STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495134	A. BUILDING _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST MANOR NURSING & REHABILI	157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/29/16 through 3/31/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 24 current Resident reviews (Resident #1 -20, and #24) and 3 closed record reviews (Residents #21-23).	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	1. The physician and families of Residents #15 and #20 have been notified of the past refusals of a daily medications ordered by the physician for periods of greater than 24 hours. Both of these medications have been discontinued by the physician. 2. All residents with prescribed medications are at risk for this issue. RECEIVED APR 27 2016 VDH/OLC	

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

4/26/2016 LNHA

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the physician and responsible party of the refusal to take medication ordered for 1 of 23 residents (Resident # 15). The findings include: The facility staff failed to report to the physician and responsible party of Resident #15's refusal of a daily rectal suppository ordered by the physician. Resident #15 was admitted to the facility on 11/16/14 with diagnoses of fractured pubis, skin cancer, dysphagia, chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, dementia, arthritis, and anxiety. The significant change Minimum Data Set (MDS) with a reference date of 11/23/15 assessed the residnet with a cognitive score of "9" of "15". The resident was assessed requiring extensive to total assistance of 1-2 persons for bed mobility, transfers, dressing, toileting, bathing, and hygiene. The clinical record was reviewed. The physician ordered Bisac-Evac 10 mg suppository unwrap and	F 157	3. The licensed nursing staff have been reeducated concerning the requirement to notify the physician and the family when a medication is refused for periods greater than 24 hours. Reeducation includes the nurse must communicate this information during the change of shift report and document it onto the 24hr report. The 24hr report will be brought to the daily clinical meeting for review by the interdisciplinary team. Any medication refused for greater than a 24 hour period will result in the interdisciplinary team checking to ensure that the physician and family have been notified. 4. The Director of Nursing or designee verify that notification of medication being refused repeatedly is documented in the resident's clinical record. This verification will be documented 5 days a week x 4 weeks and then weekly x 4 weeks. The Director of Nursing will report the results of this monitoring to the QAPI committee monthly for the duration of the monitoring for review and recommendation. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	

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F 157	Continued From page 2	F 157		

The medication administration record (MAR) for March 2016 was reviewed. The nurses had documented on the front of the MAR the resident had refused the suppository every evening from 3/1/16 through 3/16/16. There was no documentation the physician/ RP had been notified of the refusal.
The nurses also circled their initials from 3/18/16 through 3/29/16 indicating the medication was not given. There was no documentation the physician/ RP had been notified of the refusal. There was no documentation on the back of the MAR for reason the medication was not given.
The nursing notes were reviewed and no documentation was evidenced the physician/ RP were notified of the medication not administered.
The administrator, director of nursing, and assistant director of nursing were informed of the findings during a meeting with the survey team on 3/30/16 at 4:00 p.m. The director of nursing provided the facility policy on Resident Medication Rights. The policy stated the facility should document in the clinical record when a resident refuses a medication and the physician should be notified of a refusal for periods greater than 24 hours.
2. For Resident #20, facility staff failed to notify the physician when the resident refused a medication for a month.

Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension, gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment

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F 157	Continued From page 3 reference date 3/12/16. During clinical record review on 3/31/16, the surveyor noted on the medication administration record (MAR) for March 2016 that the signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused. On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. The unit manager indicated that the resident had been refusing insulin for years because he thought his blood sugar went too low between the effects of the insulin and the hemodialysis. On 3/31/16, at approximately 12:30 PM, the DON reported discussing the Lantus insulin with the physician and obtaining an order to discontinue the medication. She stated that the record indicated that the resident had not received Lantus insulin in 4 months. Staff were accustomed to the resident refusing the medication and had stopped mentioning it to the physician. During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She stated that the physician was in the building for part of most days.	F 157		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		

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F 274	Continued From page 4 A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This Requirement is not met as evidenced by: Based on staff interview, and clinical record review it was determined the facility staff failed to complete a significant change MDS (minimum data set) assessment for 1 of 24 residents (Residents #19). The findings include: The facility staff failed to complete a significant change minimum data set (MDS) assessment, for Resident #19, after he was admitted to hospice. Resident #19 was admitted to the facility on 5/12/2015, his diagnosis include but is not limited to hepatitis C, high blood pressure, renal insufficiency, alzheimer ' s disease, aphasia, dementia, psychotic disorder, and gastrostomy status. Review of the residents clinical record revealed his most recent MDS (minimum data set) assessment completed on this resident was a significate change assessment with an ARD (assessment reference date) of 02/18/16. Section K coded the resident to have a feeding tube. Section B coded the resident to understand and to be understood. This significate change MDS	F 274	1. A significant change assessment has been completed for Resident #19 to capture the admission into Hospice on 3-31-2016 need to verify and add date from MDS. 2. Audit of all residents in hospice care has been performed to ensure that the transition was captured in a significant change assessment. 3. The MDS Registered nurses have been reeducated concerning the need to complete a significant change assessment for a resident when they are admitted to hospice care. One of the MDS RNs will attend the morning clinical meeting and be present to hear the review of all recent orders, including new hospice orders. This information will be used to initiate the significant change assessment.	

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F 274	Continued From page 5 was done for the reason of the newly inserted feeding tube. Resident #19 ' s clinical record had a physician ' s order dated 2/29/16 for consult for Hospice. The order also contained the order to do not resuscitate. A nurse ' s note dated 3/1/16 at 16:01 read " spoke with (name of hospice) today. Resident will be admitted to their services today. On 3/31/16 at 2:00pm., the MDS nurse was asked why a significate change MDS was not done after resident #19 had been admitted to hospice. MDS nurse #1 said after reviewing the record said " we didn ' t do one. " At 3:20 pm the administration staff was informed of the staff failure to do the significate changes MDS when Resident #19 was placed on hospice. No further information was provided to the surveyor related to the failure to do the MDS.	F 274	4. The Director of Nursing will maintain a list of residents on hospice services. The MDS RN coordinator will review the list and document that resident started hospice, the date of the start, the date of the significant change assessment completion and submission weekly x4 weeks and then monthly x2 months. The MDS RN will report the findings of this monitoring to the QAPI committee monthly for the duration of the monitoring for review and recommendations. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016.	
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	F 278		

