for dialysis and the contract/agreement between the facility and the provider. The DON provided the dialysis communication tool--but did not have a current policy and procedure for managing dialysis services. She also said she did not have a contract/agreement with the dialysis company--but the administrator was trying to obtain one from the dialysis facility. This information was shared with the DON and administrator On 3/24/16 at 4:30 PM. The administrator did tell the survey team that no agreement/contract was in place with the dialysis company and there was no dialysis policy and procedure.	F 309	F312 Residents 5 and 7 have received nail care. All residents were reviewed for the need of nail care. 100% licensed nurses and nurse aides will be in-serviced by DON or designee on nail care policy and to document refusals. Random resident care audits will be performed by DON or designee to ensure residents have received nail care weekly for four weeks. The results of the audits will be reviewed at the monthly QA committee meeting. Completion Date 5/2/16	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 30 and oral hygiene.	F 312		

This Requirement is not met as evidenced by:
Based on observation, staff interview and clinical record review, it was determined the facility staff failed to provide adequate ADL (activities of daily living) assistance (nail care) to 2 of 16 residents (Resident #7 and #5.)

Findings:

1. Facility staff failed to assist Resident #7 with nail care as needed. Resident #7's clinical record was reviewed on 3/23/16 at 11:30 AM.

Resident #7 was admitted to the facility on 2/2/16. The diagnoses included hypertension, congestive pulmonary disease, end-stage renal disease and Hepatitis C.

The resident's annual MDS(minimum data set assessment dated 2/9/16 coded the resident with slightly impaired cognitive impairment. Resident #7 required staff assistance for all ADL activities of daily living.)The resident was coded with receiving dialysis services.

The resident's CCP (comprehensive care plan) reviewed and revised on 2/9/16 gave the problems:
1. Needs assistance with all ADLs r/t decreased mobility/function and weakness.

The CCP interventions included:
1. Provide assistance with ADLs/oral needs per routine and as needed.

The resident was observed on 3/23/16 at 11:30

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AM. He was lying quietly in his bed. The resident was observed to have long ragged fingernails with dark debris embedded under all ten nails. CNA I agreed it was time to trim his nails.

This information was shared with the DON and administrator On 3/23/16 at 3:30 PM.

2. Facility staff failed to provide Resident #5 with needed nail care. The resident's clinical record was reviewed on 3/23/16 at 9:00 AM.

Resident # 5 was admitted to the facility on 10/6/15. The diagnoses included Bipolar disorder, diabetes, coronary artery disease and cerebral vascular accident with hemi-plegia.

The resident's significant change MDS (minimum data set) assessment dated 10/13/15 coded the resident with unimpaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of daily living.)

The latest CCP, reviewed and revised on 1/18/16 documented the resident needed assistance with ADLs due to functional status, hemiparesis, and immobility. The interventions included: "Check nail length and trim and clean on bath day and as necessary."

On 3/22/16 at 2:30 PM and again on 3/23/16 at 10:30 AM the resident's fingernails were observed. The nails were long and chipped with dark debris underneath them. CNA II looked at the nails and said they "were kinda dirty." CNA II said she'd take care of it right away. CNA II said the resident had just had her shower yesterday.

This information was provided to the DON and administrator on 3/23/16 at 3:30 PM.

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F 312	Continued From page 32 This information was shared with the DON and administrator on 3/23/16 at 3:30 PM. No additional info was provided.	F 312		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This Requirement is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to provide podiatry services for 1 of 16 Residents in the sample survey, Resident #3. The Findings Included: Resident #3 was an 85 year old female who was admitted on 11/12/11. Admitting diagnoses included, but were not limited to: ischemic heart disease, restless leg syndrome, dementia, urinary tract infection, hypertension, vitamin D deficiency and paralysis agitans. The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 3/16/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #3 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's).	F 328	F328 Resident #3 was scheduled for podiatry services. Resident #3 refused podiatry services on 3/28/16 and this was documented in her record. Podiatrist will attempt to treat resident #3 each time he visits. Random resident care audits will be performed by DON or designee to ensure podiatry services offered, received and refusals documented. The results of the audits will be reviewed at the monthly QA committee meeting. Completion date 5/2/16	

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Continued review of the clinical record produced a "Podiatry Note" dated 7/20/15. The Podiatry Note documented that Resident #3 had complained of discomfort from long thick toenails. The notes also documented that pedal pulses were not palpable. The notes also documented that the toenails were thick, discolored and flaking,

On March 23, 2016 at 10:50 a.m. the surveyor requested to see Resident #3's toenails. A Restorative Aide approached the surveyor and informed the surveyor that Resident #3 was up in her wheelchair and at the side of her bed. The surveyor and Restorative Aide walked down to Resident #3's room. The surveyor observed a Licensed Practical Nurse (LPN #1) sitting beside Resident #3 administering her medications. The surveyor asked Resident #3 if she could look at her toenails and Resident #3 stated, "Yes." The surveyor pulled back a white towel exposing Resident #3's feet. The surveyor observed that the toenails were extremely long, thick and discolored. The surveyor informed the Restorative Aide and LPN (#1) that Resident #3 's toenails were too long, thick and discolored.

On March 23, 2016 at 11 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3's toenails were long, thick and discolored. The DON stated that the podiatrist usually visited quarterly. The surveyor notified the DON that Resident #3 had not been seen by the podiatrist 8 months.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #6's toenails were long, thick and discolored. The surveyor notified the AT that Resident #3 should have been seen by the podiatrist. The DON

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F 328	Continued From page 34 stated that Resident #3 refused treatment and care at times. The surveyor notified the DON that review of the nursing notes did not document a refusal of podiatry services. The surveyor notified the DON if she, the DON, was able to locate notes documenting Resident #3's refusal of podiatry services to provide a copy to the surveyor. No additional information was provided prior to exiting the facility as to why the facility staff failed to provide podiatry services to Resident #3.	F 328		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F329** Residents #2, 3, 5 and 6 now have behavior monitoring sheets in place	

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F 329	Continued From page 35 This Requirement is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to ensure that 6 of 16 Residents in the sample survey were free from unnecessary medications, Resident #2, Resident #3, Resident #6, Resident #5, Resident #8 and Resident #9. The facility staff failed to monitor psychotropic drug use in the Residents, who received psychotropic medications. The Findings Included: 1. For Resident #2 the facility staff failed to monitor for psychotropic drug (Depakote Sprinkles) use to include: specific behavior, interventions, side effects and effectiveness. Resident #2 was an 85 year old female who was originally admitted on 1/1/11 and readmitted on 2/28/14. Admitting diagnoses included, but were not limited to the following: fall, diabetes mellitus, cerebrovascular accident, hypertension, osteoarthritis, morbid obesity, urinary tract infection, cardiomyopathy, anxiety, depression, asthma and bipolar. The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 2/3/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #2 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). On March 23, 2016 at 2:30 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to: "Sertraline HCL ER 5 mg tablet for > Zoloft F/C take 1 tab (tablet) by mouth every morning for depression. Divalproex Sodium 125 mg cap (capsule) Sprink (sprinkles) for> Depakote Sprinkle take 2 capsules (250mg) by mouth twice daily for Bipolar' Disorder." (sic)	F 329	for each antipsychotic medication being administered to them with the appropriate target behaviors and diagnoses listed. Resident # 9 has been discharged home, Resident #8 psychotropic medication has been discontinued. 100% licensed nurses will be in-serviced on the behavior management policy to include utilizing and documenting behaviors each shift using the behavior monitoring form and progress notes. All residents receiving antipsychotic medications medical record reviewed to ensure the behavior monitoring form was in place with the appropriate diagnosis and target behaviors listed and that this was being documented on each shift. A review of those residents medical record will be audited by the DON or designee weekly x 4 weeks then monthly. The results of the audits will be reviewed at the monthly QA committee meeting. Completion Date 5/2/16	

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The order for the Depakote was changed on 12/11/15. The order for the Zoloft originated on 12/11/15.