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F 278	Continued From page 6 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 maintain a complete and accurate Minimum Data Set (MDS) assessment for 1 of 24 Residents in the sample survey, Resident #14. The Findings Included: For Resident #14, the facility staff failed to code section C (cognitive pattern) on the resident's quarterly MDS assessment with an ARD (assessment reference date) of 3/6/16. Resident #14 was originally admitted to the facility on 4/18/14. His diagnosis included, but was not limited to: high blood pressure, anxiety, aphasia, schizophrenia, intellectual disabilities and dementia. The current minimum data set assessment (MDS) with an assessment reference date (ARD) completed on 3/6/16 for Resident #14 was an annual MDS assessment. The surveyor observed that Section C, had dash marks. In section C the dash marks were in the staff mental status assessment.	F 278	1. There has been a modification submitted for Resident #14 and #24 on 4-26-2016 to ensure the most recent assessments are complete and accurate. 2. All residents in the facility are at risk for this issue. 3. The MDS RNs have been reeducated to review all assessments prior to submission. 4. The MDS Coordinator will verify that the sections C and L have been completed appropriately for all assessments prior to submission x 4 weeks. The MDS Coordinator will report the findings of the verifications to the QAPI committee monthly for the duration of the monitoring for review and recommendations. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	

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F 278	Continued From page 7 The MDS nurse was interviewed on 3/31/16 and asked if section C should have been assessed for mental status by staff assessment. She said the social worker codes those sections. Social worker #1 was asked why she had answered section C for mental status by staff assessment with a dash. She responded, " Didn ' t know I should go back and mark the no. " On 3/30/16, the surveyor informed the administration staff of the above findings. They were again informed on 3/31/16 at 3:20 pm. No further information was provided prior to the exit conference on 3/31/16. 2. The facility staff failed to ensure an accurate Minimum Data Set (MDS) for Resident #24 by failing to identify in Section L for Oral/ Dental Status that the resident had a broken tooth. Resident #24 was admitted to the facility on 9/7/10 with diagnoses of anoxic brain damage, respiratory failure, anxiety, anemia, and persistent vegetative state. The annual MDS with a reference date of 3/1/16 assessed the resident with coma and requiring total assistance of 1-2 persons for bed mobility, dressing, toileting, bathing, and hygiene. Resident #24 was observed to have a broken front tooth. Section " L " for Dental Oral Status was reviewed and part " D " under Section " L " was blank for " obvious or likely cavity or broken natural teeth " . The MDS coordinator (RN#3) stated the tooth had been broken for a long time. The administrator, director of nursing, and assistant director of nursing were informed of the findings during a meeting with the survey team on 3/30/16 at 4:40 p.m.	F 278		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 8 PARTICIPATE PLANNING CARE-REVISE CP	F 280		

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This Requirement is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1of 24 residents (Resident #24).
The findings include:
The facility staff failed to review and revise the comprehensive care plan for Resident #24 to reflect the resident had increased secretions requiring frequent mouth care.
Resident #24 was admitted to the facility on 9/7/10 with diagnoses of anoxic brain damage, respiratory failure, anxiety, anemia, and persistent vegetative state.
The annual MDS with a reference date of 3/1/16 assessed the resident with coma and requiring

1. The care plan for Resident #24 was updated to include the resident's excess secretions in her mouth require more frequent mouth care.
2. An audit was done to identify residents with this same issue of excessive secretions in her mouth. Their care plans have been updated.
3. The Unit Managers and Charge nurses will be reeducated to identify any resident with a new issue of increased secretions in the mouth. This will include updating the care plan when a resident has increased secretions and requires more mouth care.
4. The Director of Nursing or designee will review the care plans of each resident with increased secretions from their mouths to ensure that the care plan is updated. The Director of Nursing will report the findings of this review to the QAPI committee monthly for review and recommendation.
5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016

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F 280	Continued From page 9 total assistance of 1-2 persons for bed mobility, dressing, toileting, bathing, and hygiene. Resident #24 was observed on 3/31/16 at 10:40 a.m. returning from the shower requiring suctioning from her tracheostomy. The resident ' s mouth had a dry crust on her lips with teeth coated with secretions. The mother was present and stated the resident required frequent mouth care because of increased secretions. The respiratory therapist confirmed the resident had secretions in her mouth frequently and required mouth care often. The comprehensive care plan was reviewed. The care contained interventions to provide oral care daily and as needed. The care plan was not individualized to note the resident had excess secretions in her mouth and required more frequent mouth care. The administrator, director of nursing, and assistant director of nursing were informed of the findings during a meeting with the survey team on 3/30/16 at 4:40 p.m.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of nursing practice for medication administration for 8 of 24 residents (Resident #18, Resident #11, Resident #20, Resident #7, Resident #5, Resident #10, Resident #16, and Resident #15). The findings included: 1. The facility staff failed to document the reasons medication was not administered to	F 281	1. The physician has been notified of the medication errors for Residents #18, #11, #20, #7, #5, #10, #16, and #15. No new orders were received at that time. 2. All residents are at risk for this issue.	

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F 281	Continued From page 10	F 281		

Resident #18.
The clinical record of Resident #18 was reviewed 3/30/16 and 3/31/16. Resident #18 was admitted to the facility 5/22/13 and readmitted 12/6/15 with diagnoses that included but not limited to acute respiratory failure with tracheostomy, osteoporosis, aphasia, type 2 diabetes mellitus, morbid obesity, epilepsy, depression, anxiety, anoxic brain damage, encephalopathy, hypertension, chronic obstructive pulmonary disease, and bariatric surgery.
Resident #18's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/5/16 had dash marks for short and long term memory and severely impaired cognitive skills for decision making.
March 2016 physician orders included an order that read "Ergocalciferol 8000unit/1 ml (milliliter) drops For > Drisdol Give 1 ml via tube every day 9AM 12/10/14." Upon review of the March 2016 medication administration records (MARs), two dates had been circled-March 28 and March 29. The surveyor reviewed the reverse side of each of the March MARs and found no documentation for the circled medications.
The surveyor reviewed the March 28 and March 29 progress notes. The clinical record did not reveal the reasons the Ergocalciferol was not administered on 3/28/16 and 3/29/16.
The surveyor interviewed the director of nursing on 3/31/16 at 1:20 p.m. The director of nursing was asked to review the clinical record for the reasons the medication was not administered 3/28/16 and 3/29/16. After review, the DON stated she was unable to locate why the medications had not been administered. The DON stated the nurse had been called but no response from that nurse. The surveyor asked the DON when medications aren't administered, what would the standard of practice be. The

3. Licensed nursing staff have been reeducated concerning the medication administration/documentation policy. This includes when to notify the physician and responsible party of an issue.
The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.