Further review of the clinical record produced an original physician order for Depakote Sodium 125mg by mouth TID (three times a day) on 10/15/15.

Continued review of the clinical record failed to produce behavior monitoring for October and November 2015. Additionally the behavior monitoring sheet for December 2015 documented that Zoloft (an antidepressant) and Depakote Sodium (a psychotropic) were being administered for depression and withdrawal. The behavioral monitoring sheet did not identify that Resident #2 was receiving the Depakote for a diagnosis of being Bipolar.

On March 23, 2016 at 3:15 p.m. the surveyor notified the Director of Nursing (DON) that Resident #2 was on Depakote Sprinkles for a diagnosis of being Bipolar and Zoloft for a diagnosis of depression. The surveyor notified the DON that review of the clinical record failed to produce behavior monitoring sheets for October and November 2015. The surveyor notified the DON that the facility had to monitor for specific behaviors related to the psychotropic (Depakote) medication use, medication effectiveness, interventions and side effects. The surveyor also notified the DON that Resident #2's December 2015 behavior monitoring sheet stated that the Zoloft and Depakote were being administered for depression and withdrawal, when in fact Resident #2 was receiving the Depakote for a diagnosis of being Bipolar. The surveyor notified the DON that the behavioral monitoring for Zoloft (an antidepressant) and the Depakote (a psychotropic) could not be documented on the same behavioral monitoring sheet. The surveyor reviewed Resident #2's clinical record with the

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DON. Behavioral monitoring sheets for October and November 2015 could not be located. The surveyor reviewed the December 2015 behavioral monitoring sheet with the DON and pointed out that the behavioral monitoring sheet was inaccurate.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that that Resident #2 was on Depakote Sprinkles for a diagnosis of being Bipolar. The surveyor notified the AT that behavior monitoring was not done in October and November 2015. The surveyor also informed the AT that Resident #2's behavior monitoring sheet for December 2015 stated that Resident #2 was receiving the Zoloft and Depakote Sprinkles for withdrawal and depression, when in fact, Resident #2 was receiving the Depakote Sprinkles for a diagnosis of being Bipolar. The surveyor informed the AT that the facility staff had to monitor for specific behaviors related to the psychotropic medication use, medication effectiveness, interventions and side effects.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #2 was free from unnecessary medications. The facility staff failed to monitor for specific behaviors related to the Depakote Sprinkles (a psychotropic medication) use, medication effectiveness, interventions and side effects.

2. For Resident #3 the facility staff failed to monitor for psychotropic drug (Seroquel and Abilify) use to include: specific behavior, interventions, side effects and effectiveness. Resident #3 was an 85 year old female who was admitted on 11/12/11. Admitting diagnoses included, but were not limited to: ischemic heart

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disease, restless leg syndrome, dementia, urinary tract infection, hypertension, vitamin D deficiency and paralysis agitans.
The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 3/16/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #3 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's).
On March 24, 2016 at 9 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced the April, May, June, July and August 2015 Medication Administration Records (MAR's). Review of the MAR's documented that Resident #3 received Seroquel 25mg by mouth every night at bedtime.
Continued review of the clinical record failed to produce behavioral monitoring sheets for the Seroquel for April, May, June, July and August of 2015. The Seroquel was discontinued on 8/25/15.
Further review of the clinical record produced signed physician orders that included, but were not limited to: "Abilify 2 mg tablet take 1 tab (tablet) by mouth every morning for DPSD **Do Not Switch-Brand dispensed for Insurance**." (sic) The order for the Abilify originated on 6/23/15.
Continued review of the clinical record failed to produce behavioral monitoring sheets for the Abilify for June, July, August, September, October, November and December of 2015.
On March 23, 2016 at 10:15 a.m. the surveyor notified The Director of Nursing (DON) that Resident #3 was on Seroquel 25 mg every night at bedtime during April, May, June, July and August of 2015. The surveyor also notified the DON that Resident #3 received Abilify since

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6/23/15. The surveyor notified the DON that behavioral monitoring sheets to monitor for specific behaviors, interventions, side effects and effectiveness could not be located in the clinical record for April, May, June, July, August, September, October, November and December of 2015 for the Seroquel and the Abilify. The surveyor reviewed the clinical record with the DON. The DON was unable to locate behavioral monitoring sheets for April, May, June, July, August, September, October, November and December of 2015.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to monitor Resident #3 for psychotropic drug use (Seroquel and Abilfy) during April, May, June, July, August, Sptember, October, November and December of 2015. The surveyor informed the AT that the facility staff had to monitor for specific behaviors related to the psychotropic medication use (Seroquel and Abilify), medication effectiveness, interventions and side effects.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #3 was free from unnecessary medications. The facility staff failed to monitor Resident #3 for psychotropic drug (Seroquel and Abilify) use for specific behaviors, medication effectiveness, interventions and side effects.

3. For Resident #6 the facility staff failed to monitor for psychotropic drug (Risperidone/Risperdal) use to include: specific behavior, interventions, side effects and effectiveness.

Resident #6 was a 92 year old female who was

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admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection, encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease.
The most current MDS located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's).
On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced signed physician orders dated 2/13/16. Signed physician orders included, but not limited to: "Risperidone (Risperdal) 0.25 mg 1 po (by mouth) BID (twice daily)." (sic) The order for the Risperidone/Risperdal was changed on 3/11/16. The order was changed to: Risperdal 0.125 mg po q am (every morning) and Risperdal 0.25mg po QHS (every evening at bedtime).
Further review of the clinical record failed to produce the February and March 2016 behavioral monitoring sheets.
On March 22, 2016 at 4:55 p.m. the surveyor notified the Director of Nursing (DON) that Resident #6 was on Risperidone (Risperdal) twice a day since admission into the facility. The surveyor notified the DON that behavioral monitoring for the psychotropic drug use, Risperidone (Risperdal), for February and March 2016 could not be located in the clinical record. The surveyor reviewed the clinical record with the DON. The DON was unable to locate behavioral monitoring sheets for psychotropic drug use for Resident #6.

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On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to monitor Resident #6 for psychotropic drug use, Risperidone/Risperdal for February and March 2016. The surveyor informed the AT that the facility staff had to monitor for specific behaviors related to the psychotropic medication use (Risperidone/Risperdal), medication effectiveness, interventions and side effects. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #6 was free from unnecessary medications. The facility staff failed to monitor Resident #6 for psychotropic drug (Risperidone/Risperdal) use for specific behaviors, medication effectiveness, interventions and side effects.

4. Facility staff failed to ensure that effective behavior monitoring and medication assessment was provided for Resident #5 who was taking antipsychotics and anxiolytics. The clinical record was reviewed 3/23/16 at 9:00 AM.

Resident # 5 was admitted to the facility on 10/6/15. The diagnoses included Bipolar disorder, anxiety, diabetes, coronary artery disease and cerebral vascular accident with hemi-plegia.

The resident's significant change MDS (minimum data set) assessment dated 10/13/15 coded the resident with unimpaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of daily living.) The resident was not coded during the MDS look-back period for the use of antipsychotics --but was observed to be documented as receiving it.

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The CCP (comprehensive care plan) reviewed and revised 1/19/16 included the resident's potential for adverse drug related complications due to psychotropic med use: Diagnosis, Major depression and psychotic bipolar disorder. The interventions included:
1. Assess the resident's mood state and behavior
2. Meds per order
3. Monitor the actions of the resident for Inappropriateness
4. Monitor the resident's mental status functioning on on-going basis.

Resident #5's physician's orders, signed and dated 2/27/16, included "Trifluoperazine HcL 2 mg (milligram) ....take 1 tab by mouth every day for Bipolar." The order was implemented by staff and observed daily on the MAR (medication administration records) beginning on 10/6/15 and continued until present.

The same physician orders included an order for Lorazepam 0.5 mg. Take one tablet by mouth twice daily as needed for anxiety and agitation. This order was implemented on 10/6/15 and documented on the MAR by nursing staff on an "as needed basis." The MARS document 23 administrations of as needed Ativan between 10/6/15 and 2/24/16.

The behavior monitoring sheets, a tool used by the nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be complete for diagnoses, medications or behaviors.

The behavior sheet for March 2016 contained no diagnoses and the behaviors were listed as

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delusions/paranoia. The medications being assessed for control of the delusion/paranoia were Cymbalta, Trifluoperazine and Ativan. (Cymbalta is used to treat major depression in adults and may also be used to reduce pain from certain illnesses. It is not used to treat delusions/paranoia. Ativan is an anxiolytic used to relieve anxiety. It is not used to treat delusions/paranoia.)

The behavior sheet for February 2016 did not contain a diagnosis for the use of Triflouperazine. It did contain Ativan for assessment--but no baseline symptoms were provided to assess the effects of either drug--even if nursing staff could have figured out what drug was being provided for which diagnosis or to control what behaviors.

The January 2016 behavior sheet was lacking a diagnosis for bipolar disorder, but contained delusional paranoia and anxiety as justification for the use of triflouperazine - even though antipsychotics are not recommended for the treatment of anxiety.

On 3/23/16 the DON was asked to explain the facility's procedure to monitor a resident on antipsychotics and anxiolytics. She said it didn't have to be in the behavior sheets--it could be documented anywhere in the clinical record. The DON did not return with additional baseline symptoms or documented behaviors on Resident #5.

On 3/24/16 at 1:16 PM, LPN II was asked about Resident #5's medications and her behaviors. LPN II said the resident was taking the antipsychotic Cymbalta and Lorazepam to control her behaviors. LPN II said the resident got confused, obsessed over things and was

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withdrawn at times. (None of these symptoms warrant the use of an antipsychotic.)

LPN II stated, "Sometimes it's hard to follow these things, holding up behavior sheets for Residents #5 and #8. They have no target behaviors on here and it's hard to follow these things. I don't really know what they mean by delusional--it would just make it so much simpler if they listed what we're supposed to be watching for."

On 3/24/16 at 3:15 PM LPN III was asked about Resident # 5. She said she was schizophrenic but did not have hallucinations or delusions. She said she was "very manipulative." (manipulative behaviors are not justification for the administration of antipsychotics.)

Since the diagnoses, behaviors and medications were incomplete on the behavior sheets, neither LP II or LP III could accurately determine the diagnoses, behaviors, or effectiveness of the medications they were administering.

The DON and administrator were informed of the surveyor's findings on 3/24/16 at 4:00 PM. The surveyor asked how a medication nurse could be expected to determine the baseline behaviors of a resident she had picked up after treatment had begun with antipyretics, anilities and antidepressants. If the If the baseline symptoms are not in the records and are not clear, accurate and available when med nurses are on the floor, then the documentation hasn't been organized so as to be used effectively.

No additional info was provided.

5. Facility staff failed to ensure that effective

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behavior monitoring and medication assessment was provided for Resident #8 who was taking Pedestrian for pseudo affect. The clinical record was reviewed 3/23/16 at 9:00 AM.

Resident # 8 was admitted to the facility on 10/1/10. The diagnoses included depression, hypertension, diabetes, and coronary artery disease. The resident had previously suffered a stroke (CV.)

The resident's annual MD'S (minimum data set) assessment dated 10/6/15 coded the resident with unimpaired cognitive ability. Resident #8 required staff assistance for all ADSL (activities of daily living.)

Resident #8's MD'S did not trigger care planning for psychotropic medication--since she was not using any antipyretics, antidepressants or anilities. The latest CC (comprehensive care plan) for Resident #8 could not be located for review.

On 2/28/16 the resident's physician ordered Pedestrian 20/10 mg QED for pseudo affect. The medication was administrated by nursing staff between 2/29/16 until the physician discontinued them on 3/23/16.

Pseudo affect is characterized by emotional liability, often either crying or laughing at times when it's inappropriate. Victims may laugh when in reality, they are angry and cry when told an amusing anecdote. This is generally caused by neurological damage from a stroke or other brain injury.

There was no documentation regarding the assessments of this medication after the

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initiation. No prior baseline assessments for her behavior monitoring (pseudo affect) were observed. (No inappropriate laughing, crying etc.- Just angry, agitated outbursts--not typical of pseudo affect.)

On 1/5/16 and 2/12/16 nursing notes included, Resident is anxious, hostile and verbally abusive at times.....hoards food and trash in room..."

On 3/24/16 at 1:16 PM LP II was asked about Resident #8's Pedestrian administrations. LP II said she gave the Pedestrian for her bipolar disorder. We watch for hoarding and she gets angry and fusses and goes off sometime. She threw a fit one day because she didn't get a hot dog.

LP II said she didn't have a behavior monitoring sheet for the Pedestrian, but she didn't know why.

LP III was interviewed on 3/24/16 at 9:00 AM. She said Resident #8 didn't have a psych diagnosis, but she was very aggressive with staff and even hit one staff member with a stick and claimed later it was an accident. "She's just mean."

On 3/24/16 at 10:30 AM the DON provided psychiatric consults for Resident #8. The consult said the resident had depression associated with a stroke and a personality disorder. The DON pointed out the resident had been given the Pedestrian "because she is bipolar."

The surveyor pointed out to the DON the medication was provided for pseudo affect (written right on the psych consult), not bipolar disorder, as she thought. The surveyor asked about the resident's symptoms for administration

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and what staff was to monitor--since there was no behavior monitoring tool in place for the the medication nurses.

The DON said the resident was verbally aggressive with staff, was a hoarder, and hid staff property when she got upset. When asked if she knew the staff member who was struck with a preacher/stick--she said she had not heard that. It was not documented in the clinical record.

The surveyor asked for information that the resident's behaviors were being monitored while she was taking the Pedestrian. No more information was provided.

This information was shared with the DON and administrator on 3/23/16 at 3:30 PM. The surveyor asked how a medication nurse could be expected to determine the baseline behaviors of a resident she had picked up after treatment had begun with antipyretics, anilities and antidepressants. If the If the baseline symptoms are not in the records and are not clear, accurate and available when med nurses are on the floor, then the documentation hasn't been organized so as to be used effectively.

No additional info was provided.

6. Facility staff to ensure effective behavior monitoring and medication assessment for Resident #9 who was taking antipyretics, mood stabilizers and anticonvulsant's. The clinical record was reviewed 3/24/16 at 9:00 AM.

Resident #9 was admitted to the facility on 3/15/16. Her diagnoses from the discharging hospital, signed and dated by the hospital physician on 3/6/16, included schizophrenia,

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bipolar disorder, hypertension, diabetes, chronic obstructive pulmonary disorder, and hypothyroidism. The resident had a colostomy for reasons unknown. She had no documented history of seizures.

Resident #9 did not have an MD'S or CC since she was a new admission. Her physician's orders were in place as the acting CC.

The physician orders, signed and dated on 3/15/16, included the following medications:

1. Clozaril 150 mg at bedtime. (This is an antipsychotic used for the treatment of Schizophrenia
2. Divalproax Sodium 500 mg three times a day. (Mood stabilizer for treatment of schizocarp disorder.)
3. Haldol 20 mg two times a day. (antipsychotic for treatment of acute and chronic psychoses.)
4. Topamax 200 mg every night at bedtime. (antipsychotic for control of seizures and also used for migraine headaches and adjunct therapy for psychoses in bipolar and schizophrenic populations.)
(http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1811115/)

The progress notes were reviewed and there were no behaviors, past or present documented by the nursing staff.

A "notice of room change" documented by the (SW) social worker indicated the resident had been moved due to "conflict with roommate." This change took place on 3/15/16--the day of her admission. No other details were described.