4. The Director of Nursing or designee will monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 weeks, 3 days a week for 4 weeks, and then weekly for 4 weeks. The Director of Nursing or designee will review the MARs for each resident and document their findings weekly for 12 weeks.
The Director of Nursing will report results of the monitoring to the monthly QAPI committee for review and recommendations.

5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016

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DON stated to circle the medication and put the reasons the medications weren't administered on the reverse side of the MAR or chart in the nurse's notes. The surveyor requested the facility policy on standard of nursing practice for medication administration.

The surveyor reviewed the facility standard of nursing practice for medication administration titled "6.0 General Dose Preparation and Medication Administration" on 3/31/16. The policy read in part "Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure: 6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information [e.g., (that is) when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever necessary) medications, application sight] on appropriate forms."

During the interview with the DON, the surveyor asked what "appropriate forms" were. The DON stated "on the reverse side of the MAR or in the chart."

The surveyor informed the administrative staff of the above finding on 3/31/16 at 3:20 p.m.

No further information was made available prior to the exit conference on 3/31/16.

2. The facility staff failed to document the reasons medications were not administered to Resident #11.

The clinical record was reviewed 3/30/16 and 3/31/16. Resident #11 was admitted to the facility 4/25/14 with diagnoses that included but not limited to rectocele/cystocele without uterine prolapse, diabetes mellitus type 2, urine retention, senile dementia, nephritis and nephropathy,

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diabetic retinopathy, hypertension, congestive heart failure, pain, and osteoporosis.
Resident #11's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/1/16 assessed the resident with a cognitive summary score of 12 out of 15.
The March 2016 physician orders included insulin orders both scheduled and sliding scale. The surveyor reviewed the March 2016 medication administration records (MARs). There were blanks for the administration of Lantus insulin on 3/3/16 and 3/4/16 at 9:00 p.m., blanks on 3/15/16 at 9:00 p.m., blanks on 3/20/16 and 3/21/16 at 9:00 a.m., blanks on 3/23/16 at 9:00 a.m., blanks on 3/26/16 at 9:00 a.m., and blanks on 3/30/16 at 9:00 p.m.
The sliding scale insulin entry had no evidence the blood sugar was obtained on 3/23/16 at 6:00 a.m.
The surveyor reviewed the reverse side of the March 2016 medication administration records. There was no documentation as to the reason the insulins were not administered or the blood sugar obtained. The March 2016 progress notes were reviewed as well. There was no evidence why Resident #11 did not receive insulin as ordered or blood sugar as ordered.
The surveyor interviewed licensed practical nurse #2 on 3/30/16 at 3:03 p.m. The surveyor showed L.P.N. #2 the March 2016 MAR and specifically the scheduled and sliding scale insulin documentation. The surveyor asked L.P.N. #2 what nurses do when medications are administered. L.P.N. #2 stated when medications are administered they are initialed. L.P.N. #2 stated there were blanks on the March 2016 MAR.
The surveyor interviewed the director of nursing on 3/31/16 at 1:20 p.m. The surveyor asked the DON when medications aren't administered, what

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would the standard of practice be. The DON stated to circle the medication and put the reasons the medications weren't administered on the reverse side of the MAR or chart in the nurse's notes. The surveyor requested the facility policy on standard of nursing practice for medication administration.
The surveyor reviewed the facility standard of nursing practice for medication administration titled "6.0 General Dose Preparation and Medication Administration" on 3/31/16. The policy read in part "Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure: 6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information [e.g., (that is) when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever necessary) medications, application sight] on appropriate forms."
During the interview with the DON, the surveyor asked what "appropriate forms" were. The DON stated "on the reverse side of the MAR or in the chart."
The surveyor informed the administrative staff of the above finding on 3/31/16 at 3:20 p.m.
No further information was made available prior to the exit conference on 3/31/16.
3a. For Resident #20, facility staff failed to follow standard nursing practice for medication administration for insulin.

Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension,

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gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment reference date 3/12/16.

During clinical record review on 3/31/16, the surveyor noted on the medication administration record (MAR) for March 2016 that the signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units / 1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0; 141-180=1 units; 181-220=2units; 221-260=3units; 261-300= 4units; 301-340= 5units; 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23. 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered..

On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. The unit manager indicated that the resident had been refusing insulin for years because he thought his blood sugar went too low between the effects of the insulin and the hemodialysis. On 3/31/16, at approximately 12:30 PM, the DON reported discussing the Lantus insulin with the physician and obtaining an order to discontinue the

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medication. She stated that the record indicated that the resident had not received Lantus insulin in 4 months. Staff were accustomed to the resident refusing the medication and had stopped mentioning it to the physician.

During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days.

3b. For Resident #20, facility staff failed to follow nursing standards of practice for medication administration for insulin and antibiotics.

Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension, gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment reference date 3/12/16.

During clinical record review on 3/31/16, the surveyor reviewed the medication administration record (MAR) for March 2016. Bactrim DS 1 tab PO (by mouth) BID (by mouth) X 5 days ordered 3/24/16. Two times per day for 5 days required 10 doses. The MAR had only 9 spaces indicated for documentation of administration of Bactrim, with staff documenting 2 doses on 3/25, 26, 27, and

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28. Only one dose was documented on 3/29/16. The space for the second dose on 3/29 was X'd out. There was no documentation to indicate that a 10th dose of Bactrim had been administered. The signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units / 1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0; 141-180=1 units; 181-220=2units; 221-260=3units; 261-300= 4units; 301-340= 5units; 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23. 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered..

On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. Both counted the doses of Bactrim administered and agreed that only 9 had been administered. They acknowledged that the insulin had not been documented administered as ordered.

During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the

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physician was in the building for part of most days.

4. For Resident #7, facility staff failed to follow standard nursing practice for medication administration for insulin.

Resident #7 was admitted to the facility on 11/16/15 with diagnoses including end stage renal disease with kidney failure, hypertension, dementia, and insulin dependent diabetes mellitus. The resident scored 10/15 on the brief interview for mental status on the minimum data set assessment with assessment reference date 2/27/16.