On 3/24/16 at 1:33 PM the DON was asked why

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the resident was moved. She said it was because she and her roomate had a screaming match over who was to operated the TV control. "The were both giving it to each other and F----ing this and that, but no one hit anybody. Staff promptly made the room change."

The DON was asked why this angry outburst was not documented in the nursing notes or on the behavior sheets--as it should be a behavior monitored by the staff given the resident's many psychiatric diagnoses and antipsychotic medications and mood stabalizers.

The resident's behavior monitoring sheet listed only "paranoia" as a behavior and Schizoaffective disorder as her diagnosis. The medications they were supposed to assess for the paranoia were listed as divalproax sodium, clozaril, Haldol and Topamax.

The diagnosis for bipolar disorder and angry agitation noted on her first day in the facility were not documented for behavior monitoring.

On 3/24/16 at 2:00 PM LPN I was asked about the resident's diagnoses and behavior monitoring for the medications she was providing. LPN I, who said she had cared for the resident since her admission said she didn't know anyting about that--she'd have to look at the chart.

When informed the surveyor in question had the records already in hand--the LPN left the desk and disappeared, refusing to answer further questions. She was later seen walking out of the DON's office--but again refused to discuss the resident's treatment assessment and kept walking down the hall.

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F 329	Continued From page 50 The DON and administrator were informed of the surveyor's findings on 3/24/16 at 4:00 PM. The surveyor asked how a medication nurse could be expected to determine the baseline behaviors of a resident she had picked up after treatment had begun with antipsychotics, anxiolytics and antidepressants. If the If the baseline symptoms are not in the records and are not clear, accurate and available when med nurses are on the floor, then the documentation hasn't been organized so as to be used effectively. No additional info was provided.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined the facility staff failed to store, prepare, distribute and serve food under sanitary conditions. On 3/22/16 at 1:15 PM, during the initial tour of the kitchen the following were observed: 1. Paper toweling shelved with "Thick & Easy", pie crusts and cake flour. 2. Cups, napkins and trash bags stored on the same shelving with sugar fruit flakes and raisin bran.	F 371	**F371** The facility is in compliance with the regulations for dry goods storage. The food in the pantry refrigerator was removed and disposed of. All food storage areas will be reviewed to assure storage procedures are followed both dry storage and refrigerated storage. All staff will be in-serviced on proper food storage both dry and refrigerated.	

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3. Boxes of Styrofoam bowls housed on shelving with toasted oat cereal.
4. Eight boxes of plastic cutlery housed on shelving with crackers, condiments and drinks.

DM I (dietary manager) was asked during this tour if she was aware the food items were to be stored separately from the non-food items in the dry good section. DM I said she tried to keep the non-food items on a center rack away from the food racks--but they just ran out of room.

On 3/24/16 at 2:45 PM the resident's pantry refrigerator was inspected. It contained:
1. A plastic bag with an expiration date on it of 3/21/16. The bag was labeled for Room 104-b, but did not appear to be opened. It contained several single servings of V-8 juice, and a metal tin completely full of spaghetti, which had not been opened/served to resident.
2. A second plastic bag contained a Tupperware dish with unidentified foods contents in it. This bag did have a resident name on it--but the food had expired on 3/23/16.

LPN III was asked if she had the policy and procedure for storing refrigerated items in the pantry refrigerator. She said she did not.

At 3:00 PM the administrator was asked if he had a policy and procedure for food storage in the facility. He said he did not.

On 3/24/16 at 4:00 PM the DON (director of nursing) and administrator were informed of these findings.

The Administrator or designee will audit the pantry refrigerator weekly for four weeks to assure appropriate dating on any items stored within.

The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting.

Completion Date: 5/2/16

F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS — F 441

The facility must establish and maintain an

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Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

This Requirement is not met as evidenced by:
Based on a medication pass and pour observation, staff interview, clinical record review and facility document review it was determined

F441

LPN #2 has been educated on the infection control policy and medication administration to include but not limited to not touching medications with bare hands.

100% licensed nurses will be educated on the infection control policy and medication administration to include but not limited to not touching medications with bare hands.

Med pass observations will be performed weekly x 4 weeks by DON or designee then at random to ensure the infection control policy is being followed and no medications are being touched with bare hands.

The audit results will be reviewed at the monthly QA Committee meeting.

Completion date 5/2/16

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that the facility staff failed to implement an infection control policy and procedure for 1 of 16 Residents in the sample survey, Resident #5.
The Findings Included:
Resident #5 was a 66 year old female who was originally admitted on 2/21/15 and readmitted on 10/6/15. Admitting diagnoses included, but were not limited to: dysphagia, chronic kidney disease, hemiplegia, cerebrovascular accident, atherosclerotic heart disease, anxiety, hypertension and bipolar.
The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 1/13/16. The facility staff coded that Resident #5 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #5 required total nursing care (4/2) with Activities of Daily Living (ADL's).
On March 23, 2016 at 8:05 a.m. the surveyor made a medication pass and pour observation with Licensed Practical Nurse (LPN #2). The surveyor observed LPN (#2) pour several medications into a plastic medication cup. The surveyor documented that one of the medications was a Colace 100mg capsule. The surveyor observed LPN (#2) approach Resident #5's bedside and place the plastic medication cup on the over the bed table. Resident #5 reached into the medication cup and obtained several medications and placed the medications in her mouth. Resident #5 then obtained a cup of water and swallowed the pills. Resident #5 reached back into the plastic medication cup, the surveyor observed the Colace capsule roll across the over the bed table. LPN (#2) reached down with an ungloved hand, pick up the Colace capsule and place the Colace capsule back into the plastic medication cup. Resident #5 continued to take the remainder of her medications, including the

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Colace.
On March 23, 2016 at 8:25 a.m. the surveyor reviewed Resident #5's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to: "Colace 100mg 1 po (by mouth) BID (twice daily)-constipation." (sic)
On March 23, 2016 at 8:30 a.m. the surveyor informed LPN (#2) that the surveyor had observed LPN (#2) pick up the Colace off of the bedside table, with an ungloved hand, and place the Colace capsule into the plastic medication cup. The surveyor notified LPN (#2) that Resident #5 had taken the Colace. LPN (#2) stated, "I should have just thrown it away and got another one."
On March 23, 2016 at 9 a.m. the surveyor asked the Director of Nursing (DON) for a copy of the facility policy and procedure for infection control and medication administration.
On March 23, 2016 at 10:40 a.m. the DON hand delivered the policy and procedure titled, "6.0 General Dose Preparation and Medication Administration." The surveyor reviewed the policy and procedure with the DON. The policy and procedure read in part ... "3.4 Facility staff should not touch the medication when opening a bottle or unit dose package. (sic) The surveyor notified the DON that LPN (#2) touched Resident #5's Colace with a bare hand and place it back into Resident #5's plastic medication cup. The DON stated, "(name of staff member withheld) already told me."
On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that LPN (#2) touched Resident #5's Colace with her bare hand. The surveyor notified the AT that Resident #5

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F 441	Continued From page 55 took the medication after the Colace was placed back into the plastic medication cup by LPN (#2). The surveyor notified the AT that she had a concern regarding infection control. No additional information was provided prior to exiting the facility as to why the facility staff failed to implement a policy and procedure for medication administration, regarding infection control for Resident #5.	F 441	**F514** Residents #2, #3, #5 and #8's thinned medical records are now systematically organized. Resident #9 has been discharged, the closed record is systematically organized. The medical records clerk has been educated on the proper way to systematically thin a record. All current resident's thinned records have been systematically organized. Random audits will be completed by DON or designee to ensure thinned records are systematically organized. The audit results will be reviewed at the monthly QA Committee meeting. Completion date 5/2/16	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain clinical records on 5 of 16 residents in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. (Residents #2, 3, 5, 8, and 9). The Findings Included: 1. For Resident #2 the facility staff failed to ensure complete and accurate clinical records, December 2015 behavior monitoring sheets.	F 514		

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Additionally the facility staff failed to ensure that the thinned record was systematically organized. Resident #2 was an 85 year old female who was originally admitted on 1/1/11 and readmitted on 2/28/14. Admitting diagnoses included, but were not limited to the following: fall, diabetes mellitus, cerebrovascular accident, hypertension, osteoarthritis, morbid obesity, urinary tract infection, cardiomyopathy, anxiety, depression, asthma and bipolar.