During clinical record review on 3/31/16, the surveyor noted on the medication administration record (MAR) for March 2016 that the signature space for Lantus (insulin) 100 units per 1 ml inject 20 units subcutaneously at bedtime for DMII scheduled for 9 PM was blank on 3/17. Humalog 100 units / 1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 151-200=2units; 201-250=3units; 251-300= 5units; 301-350= 7 units; >350= 9units and call MD contained blanks on 3/14 and three blanks on 3/25. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had not been administered as ordered..

During a summary meeting on 3/30/16, the surveyor reported the concern. The director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said

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she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days.

5. For Resident #5, facility staff failed to follow standard nursing practice for medication administration for insulin.

Resident #5 was admitted to the facility on 3/31/11 with diagnoses including hypertension, diabetes mellitus, anxiety, depression, and bipolar disorder. The resident scored 13/15 on the brief interview for mental status on the minimum data set assessment dated 2/5/16, and was assessed without symptoms of delirium, psychosis, or behavior issues.

Clinical record review on 3/30/16, revealed that Lantus insulin 30 units twice per day was not documented as administered on the medication administration record (MAR) at 9 AM on 3/26/16. No explanation for the omission was found in the nurse's progress notes.

The concern was reported to administrative staff during a summary meeting on 3/30/16. The director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days.

6.The facility staff failed to follow nursing standards of pracice concering physician orders for insulin administration for Resident #16

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resulting in a significant medication error.

Resident #16 was admitted to the facility on 10/08/14. Diagnoses included, but were not limited to, seizure disorder, chronic pain, depression, anxiety, heart failure, diabetes and COPD (chronic obstructive pulmonary disease).

The most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 03/04/16. Section C (cognitive patterns) of this assessment scored the resident 14 out of a possible 15 points indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood.

The comprehensive care plan was reviewed on 3/9/16. The care plan contained a focus area the resident was an insulin dependent diabetic. The interventions included to administer insulin and /or oral medication as ordered, obtain blood sugars as ordered report to physician any BS (blood sugar outside parameters.

The clinical record was reviewed on 3/31/16. The physician orders dated 12/19/15 included an order for administration of sliding scale insulin as follows: "Novolog 100 Unit/ML vial inject subcutaneously per slicing scale before meals and bedtime as follows:
"If blood sugar is 0-150=0 units
151-200 =2 units
201-250=4 units
251-300=6 units
301-350= 8 units
Over 351=10 units"

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The medication administration record (MAR) for March 2016, was also reviewed. On 3/21/16 there was no documentation for a blood sugar.

The nursing notes were reviewed and did not contain any documentation to provide a reason as to why the blood sugar was not obtained/documented.

Continued review of the MAR revealed the following order Novolog Mix 70-30 units/ml vial inject 25 units subcutaneously twice daily with breakfast and dinner (6am and 5pm).

The MAR revealed on the following dates and times no documentation to support that the insulin was given: 3/4/16 at 5pm, 3/6/16 at 6am, 3/20/16 at 6am, and on 3/26/16 at 5pm.

On 3/31/16, at 1:25 p.m., LPN #1 was asked to look at the MAR and tell the surveyor if the insulin had been administered after looking she said "I can't speak to that they aren't mine."

In the afternoon of 3/31/16 the administrator and director of nurses were informed of the insulin medication errors.

Prior to exit the medication administration policy was provided to the survey team.
The survey team was provided the facility standard of nursing practice for medication administration titled "6.0 General Dose Preparation and Medication Administration" on 3/31/16. The policy read in part " Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure: 6. After medication administration, Facility staff should take all measures required by Facility policy and

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Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information [e.g., (that is) when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever necessary) medications, application sight] on appropriate forms.

7. The facility staff failed follow nursing standards of practice in documenting and administer the physician ordered medication Levaquin 750mg by mouth every day for Resident #10.

Resident #10 was admitted to the facility 08/4/15. Diagnoses included, but were not limited to dementia, hypertension, arthritis and osteoporosis.

The most recent MDS (minimum data set) assessment completed on this resident was a quarterly with an ARD (assessment reference date) of 01/12/16, assessed the resident to usually understand and to usually be understood.

Review of Resident #10 ' s clinical record revealed a physician ' s order dated 3/10/16 for Levaquin 750mg by mouth every day.

A review of the residents current MAR (medication administration record) indicated the facility staff had not administered all 7 days of the medication Levaquin. The medication was documented as administered starting on 3/10/16 through 3/15/16. However, on the 16th there was no documentation on the front or the back of the MAR to indicate the medication was not administered or administered. There was no corresponding nurse ' s note related to the lack of

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documentation of the medication Levaquin.

On 3/30/16 at 9:30 am licensed practical nurse (LPN) #2 was asked if she had given the medication Levaquin on the 16th. She stated " I wasn ' t here at 9 pm. "

At 2:00 pm the director of nurses was asked if the nurse who worked on the 16th had given the medication. She stated " I ' m not sure the nurse said she didn ' t know. " The pharmacy manifest said we sent 4 back and pulled 4 from the stat box the math is off. The pharmacy said they had 2 stat box slips that requested the Levaquin 750mg one dose each. They also had 2 stat box slips that also requested the Levaquin 750 each one dose that had no residents name on it. "

The survey team was provided the facility standard of nursing practice for medication administration titled " 6.0 General Dose Preparation and Medication Administration " on 3/31/16. The policy read in part " Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure: 6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information [e.g., (that is) when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever necessary) medications, application sight] on appropriate forms.
The surveyor informed the administrative staff of the above finding on 3/31/16 at 3:20 p.m.
No further information was made available prior to the exit conference on 3/31/16.

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F 281	Continued From page 23 8. The facility staff failed to follow professional standards of nursing service by failing to notify the physician/responsible party (RP) of medication not administered for Resident #15. Resident #15 was admitted to the facility on 1/5/14 with diagnoses of fracture pubis, skin cancer, dysphagia, anemia, hypertension, Gastro-esophageal reflux disease, chronic obstructive pulmonary disease, dementia, anxiety, coronary artery disease, and arthritis. The significant change Minimum Data Set (MDS) with a reference date of 11/23/15 assessed the resident with a cognitive score of " 9 " of " 15 " . The resident was assessed requiring total assistance of 2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene. The medication administration record (MAR) for March 2016 was reviewed. The nurses had documented on the front of the MAR the resident had refused the suppository every evening from 3/1/16 through 3/16/16. There was no documentation the physician/ RP had been notified of the refusal. The nurses also circled their initials from 3/18/16 through 3/29/16 indicating the medication was not given. There was no documentation the physician/ RP had been notified of the refusal. There was no documentation on the back of the MAR for reason the medication was not given. The nursing notes were reviewed and no documentation was evidenced the physician/ RP were notified of the medication not administered. The administrator, director of nursing, and assistant director of nursing were informed of the findings during a meeting with the survey team on 3/30/16 at 4:00 p.m. The director of nursing provided the facility policy on Resident Medication Rights. The policy stated the facility should document in the clinical record when a resident	F 281		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 24 refuses a medication and the physician should be notified of a refusal for periods greater than 24 hours.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to follow physician orders for 5 of 27 residents in the survey sample (Residents #20, 1, 6, 10, and 15) 1. For Resident #20, facility staff failed to follow physician orders for medication administration for insulin and antibiotics. Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension, gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment reference date 3/12/16. During clinical record review on 3/31/16, the surveyor reviewed the medication administration record (MAR) for March 2016. Bactrim DS 1 tab PO (by mouth) BID (by mouth) X 5 days ordered	F 309	1. The physician was notified concerning the medication errors for Residents #20, #1, #6, #10, and #15. There were no new orders at that time. 2. All residents are at risk for this issue. 3. Licensed nursing staff have been reeducated concerning the medication administration/documentation policy. This includes how to transcribe medication orders and when to notify the physician and responsible party of an issue. The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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3/24/16. Two times per day for 5 days required 10 doses. The MAR had only 9 spaces indicated for documentation of administration of Bactrim, with staff documenting 2 doses on 3/25, 26, 27, and 28. Only one dose was documented on 3/29/16. The space for the second dose on 3/29 was X'd out. There was no documentation to indicate that a 10th dose of Bactrim had been administered. The signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units / 1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0; 141-180=1 units; 181-220=2units; 221-260=3units; 261-300= 4units; 301-340= 5units; 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23. 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered..

On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. Both counted the doses of Bactrim administered and agreed that only 9 had been administered. They acknowledged that the insulin had not been documented administered as ordered.

During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of

4. The Director of Nursing or designee will monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 weeks, 3 days a week for 4 weeks, and then weekly for 4 weeks. The Director of Nursing or designee will review the MARs for each resident and document their findings weekly for 12 weeks. The Director of Nursing will report the results of the monitoring to the monthly QAPI committee for review and recommendations.

5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016

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the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days.
2. The facility staff failed to administered the physician ordered medication Nudexta 10x20 1 cap every day x 1 week start after EKG (Electrocardiography) for Resident #1.

Resident #1 was admitted to the facility 07/7/15. Diagnoses included, but were not limited to dementia, hypertension, and atrial fibrillation.

The most recent MDS (minimum data set) assessment completed on this resident was a quarterly with an ARD (assessment reference date) of 02/29/16, assessed the resident to usually understand and to usually be understood.

The clinical record included a physician signed order dated 2/23/16 that included the order Nudexta 10-20mg 1 cap every day x 1 week start after EKG. 2nd week give Nudexta 20-10mg I cap BID (twice daily) every 12 hours. EKG prior first dose of Nudexta, EKG 4 hours after 1st dose of Nudexta.

A review of the residents current MAR (medication administration record) indicated the facility staff had administered the 1st dose after the EKG was done on 2/24/16. However there was an extra dose of Nudexta given on 2/24/16 at 5:00pm.

The Nudexta was not documented as given on 2/25/16.

Licensed practical nurse (LPN) #2 stated she had

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given the Nudexta on 2/24/16 at 1:00 pm after the EKG and at 5:00pm, but was not working on the 25th.

On 03/30/16 at approximately 2:55 p.m., during an end of the day meeting with the administrator, DON (director of nursing). The administrative staff was notified that the facility staff had administered the medication incorrectly.

The survey team was provided the facility standard of nursing practice for medication administration titled " 6.0 General Dose Preparation and Medication Administration " on 3/31/16. The policy read in part " Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure: 6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information [e.g., (that is) when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever necessary) medications, application sight] on appropriate forms.

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

3. The facility staff failed to administer the physician ordered medication Levaquin 750mg by mouth every day for Resident #10.

Resident #10 was admitted to the facility 08/4/15. Diagnoses included, but were not limited to dementia, hypertension, arthritis and

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osteoporosis.

The most recent MDS (minimum data set) assessment completed on this resident was a quarterly with an ARD (assessment reference date) of 01/12/16, assessed the resident to usually understand and to usually be understood.

Review of Resident #10 ' s clinical record revealed a physician ' s order dated 3/10/16 for Levaquin 750mg by mouth every day.

A review of the residents current MAR (medication administration record) indicated the facility staff had not administered all 7 days of the medication Levaquin. The medication was documented as administered starting on 3/10/16 through 3/15/16. However, on the 16th there was no documentation on the front or the back of the MAR to indicate the medication was not administered or administered. There was no corresponding nurse ' s note related to the lack of documentation of the medication Levaquin.

On 3/30/16 at 9:30 am licensed practical nurse (LPN) #2 was asked if she had given the medication Levaquin on the 16th. She stated " I wasn ' t here at 9 pm. "

At 2:00 pm the director of nurses was asked if the nurse who worked on the 16th had given the medication. She stated " I ' m not sure the nurse said she didn ' t know. " The pharmacy manifest said we sent 4 back and pulled 4 from the stat box the math is off. The pharmacy said they had 2 stat box slips that requested the Levaquin 750mg one dose each. They also had 2 stat box slips that also requested the Levaquin 750 each one dose that had no residents name on it. "

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The surveyor informed the administrative staff of the above finding on 3/31/16 at 3:20 p.m. No further information was made available prior to the exit conference on 3/31/16.

4. The facility staff failed to follow physician orders for medication administration to Resident #6. The facility staff failed to administer Lactulose as ordered to Resident #6.