The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 2/3/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #2 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On March 23, 2016 at 2:30 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to: "Sertraline HCL ER 5 mg tablet for > Zoloft F/C take 1 tab (tablet) by mouth every morning for depression. Divalproex Sodium 125 mg cap (capsule) Sprink (sprinkles) for> Depakote Sprinkle take 2 capsules (250mg) by mouth twice daily for Bipolar' Disorder." (sic) The order for the Depakote was changed on 12/11/15. The order for the Zoloft originated on 12/11/15.

Further review of the clinical record produced an original physician order for Depakote Sodium 125mg by mouth TID (three times a day) on 10/15/15.

Continued review of the clinical record produced the thinned clinical record. Review of the clinical record failed to produce behavior monitoring for October and November 2015. Additionally the behavior monitoring sheet for December 2015 documented that Zoloft (an antidepressant) and

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Depakote Sodium (a psychotropic) were being administered for depression and withdrawal. The behavioral monitoring sheet did not identify that Resident #2 was receiving the Depakote for a diagnosis of being Bipolar. The surveyor reviewed the clinical record for a prolonged time, attempting to find necessary documentation regarding the Depakote Sprinkles. The thinned record was not systematically organized.

On March 23, 2016 at 3:15 p.m. the surveyor notified the Director of Nursing (DON) that Resident #2 was on Depakote Sprinkles for a diagnosis of being Bipolar and Zoloft for a diagnosis of depression. The surveyor notified the DON that review of the clinical record failed to produce behavior monitoring sheets for October and November 2015. The surveyor also notified the DON that Resident #2's December 2015 behavior monitoring sheet stated that the Zoloft and Depakote were being administered for depression and withdrawal, when in fact Resident #2 was receiving the Depakote for a diagnosis of being Bipolar. The surveyor notified the DON that the behavioral monitoring for Zoloft (an antidepressant) and the Depakote (a psychotropic) could not be documented on the same behavioral monitoring sheet. The surveyor reviewed the December 2015 behavioral monitoring sheet with the DON and pointed out that the behavioral monitoring sheet was inaccurate. The surveyor reviewed the thinned record with the DON. The surveyor and DON reviewed the thinned clinical record for a prolonged time, attempting to find necessary documentation regarding the Depakote Sprinkles. The thinned record was not systematically organized.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate

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Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that that Resident #2 was on Depakote Sprinkles for a diagnosis of being Bipolar and Zoloft for depression. The surveyor also informed the AT that Resident #2's behavior monitoring sheet for December 2015 stated that Resident #2 was receiving the Zoloft and Depakote Sprinkles for withdrawal and depression, when in fact, Resident #2 was receiving the Depakote Sprinkles for a diagnosis of being Bipolar. The surveyor notified the AT that the behavior sheet was not accurate/complete. The surveyor also notified the AT that behavior monitoring sheets could not be located for October and November 2015.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record, December 2015 behavior monitoring sheets. Furthermore, no additional information was provided prior to exit as to why the thinned record was not systematically organized.
2. For Resident #3 the facility staff failed to ensure a complete and accurate clinical record. Resident #3 was an 85 year old female who was admitted on 11/12/11. Admitting diagnoses included, but were not limited to: ischemic heart disease, restless leg syndrome, dementia, urinary tract infection, hypertension, vitamin D deficiency and paralysis agitans.
The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 3/16/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #3 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's).
On March 24, 2016 at 9 a.m. the surveyor reviewed Resident #3's clinical record. Review of

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the clinical record produced the April, May, June, July and August 2015 Medication Administration Records (MAR's). Review of the MAR's documented that Resident #3 received Seroquel 25mg by mouth every night at bedtime.
Continued review of the clinical record failed to produce behavioral monitoring sheets for the Seroquel for April, May, June, July and August of 2015. The Seroquel was discontinued on 8/25/15.
Further review of the clinical record produced signed physician orders that included, but were not limited to: "Abilify 2 mg tablet take 1 tab (tablet) by mouth every morning for DPSD **Do Not Switch-Brand dispensed for Insurance**." (sic) The order for the Abilify originated on 6/23/15.
Continued review of the clinical record failed to produce behavioral monitoring sheets for the Abilify for June, July, August, September, October, November and December of 2015.
Further review of the clinical record failed to produce the MAR's for October and November 2015.
On March 23, 2016 at 10:15 a.m. the surveyor notified The Director of Nursing (DON) that Resident #3 was on Seroquel 25 mg every night at bedtime during April, May, June, July and August of 2015. The surveyor also notified the DON that Resident #3 received Abilify since 6/23/15. The surveyor notified the DON that behavioral monitoring sheets to monitor for specific behaviors, interventions, side effects and effectiveness could not be located in the clinical record for April, May, June, July, August, September, October, November and December of 2015 for the Seroquel and the Abilify. The surveyor reviewed the clinical record with the DON. The DON was unable to locate behavioral monitoring sheets for April, May, June, July,

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August, September, October, November or December 2015. Additionally, the surveyor pointed out that MAR's for October and November 2015 could not be located in the clinical record. The DON was unable to locate the October and November 2015 MAR's.
On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to monitor Resident #3 for psychotropic drug use (Seroquel and Abilfy) during April, May, June, July, August, September, October, November and December of 2015. The surveyor informed the AT that the facility staff had to monitor for specific behaviors related to the psychotropic medication use (Seroquel and Abilify), medication effectiveness, interventions and side effects. The surveyor also notified the AT that Resident #3's MAR's for October and November 2015 could not be located in the clinical record.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure to ensure a complete and accurate, and systematically organized record for Resident #3.
3. The facility failed to maintain clinical records Resident #5 in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record was reviewed 3/23/16 at 9:00 AM.

Resident # 5 was admitted to the facility on 10/6/15. The diagnoses included Bipolar disorder, anxiety, diabetes, coronary artery disease and cerebral vascular accident with hemi-plegia.

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The resident's significant change MDS (minimum data set) assessment dated 10/13/15 coded the resident with unimpaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of daily living.) The resident was not coded during the MDS look-back period for the use of antipsychotics --but was observed to be documented as receiving it.

The CCP (comprehensive care plan) reviewed and revised 1/19/16 included the resident's potential for adverse drug related complications due to psychotropic med use: Diagnosis, Major depression and psychotic bipolar disorder. The interventions included:
1. Assess the resident's mood state and behavior
2. Meds per order
3. Monitor the actions of the resident for inappropriateness
4. Monitor the resident's mental status functioning on on-going basis.

Resident #5's physician's orders, signed and dated 2/27/16, included "Trifluoperazine HcL 2 mg (milligram) ....take 1 tab by mouth every day for Bipolar." The order was implemented by staff and observed daily on the MAR (medication administration records) beginning on 10/6/15 and continued until present.

The same physician orders included an order for Lorazepam 0.5 mg. Take one tablet by mouth twice daily as needed for anxiety and agitation. This order was implemented on 10/6/15 and documented on the MAR by nursing staff on an "as needed basis." The MARS document 23 administrations of as needed Ativan between 10/6/15 and 2/24/16.

The behavior monitoring sheets, a tool used by

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the nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be complete for diagnoses, medications or behaviors.

The behavior sheet for March 2016 contained no diagnoses and the behaviors were listed as delusions/paranoia. The medications being assessed for control of the delusion/paranoia were Cymbalta, Trifluoperazine and Ativan. (Cymbalta is used to treat major depression in adults and may also be used to reduce pain from certain illnesses. It is not used to treat delusions/paranoia. Ativan is an anxiolytic used to relieve anxiety. It is not used to treat delusions/paranoia.)