The surveyor reviewed Resident #6's clinical record 3/30/16 and 3/31/16. Resident #6 was admitted to the facility 12/26/14 and readmitted 4/20/15 with diagnoses that included but not limited to fracture of first and fourth cervical vertebra, acute and chronic respiratory failure, ventilator associated pneumonia, tracheostomy, malnutrition, gastrostomy, metabolic encephalopathy, sinusitis, aphonia, dysphagia, hypothyroidism, hyperlipidemia, hypertension, gastrointestinal hemorrhage, osteoarthritis, osteoporosis, sacral pressure ulcer, anemia, anxiety, and depressive disorder.

Resident #6's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 2/1/16 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Summary Score.

The surveyor reviewed the February 2016 and March 2016 physician orders. Telephone order written 2/24/16 1550 (3:50 p.m.) read in part "Lactulose 10G (grams)/15 ml (milliliter), 30 ml PT (peg tube) q (every) 8 h (hour) x 5 doses then 30 ml PT daily. ?NH3 (ammonia level)."

The February 2016 medication administration records were reviewed. The entry on the February 2016 MARs read "Lactulose 10G/15 ml 30 ml PT q 8h x 5 doses 6A, 2P, 10P 2/24."

The first entry on 2/24/16 at 10P for Lactulose 30 ml was initialed and circled. The surveyor reviewed the reverse side of the February 2016 MAR. There was no documentation as to why

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the medication was not administered. The progress notes for 2/24/16 did not reveal a reason for the medication omission.
The surveyor interviewed the director of nursing on 3/30/16 at 12:30 p.m. concerning the order for Lactulose. The director of nursing was unable to identify the reason Resident #6 did not receive the initial or first dose of Lactulose on 2/24/16.
The surveyor informed the administrative staff of the above finding on 3/30/16 at 4:40 p.m.
No further information was provided prior to the exit conference on 3/31/16.
5. The facility staff failed to follow the physician orders for administration of medication for Resident #15.
Resident #15 was admitted to the facility on 1/5/14 with diagnoses of fracture pubis, skin cancer, dysphagia, anemia, hypertension, Gastro-esophageal reflux disease, chronic obstructive pulmonary disease, dementia, anxiety, coronary artery disease, and arthritis.
The significant change Minimum Data Set (MDS) with a reference date of 11/23/15 assessed the resident with a cognitive score of " 9 " of " 15 ". The resident was assessed requiring total assistance of 2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene.
Resident #15 was observed on 3/30/16 at 8:15 a.m. receiving morning medications administered by a staff nurse (LPN#2). The medications were reconciled with the current physician orders. The physician had written a telephone order dated 3/7/16 to administer the medication, Dronabinol (Marinol) 5mg twice daily before lunch and supper. LPN#2 administered the Dronabinol at 8:15 a.m. immediately after breakfast. LPN#2 was asked about the medication and stated she had given it too early.
The administrator, director of nursing, and

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F 309	Continued From page 31 assistant director of nursing were informed of the findings during a meeting with the survey team on 3/30/16 at 4:00 p.m.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: Based on observation, staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to provide mouth care as needed for 1 of 24 residents (Resident #24). The findings include: The facility staff failed to provide mouth care as needed (prn) for Resident #24. Resident #24 was admitted to the facility on 9/7/10 with diagnoses of anoxic brain damage, respiratory failure, anxiety, anemia, and persistent vegetative state. The annual MDS with a reference date of 3/1/16 assessed the resident with coma and requiring total assistance of 1-2 persons for bed mobility, dressing, toileting, bathing, and hygiene. Resident #24 was observed on 3/31/16 at 10:40 a.m. returning from the shower requiring suctioning from her tracheotomy. The resident ' s mouth had a dry crust on her lips with teeth coated with secretions. The mother was present and stated the resident required frequent mouth care because of increased secretions. The respiratory therapist confirmed the resident had secretions in her mouth frequently and required mouth care often.	F 312	1. Resident #24 had mouth care as soon as it was identified as being needed on 3/31/16. 2. All residents with increased oral secretions are at risk for this issue. 3. Current nursing staff have been reeducated concerning the proper procedure and that the mouths of these residents must be assessed with each visit into the room, at the least each hour. Resident #24, and any other resident identified, now has a sheet that allows for as frequent as hourly documentation of any mouth care performed. These sheets are kept in the ADL book for CNA documentation and in the MAR book for licensed staff documentation. The Administrator is no longer with the facility. The current Administrator is aware that documentation of the resolution and the family's response should be documented.	

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The respiratory therapist (RT#1) was interviewed on 3/31/16 at 11:00 a.m. RT#1 stated the resident had " stiff lungs " making it difficult for the resident to cough and clear her secretions. RT#1 stated the resident had a lip balm applied to her lips per request of the mother and this tended to dry and crust because the resident was a " mouth breather " . RT#1 stated Resident #24 frequently had secretions come from the tracheotomy requiring suctioning and also up into her mouth requiring frequent mouth care. RT#1 stated this was a nursing responsibility to provide the mouth care as needed. RT#1 stated the resident ' s lips would become dry and crusted appearing.

The comprehensive care plan was reviewed. The care plan contained an intervention to provide good oral care daily and prn (as needed).

The unit manager (RN#3) was interviewed on 3/30/16 at 1:20 p.m. RN#3 stated the nurses provided mouth care and checked the resident whenever they went in the room. There was no documentation in the clinical record the resident had received mouth care more often than twice daily.

A staff nurse (LPN#5) was asked how often in a 12 hours shift was mouth care provided and she stated she checked the resident 3-4 times a day. The resident was also ordered to have medication applied to her mouth twice daily.

The director of nursing provided the grievance log for the facility. The grievance log included a complaint from the resident's mother dated 9/28/15 that oral care was not done. The staff were re-educated and oral care provided. Another grievance was dated 3/25/16 from the mother that mouth care was not done and the care was offered. Another grievance dated 3/29/16 also was regarding turning and mouth care not done. The resident was changed and

4. The Director of Nursing or designee will monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 weeks, 3 days a week for 4 weeks, and then weekly for 4 weeks.
   The Director of Nursing or designee will review the MARs for each resident and document their findings weekly for 12 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the monitoring process.

5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016

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F 312	Continued From page 33 repositioned. The administrator, director of nursing, and assistant director of nursing were informed of the findings during a meeting with the survey team on 3/30/16 at 4:00 p.m. This is a complaint deficiency.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow the physician order for monthly Foley catheter changes for 1 of 24 residents (Resident #11). The findings included: The facility staff failed to change Resident #11's indwelling Foley catheter in January 2016. The clinical record was reviewed 3/30/16 and 3/31/16. Resident #11 was admitted to the facility 4/25/14 with diagnoses that included but not limited to rectocele/cystocele without uterine prolapse, diabetes mellitus type 2, urine retention, senile dementia, nephritis and nephropathy, diabetic retinopathy, hypertension, congestive heart failure, pain, and osteoporosis. Resident #11's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/1/16 assessed the resident with a	F 315	1. Resident # 11's Foley catheter was changed on 3-30-2016. The resident has shown no adverse effects from this delay. 2. All residents with catheters have had their orders reviewed and the MAR checked to ensure that there have been no others affected by this issue. 3. Licensed nursing staff have been reeducated concerning the responsibility to follow physician orders as written. The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.	

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F 315	Continued From page 34 cognitive summary score of 12 out of 15. Section H Bladder and Bowel was marked for indwelling catheter (H0100). Urinary continence was marked "9" (not rated, resident had a catheter) in H0300. The January 2016 physician orders were reviewed 3/30/16. Resident #11 had orders for the Foley catheter to be changed monthly and as needed with an 18 Fr (French) 30 ml (milliliter) balloon. The surveyor reviewed the January 2016 medication administration records (MARs). An entry on the MARs indicated the Foley catheter was to be changed on 1/16/16 (the border of the box was darkened to indicate the day of the catheter change). However, the box was not initialed that would indicate the staff had changed the Foley catheter. The surveyor reviewed the January 2016 progress notes with licensed practical nurse #1 on 3/30/16 at 3:30 p.m. The progress noted did not contain documentation that the Foley catheter had been changed in January. L.P.N. #1 stated Resident #11 had been sent to the emergency room on 1/9/16. She stated the Foley catheter could have been changed at the hospital. The surveyor informed the administrative staff of the above concern on 3/30/16 at 4:40 p.m. The surveyor requested the facility policy on Foley catheter changes from the director of nursing on 3/31/16. The director of nursing stated the facility did not have a policy on Foley catheter changes and Resident #11's catheter was not changed at the emergency room. No further information was provided prior to the exit conference on 3/31/16.	F 315	4. The Director of Nursing or designee will review the documentation 5 days a week for 4 weeks, 3 days a week for 4 weeks, and then weekly for 8 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee monthly for review and recommendations. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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F 329	Continued From page 35 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. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician ordered parameters for the administration of an antihypertensive medication for 1 of 24 residents (Resident #13). The findings include: The facility staff failed to obtain the blood pressure of Resident #13 before administering the antihypertensive medication Carvedilol (Coreg). The physician had ordered to hold the medication if the systolic blood pressure was less than 110. The clinical record of Resident #13 was reviewed 3/30/16. Resident #13 was admitted to the facility	F 329	1. The physician for Resident # 13 has been notified of the missing documentation listed. There were no new orders. 2. All residents who have blood pressure ordered to be taken prior to the administration of medication are at risk for this issue. 3. Licensed nursing staff have been reeducated concerning the responsibility to follow physician orders as written. The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.	

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F 329	Continued From page 36 11/4/15 with diagnoses that included but not limited to hypertension, Alzheimer's disease, pituitary gland neoplasm, type 2 diabetes mellitus, hyperlipidemia, vascular dementia with behavioral disturbances, major depressive disorder, visual hallucinations, restlessness and agitation. Resident #13's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/14/16 assessed the resident with a cognitive summary score of 13 out of 15 in Section C Summary Score. Resident #13's current comprehensive care plan revised on 11/17/15 included a focus area for hypertension and read "I have HTN (hypertension). I am taking medication for this. I am at risk for complications from this." Interventions in part "Administer medication as ordered. Give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate (tachycardia) and effectiveness. Vital signs and weights as ordered." The March 2016 signed physician orders included the following order for the administration of Carvedilol (Coreg): "Carvedilol 12.5 mg (milligrams) tablet for > Coreg F/C 1 tab (tablet) by mouth twice daily-Hold if SBP (systolic blood pressure) less than 110." The surveyor reviewed the March 2016 medication administration records (MARs). There were no blood pressures obtained and/or documented on 3/1/16, 3/2/16, 3/11/16, 3/12/16, 3/18/16, 3/23/16, 3/27/16, and 3/28/16 at 9:00 p.m. The surveyor reviewed the Weights and Vitals Summary form for March 2016. There were no blood pressures documented on the above dates for 9:00 p.m. The surveyor interviewed licensed practical nursing #5 on 3/30/16 at 2:30 p.m. L.P.N. #5 provided the facility "paper" form for March 2016 vital signs.	F 329	4. The Director of Nursing or designee will monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 weeks, 3 days a week for 4 weeks, and then weekly for 4 weeks. The Director of Nursing or designee will review the MARs for each resident and document their findings weekly for 12 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the monitoring process. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	

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F 329	Continued From page 37 None of the blood pressure listed above had been obtained and documented on these forms. At 2:36 p.m., L.P.N. #1 stated "Blood pressures not done." The surveyor informed the administrative staff of the failure of the facility staff to obtain blood pressures prior to the administration of the antihypertensive Carvedilol (Coreg) on 3/30/16 at 4:40 p.m. No further information was provided by the exit conference on 3/31/16.	F 329		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This Requirement is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure that 4 of 24 residents in the sample survey were free from significant medication errors (Resident #11, Resident #16, Resident #20, and Resident #5). The findings included: 1. The facility staff failed to administer physician ordered insulin (Lantus) nine times in March 2016 and failed to obtain an accucheck on 3/23/16 at 6:00 a.m. The clinical record was reviewed 3/30/16 and 3/31/16. Resident #11 was admitted to the facility 4/25/14 with diagnoses that included but not limited to rectocele/cystocele without uterine prolapse, diabetes mellitus type 2, urine retention, senile dementia, nephritis and nephropathy, diabetic retinopathy, hypertension, congestive heart failure, pain, and osteoporosis. Resident #11's annual minimum data set (MDS) assessment with an assessment reference date	F 333	1. The physician has been notified concerning the medication errors for Residents #11, #16, #20, and #5. There were no new orders at that time. 2. Residents receiving medication are at risk for this issue. 3. Licensed nursing staff have been reeducated concerning the policy and procedure of medication administration/documentation, including the responsibility to follow physician orders as written. The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.	