The behavior sheet for February 2016 did not contain a diagnosis for the use of Triflouperazine. It did contain Ativan for assessment--but no baseline symptoms were provided to assess the effects of either drug--even if nursing staff could have figured out what drug was being provided for which diagnosis or to control what behaviors.

The January 2016 behavior sheet was lacking a diagnosis for bipolar disorder, but contained delusional paranoia and anxiety as justification for the use of triflouperazine - even though antipsychotics are not recommended for the treatment of anxiety.

On 3/23/16 the DON was asked to explain the facility's procedure to monitor a resident on antipsychotics and anxiolytics. She said it didn't have to be in the behavior sheets--it could be documented anywhere in the clinical record. The DON did not return with additional baseline

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symptoms or documented behaviors on Resident #5.

On 3/24/16 at 1:16 PM, LPN II was asked about Resident #5's medications and her behaviors. LPN II said the resident was taking the antipsychotic Cymbalta and Lorazepam to control her behaviors. LPN II said the resident got confused, obsessed over things and was withdrawn at times. (None of these symptoms warrant the use of an antipsychotic.)

LPN II stated, "Sometimes it's hard to follow these things, holding up behavior sheets for Residents #5 and #8. They have no target behaviors on here and it's hard to follow these things. I don't really know what they mean by delusional--it would just make it so much simpler if they listed what we're supposed to be watching for."

On 3/24/16 at 3:15 PM LPN III was asked about Resident # 5. She said she was schizophrenic but did not have hallucinations or delusions. She said she was "very manipulative." (manipulative behaviors are not justification for the administration of antipsychotics.)

Since the diagnoses, behaviors and medications were incomplete on the behavior sheets, neither LP II or LP III could accurately determine the diagnoses, behaviors, or effectiveness of the medications they were administering.

The DON and administrator were informed of the surveyor's findings on 3/24/16 at 4:00 PM. The surveyor asked how a medication nurse could be expected to determine the baseline behaviors of a resident she had picked up after treatment had begun with antipyretics, anilities and

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antidepressants. If the If the baseline symptoms are not in the records and are not clear, accurate and available when med nurses are on the floor, then the documentation hasn't been organized so as to be used effectively.

No additional info was provided.

4. The facility failed to maintain clinical records Resident #8 in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record was reviewed 3/23/16 at 9:00 AM.

Resident # 8 was admitted to the facility on 10/1/10. The diagnoses included depression, hypertension, diabetes, and coronary artery disease. The resident had previously suffered a stroke (CV.)

The resident's annual MD'S (minimum data set) assessment dated 10/6/15 coded the resident with unimpaired cognitive ability. Resident #8 required staff assistance for all ADSL (activities of daily living.)

Resident #8's MD'S did not trigger care planning for psychotropic medication--since she was not using any antipyretics, antidepressants or anilities. The latest CC (comprehensive care plan) for Resident #8 could not be located for review.

On 2/28/16 the resident's physician ordered Pedestrian 20/10 mg QED for pseudo affect. The medication was administrated by nursing staff between 2/29/16 until the physician discontinued them on 3/23/16.

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Pseudo affect is characterized by emotional liability, often either crying or laughing at times when it's inappropriate. Victims may laugh when in reality, they are angry and cry when told an amusing anecdote. This is generally caused by neurological damage from a stroke or other brain injury.

There was no documentation regarding the assessments of this medication after the initiation. No prior baseline assessments for her behavior monitoring (pseudo affect) were observed. (No inappropriate laughing, crying etc.- Just angry, agitated outbursts--not typical of pseudo affect.)

On 1/5/16 and 2/12/16 nursing notes included, Resident is anxious, hostile and verbally abusive at times.....hoards food and trash in room..."

On 3/24/16 at 1:16 PM LP II was asked about Resident #8's Pedestrian administrations. LP II said she gave the Pedestrian for her bipolar disorder. We watch for hoarding and she gets angry and fusses and goes off sometime. She threw a fit one day because she didn't get a hot dog.

LP II said she didn't have a behavior monitoring sheet for the Pedestrian, but she didn't know why.

LP III was interviewed on 3/24/16 at 9:00 AM. She said Resident #8 didn't have a psych diagnosis, but she was very aggressive with staff and even hit one staff member with a stick and claimed later it was an accident. "She's just mean."

On 3/24/16 at 10:30 AM the DON provided psychiatric consults for Resident #8. The consult

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said the resident had depression associated with a stroke and a personality disorder. The DON pointed out the resident had been given the Pedestrian "because she is bipolar."

The surveyor pointed out to the DON the medication was provided for pseudo affect (written right on the psych consult), not bipolar disorder, as she thought. The surveyor asked about the resident's symptoms for administration and what staff was to monitor--since there was no behavior monitoring tool in place for the the medication nurses.

The DON said the resident was verbally aggressive with staff, was a hoarder, and hid staff property when she got upset. When asked if she knew the staff member who was struck with a preacher/stick--she said she had not heard that. It was not documented in the clinical record.

The surveyor asked for information that the resident's behaviors were being monitored while she was taking the Pedestrian. No more information was provided.

This information was shared with the DON and administrator on 3/23/16 at 3:30 PM. The surveyor asked how a medication nurse could be expected to determine the baseline behaviors of a resident she had picked up after treatment had begun with antipyretics, anilities and antidepressants. If the If the baseline symptoms are not in the records and are not clear, accurate and available when med nurses are on the floor, then the documentation hasn't been organized so as to be used effectively.

No additional info was provided.

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5. The facility failed to maintain clinical records Resident #9 in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record was reviewed 3/24/16 at 9:00 AM.

Resident #9 was admitted to the facility on 3/15/16. Her diagnoses from the discharging hospital, signed and dated by the hospital physician on 3/6/16, included schizophrenia, bipolar disorder, hypertension, diabetes, chronic obstructive pulmonary disorder, and hypothyroidism. The resident had a colostomy for reasons unknown. She had no documented history of seizures.

Resident #9 did not have an MD'S or CC since she was a new admission. Her physician's orders were in place as the acting CC.

The physician orders, signed and dated on 3/15/16, included the following medications:

1. Clozaril 150 mg at bedtime. (This is an antipsychotic used for the treatment of Schizophrenia
2. Divalproax Sodium 500 mg three times a day. (Mood stabilizer for treatment of schizocarp disorder.)
3. Haldol 20 mg two times a day. (antipsychotic for treatment of acute and chronic psychoses.)
4. Topamax 200 mg every night at bedtime. (antipsychotic for control of seizures and also used for migraine headaches and adjunct therapy for psychoses in bipolar and schizophrenic populations.) (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1811115/)

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The progress notes were reviewed and there were no behaviors, past or present documented by the nursing staff.

A "notice of room change" documented by the (SW) social worker indicated the resident had been moved due to "conflict with roommate." This change took place on 3/15/16--the day of her admission. No other details were described.

On 3/24/16 at 1:33 PM the DON was asked why the resident was moved. She said it was because she and her roomate had a screaming match over who was to operated the TV control. "The were both giving it to each other and F----ing this and that, but no one hit anybody. Staff promptly made the room change."

The DON was asked why this angry outburst was not documented in the nursing notes or on the behavior sheets--as it should be a behavior monitored by the staff given the resident's many psychiatric diagnoses and antipsychotic medications and mood stabalizers.

The resident's behavior monitoring sheet listed only "paranoia" as a behavior and Schizoaffective disorder as her diagnosis. The medications they were supposed to assess for the paranoia were listed as divalproax sodium, clozaril, Haldol and Topamax.

The diagnosis for bipolar disorder and angry agitation noted on her first day in the facility were not documented for behavior monitoring.

On 3/24/16 at 2:00 PM LPN I was asked about the resident's diagnoses and behavior monitoring for the medications she was providing. LPN I, who said she had cared for the resident since her

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admission said she didn't know anyting about that--she'd have to look at the chart.

When informed the surveyor in question had the records already in hand--the LPN left the desk and disappeared, refusing to answer further questions. She was later seen walking out of the DON's office--but again refused to discuss the resident's treatment assessment and kept walking down the hall.

The DON and administrator were informed of the surveyor's findings on 3/24/16 at 4:00 PM. The surveyor asked how a medication nurse could be expected to determine the baseline behaviors of a resident she had picked up after treatment had begun with antipsychotics, anxiolytics and antidepressants. If the If the baseline symptoms are not in the records and are not clear, accurate and available when med nurses are on the floor, then the documentation hasn't been organized so as to be used effectively.

No additional info was provided.

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F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 03/22/16 through 03/24/16. One complaint was investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 52 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 1 through 12) and 4 closed record reviews (Residents 13 through 16).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: I. 12 VAC 5-371-140. Policies and procedures Based on staff interview it was determined the facility staff failed to implement and operationalize policies and procedures concerning 1. Food storage and 2. Contractual dialysis service. During the survey the team requested policies and procedures for the aforementioned. On 3/24/16 at 3:30 PM the administrator told the team he did not have an agreement or contract with the dialysis service used by the facility. Neither was there a policy and procedure in place for dialysis services. (Refer to F- 309 for	F 001	**F309** The facility has a signed contract with the Dialysis provider and a dialysis policy. All residents are at risk who are receiving dialysis. The Administrator will review all contracted resident services to assure contracts and policies are present and current. The Administrator will review the Dialysis contract and policy monthly for three months. Results will be reviewed at the monthly Quality Assurance Committee meeting. Completion Date: 5/2/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 4/13/16

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additional info.

The administrator also told the survey team he did not have a written policy & procedure for food storage. Refer to F-371 for additional info.

The Virginia Rules and Regulations require the following policies and procedures be maintained and operationalized for the Licensure of Nursing Facilities.

12 VAC 5-371-140. Policies and procedures. (amended 9/2011)
A. The nursing facility shall implement written policies and procedures approved by the governing body.
B. All policies and procedures shall be reviewed at least annually, with recommended changes submitted to the governing body for approval.
C. A written record of the annual policy review, including at least the review dates, participants, recommendations and action dates of the governing body, shall be maintained.
D. Administrative and operational policies and procedures shall include, but are not limited to:
1. Administrative records;
2. Admission, transfer and discharge;
3. Medical direction and physician services;
4. Nursing direction and nursing services;
5. Pharmaceutical services, including drugs purchased outside the nursing facility;
6. Dietary services;
7. Social services;
8. Activities services;
9. Restorative and rehabilitative resident services;
10. Contractual services;
11. Clinical records;
12. Resident rights and grievances;
13. Quality assurance and infection control;
14. Safety and emergency preparedness procedures; and

F371

The facility is in compliance with the regulations for dry goods storage. The food in the pantry refrigerator was removed and disposed of. Food storage policy completed.

All food storage areas will be reviewed to assure storage procedures are followed both dry storage and refrigerated storage. All staff will be in-serviced on proper food storage policy both dry and refrigerated.

The Administrator or designee will audit the pantry refrigerator weekly

for four weeks to assure appropriate dating on any items stored within.

The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting.

Completion Date: 5/2/16

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15. Professional and clinical ethics, including:
a. Confidentiality of resident information;
b. Truthful communication with residents;
c. Observance of appropriate standards of informed consent and refusal of treatment; and
d. Preservation of resident dignity, with special attention to the needs of the aged, the cognitively impaired, and the dying; and
16. Facility security.

No additional information was offered prior to the survey team exit.

2. 12 VAC 5-371-140. Resident Behavior & Facility Practices.
12 VAC 5-371-140 (A,D.12,E.2,E.3): Cross reference to F-226.
Based on staff interview, employee record review and facility document review it was determined that the facility staff failed to implement policies and procedures to prohibit abuse.
The facility staff failed to obtain criminal background checks, check for licenses and check references for 11 of 20 Employees hired within the past 12 months.
The Findings Included:
On March 24, 2016 at 2 p.m. the surveyor reviewed the facility policy and procedures titled, "Resident Abuse." The policy and procedure read in part ...
"Policy: This facility will not tolerate Mistreatment, Abuse, Involuntary Seclusion or Neglect of its residents or Misappropriation of residents property by anyone. ... Procedure: 1). Screening It is the policy to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. a. The Facility will do the following prior to hiring a new employee; i. Generally attempt to obtain references from prior employers for an applicant;

F226

Employees that did not have background checks have had background checks completed. All potential new hires will have reference checks completed. The Occupational Therapist hired on 12/21/15 has had their licensure verified.

All employee files will be reviewed to assure that background checks, licensure verification, and reference checks completed.

All potential new hires will have reference checks completed. The Administrator will conduct an audit monthly for three months of all new hires to assure they have competed reference checks, background checks, and licensure verification.

The results of the audits will be reviewed at the monthly Quality Assurance Committee Meeting.

Completion Date: 5/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HEALTHCARE CENTER	508 RISON STREET DANVILLE, VA 24541

(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) COMPLETE DATE
F 001	Continued From Page 3	F 001		

ii. Check with applicable nurse assistant registry, and any other nurse assistant registries that the Facility has reason to believe contain information on the individual, prior to using the individual as a nurse assistant; iii. Check with all applicable licensing and certification status to ensure that the employee hold the requisite license/and/or certification stats to perform their job functions; iv. Conduct criminal background check in accordance with Stat law and facility policy; ..." (sic)

On March 24, 2016 at 2:10 p.m. the surveyor reviewed 20 employee records with the Human Resources Director HRD). The surveyor made the following observations:

1. A Housekeeping employee hired on 12/1/15 did not have reference checks.
2. A Dietary employee hired on 11/11/15 did not have reference checks.
3. An Occupational Therapist hired on 4/1/15 did not have a Criminal Background Check (CBD) or reference checks.
4. An Activities employee hired on 2/9/16 did not have reference checks.
5. A Dietary employee hired on 6/5/15 did not have reference checks.
6. An Admission Coordinator employee hired on 6/15/15 did not have reference checks.
7. An Occupational Therapist hired on 12/21/15 did not have Licensure verification and reference checks.
8. A Physical Therapist hired on 4/16/15 did not have reference checks.
9. A dietary employee hired on 7/29/15 did not have reference checks.
10. A Certified Nursing Assistant (C.N.A.) did not have reference checks.
11. An Other Admission employee hired on 6/23/15 did not have reference checks.

The surveyor pointed out to the HRM that the employee records were missing License

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F 001	Continued From Page 4	F 001		

Verifications, CBC and References. The HRM acknowledged that she had not obtained the reference checks. The HRM stated that one of the employees was transferred from a sister facility and that was the reason she did not have the CBC. The surveyor notified the HRM that she, the HRD, should have the CBC on file. No additional information was provided as to why the HRD failed to implement the policy and procedure to prohibit abuse.
On March 24, 2016 at 3:05 p.m. the surveyor notified the Administrator (Adm) that the HRD failed to obtain license verification CBC and reference checks on 11 of 20 employees hired within the past 12 months.

12 VAC 5-371-140. Resident Behavior & Facility Practices.
12 VAC 5-371-140 (A,D.12,E.2,E.3): Cross reference to F-226.

12 VAC 5-371-150. Quality of Life.
12 VAC 5-371-150 (A, B.1-3): Cross reference to F-244.

12 VAC 5-371-370. Quality of Life.
12 VAC 5-371-370 (A, B,C,D,E,G,H,I): Cross reference to F-252 & 253.

12 VAC 5-371-250. Resident assessment and care planning.
12 VAC 5-371-250 (A.1 THRU A.14) Cross Reference to F-272

12 VAC 5-371-250. Resident assessment and care planning.
12 VAC 5-371-250 (A,D.E) Cross Reference to F-278

12 VAC 5-371-250. Resident assessment and

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care planning.
12 VAC 5-371-250 (G) Cross Reference to F-279

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (A THRU G) Cross reference to F-309.

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (A THRU G) Cross reference to F-312.

12 VAC 5-371-370. Physical Environment.
12 VAC 5-371-370 Cross reference to F-252.

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (A, B) Cross reference to F-328.

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (B) Cross reference to F-329.

12 VAC 5-371-340. Dietary Services.
12 VAC 5-371-340 (A) Cross reference to F-371.

12 VAC 5-371-180. Infection Control.
12 VAC 5-371-180 (A,B,C) Cross reference to F-441.

12 VAC 5-371-370. Physical Environment.
12 VAC 5-371-370 Cross reference to F-252.

12 VAC 5-371-360. Clinical Records
12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514

COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Melvin D. Carter
EXECUTIVE DIRECTOR

State Fire Marshal's Office
Western **Region**
6744 Thirlane Road
Roanoke, VA 24019
Phone: 540-561-7033

Kathaleen Creegan-Tedeschi, Director
Office of Licensure/Certification
Division of Long Term Care
Virginia Department of Health
9960 Mayland Drive
Perimeter Center Suite 401
Henrico, VA 23233

RE: Stratford Healthcare Center
508 Rison Street
Danville, VA
File Number: **W-0733-004**
CMS Certification Number: **495166**
Event ID Number: **MF6E21**

The attached report is forwarded to you with the following comments:

I. SURVEY | X |

[ ] Recommend certification based on compliance with Life Safety Code.
[X] Recommend certification based on acceptable POC.
[ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[ ] Recommend certification based on compliance with LSC by requested continuous waiver.
[X] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[ ] Recommend certification based on satisfactory results from application of the FSES.
[ ] Do not recommend certification.

II. POST SURVEY | |

[ ] All deficiencies corrected:

[ ] All deficiencies not corrected:

- [ ] Recommend certification based on acceptable POC
- [ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
- [ ] Recommend certification based on approved or requested continuous waiver.
- [ ] Recommend certification based on approved or requested Time Limited waiver.
- [ ] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at 804-371-0220

Sincerely,

Ronald C. Reynods - RCR

Ronald C. Reynolds
Interim State Fire Marshal

Survey Date: 04/07/2016 **SOD Sent: 4/11/16** **POC Rec ' d: 4/25/16** **POC to HQ: 4/25/16**
Highest Scope/Severity: F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/07/2016

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K 000	INITIAL COMMENTS Surveyor: 21761 Construction Type: V (111) Description of structure: The facility is a one story wood framed building on a concrete slab floor. The facility is divided into three smoke zones. Sprinkler Status: The facility is fully sprinklered with a NFPA 13 system of wet and dry pipe systems. The systems are supplied by municipal water. An unannounced recertification Life Safety Code survey was conducted 04/07/16 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2000 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000		
K 021 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required	K 021	K021 The soiled linen room door has been adjusted so that it closes completely. The Maintenance Director or designee will test all doors in the facility to assure that they close completely. The Maintenance Director or designee will test all doors in the facility to assure that they close completely. This will be weekly for six weeks. The results of the tests will be reviewed at the monthly Quality Assurance Committee meeting. Completion Date: 4/8/16	

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

Administrator 4/12/16

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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K 021	Continued From page 1 smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This Standard is not met as evidenced by: Surveyor: 21761 Based on observation, it was revealed through observation and interview that the facility failed to maintain smoke doors. Survey findings include: On 04/07/16, at approximately 12:25 PM, it was revealed by observation and interview, the Soiled Linen room smoke door is not completely closing. The Engineering Director witnessed this evidence through observation and interview.	K 021	**K029** **The unprotected penetration through the Laundry Room wall has been secured with appropriate protection.** **The Maintenance Director or designee will inspect similar penetrations where protection would be required to assure the protection is appropriate.** **The Maintenance Director or designee will conduct weekly audits of similar penetrations assure the protection is appropriate. This will be done weekly for six weeks.** **The results of the audits will be reviewed at the monthly**	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by:	K 029	**Quality Assurance Committee meeting.** **Completion Date: 4/8/16**	

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K 029	Continued From page 2 Surveyor: 21761 Based on observation, it was revealed through observation and interview that the facility failed to maintain smoke partitions. Survey findings include: On 04/07/16, at approximately 12:32 PM, it was revealed by observation and interview, there is an unprotected penetration through the Laundry Room wall into the corridor by a 1 1/2 inch plumbing line. The Engineering Director witnessed this evidence through observation and interview.	K 029	**K051** **The fire alarm panel power supply breaker is now indicated at the main fire alarm panel. The fire alarm panel power supply breaker has had a lock installed.** **The Maintenance Director or designee will examine all alarm panels to assure they are indicated on the main fire alarm panel and that any other panel power supply breakers also have a lock installed.** **The Maintenance Director will audit all fire alarm panels weekly for six weeks to assure they are in compliance.** **The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting.** **Completion Date: 4/8/16**	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available.	K 051		

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K 051	Continued From page 3 18.3.4, 19.3.4, 9.6 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation, it was revealed through observation and interview that the facility failed to maintain the fire alarm system. Survey findings include: 1. On 04/07/16, at approximately 11:50 AM, it was revealed by observation and interview, the fire alarm panel power supply breaker location is not indicated at the main fire alarm panel. 2. On 04/07/16, at approximately 11:55 AM, it was revealed by observation and interview, the fire alarm panel power supply breaker does not have a breaker lock. The Engineering Director witnessed this evidence through observation and interview.	K 051	**K062** **The sprinkler at the central nursing station has be cleaned and is dust free. The sprinkler in the walk in cooler will be replaced.** **The Maintenance Director or designee will examine all sprinkler heads in the facility to assure they are dust free and not corroded.** **The Maintenance Director or designee will examine all sprinkler heads in the facility weekly for six weeks to assure they are dust free and not corroded.** **The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting.** **Completion Date: ~~7/9/16~~ 7/16/16** **Facility is requesting a time limited waiver request for this deficiency. The issue is availability of the sprinkler head in the walk in cooler.**	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation, it was revealed through observation and interview that the facility failed to maintain the sprinkler system. This violation affected 3 of 3 smoke compartments. Survey findings include: 1. On 04/07/16, at approximately 11:53 AM, it was revealed by observation and interview, there	K 062		

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K 062	Continued From page 4 are two corroded sprinklers in the kitchen pantry. 2. On 04/07/16, at approximately 12:04 PM, it was revealed by observation and interview, there is a dust laden sprinkler in the Central Nurses' Station area. 3. On 04/07/16, at approximately 12:06 PM, it was revealed by observation and interview, there is a corroded sprinkler in the kitchen walk-in cooler. The Engineering Director witnessed this evidence through observation and interview.	K 062	**K147** **The extension cords in the Physical Therapy Room and Beauty shop (Director of Nursing Office) have been removed.** **The Maintenance Director or designee will review all rooms in the facility to assure no extension cords are being used. If they are present they will be removed.** **The Maintenance Director or designee will review all rooms in the facility weekly for six weeks to assure no extension cords are being used.** **The results of the audits will be reviewed at the monthly** **Quality Assurance Committee meeting.** **Completion date: 4/8/16**	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation, it was revealed through observation and interview that the facility failed to properly use electrical equipment. Survey findings include: 1. On 04/07/16, at approximately 11:40 AM, it was revealed by observation and interview, an extension cord is being used as permanent wiring in Physical Therapy. 2. On 04/07/16, at approximately 12:20 PM, it was revealed by observation and interview, an extension cord is being used as permanent wiring in the Beauty Shop. The Engineering Director witnessed this evidence through observation and interview.	K 147		