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F 333	Continued From page 38 (ARD) of 3/1/16 assessed the resident with a cognitive summary score of 12 out of 15. The March 2016 physician orders were reviewed 3/30/16. Two insulin orders were written and read: "Lantus 100 units/1 ml (milliliter) vl (vial) Inject 10 units subcutaneously twice daily" and "Humalog 100 units/1 ml vl Inject subcutaneously before meals and at bedtime per sliding scale for blood sugar: 0-50=0 units, house protocol and call MD (medical doctor); 51-70=0 units & house protocol; 71-150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units for DM (diabetes mellitus)." The surveyor reviewed the March 2016 medication administration records (MARs). There were blanks for the administration of Lantus insulin on 3/3/16 and 3/4/16 at 9:00 p.m., blanks on 3/15/16 at 9:00 p.m., blanks on 3/17/16 at 9:00 p.m., blanks on 3/20/16 and 3/21/16 at 9:00 a.m., blanks on 3/23/16 at 9:00 a.m., blanks on 3/26/16 at 9:00 a.m., and blanks on 3/30/16 at 9:00 p.m. The sliding scale insulin entry had no evidence the blood sugar was obtained on 3/23/16 at 6:00 a.m. The surveyor reviewed the reverse side of the March 2016 medication administration records. There was no documentation as to the reason why the insulins were not administered or the blood sugar obtained. The March 2016 progress notes were reviewed as well. There was no evidence why Resident #11 did not receive insulin as ordered or blood sugar as ordered. The surveyor interviewed licensed practical nurse #2 on 3/30/16 at 3:03 p.m. The surveyor showed L.P.N. #2 the March 2016 MAR and specifically the scheduled and sliding scale insulin documentation. The surveyor asked L.P.N. #2 what nurses do when medications are	F 333	4. The Director of Nursing or designee will monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 weeks, 3 days a week for 4 weeks, and then weekly for 4 weeks. The Director of Nursing or designee will review the MARs for each resident and document their findings weekly for 12 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the monitoring process. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	

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administered. L.P.N. #2 stated when medications are administered they are initialed. L.P.N. #2 stated there were blanks on the March 2016 MAR.

The surveyor interviewed the director of nursing on 3/31/16 at 1:20 p.m. The surveyor asked the DON when medications aren't administered, what would the standard of practice be. The DON stated to circle the medication and put the reasons the medications weren't administered on the reverse side of the MAR or chart in the nurse's notes. The surveyor requested the facility policy on standard of nursing practice for medication administration.

The surveyor reviewed the facility standard of nursing practice for medication administration titled "6.0 General Dose Preparation and Medication Administration" on 3/31/16. The policy read in part "Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure: 6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information [e.g., (that is) when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever necessary) medications, application sight] on appropriate forms."

During the interview with the DON, the surveyor asked what "appropriate forms" were. The DON stated "on the reverse side of the MAR or in the chart."

The surveyor informed the administrative staff of the above finding on 3/31/16 at 3:20 p.m.

No further information was made available prior to the exit conference on 3/31/16.

2.The facility staff failed to follow physician orders

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for insulin administration for Resident #16 resulting in a significant medication error.

Resident #16 was admitted to the facility on 10/08/14. Diagnoses included, but were not limited to, seizure disorder, chronic pain, depression, anxiety, heart failure, diabetes and COPD (chronic obstructive pulmonary disease).

The most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 03/04/16. Section C (cognitive patterns) of this assessment scored the resident 14 out of a possible 15 points indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood.

The comprehensive care plan was reviewed on 3/9/16. The care plan contained a focus area the resident was an insulin dependent diabetic. The interventions included to administer insulin and /or oral medication as ordered, obtain blood sugars as ordered report to physician any BS (blood sugar outside parameters.

The clinical record was reviewed on 3/31/16. The physician orders dated 12/19/15 included an order for administration of sliding scale insulin as follows: "Novolog 100 Unit/ML vial inject subcutaneously per slicing scale before meals and bedtime as follows:
"If blood sugar is 0-150=0 units
151-200 =2 units
201-250=4 units
251-300=6 units
301-350= 8 units
Over 351=10 unit"

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The medication administration record (MAR) for March 2016, was also reviewed. On 3/21/16 there was no documentation for a blood sugar.

The nursing notes were reviewed and did not contain any documentation to provide a reason as to why the blood sugar was not obtained/documented.

Continued review of the MAR revealed the following order Novolog Mix 70-30 units/ml vial inject 25 units subcutaneously twice daily with breakfast and dinner (6am and 5pm).

The MAR revealed on the following dates and times no documentation to support that the insulin was given: 3/4/16 at 5pm, 3/6/16 at 6am, 3/20/16 at 6am, and on 3/26/16 at 5pm.

On 3/31/16, at 1:25 p.m., LPN #1 was asked to look at the MAR and tell the surveyor if the insulin had been administered after looking she said "I can't speak to that they aren't mine."

In the afternoon of 3/31/16 the administrator and director of nurses were informed of the insulin medication errors.

Prior to exit the medication administration policy was provided to the survey team.
The survey team was provided the facility standard of nursing practice for medication administration titled " 6.0 General Dose Preparation and Medication Administration " on 3/31/16. The policy read in part " Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure: 6. After medication administration, Facility staff should take all

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measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information [e.g., (that is) when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever necessary) medications, application sight] on appropriate forms.
3. For Resident #20, facility staff failed to follow standard nursing practice for medication administration for insulin.

Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension, gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment reference date 3/12/16.

During clinical record review on 3/31/16, the surveyor noted on the medication administration record (MAR) for March 2016 that the signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units / 1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0; 141-180=1 units; 181-220=2units; 221-260=3units; 261-300= 4units; 301-340= 5units; 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23. 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather

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than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered..

On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. The unit manager indicated that the resident had been refusing insulin for years because he thought his blood sugar went too low between the effects of the insulin and the hemodialysis. On 3/31/16, at approximately 12:30 PM, the DON reported discussing the Lantus insulin with the physician and obtaining an order to discontinue the medication. She stated that the record indicated that the resident had not received Lantus insulin in 4 months. Staff were accustomed to the resident refusing the medication and had stopped mentioning it to the physician.

During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days.

4. For Resident #5, facility staff failed to follow physician orders for medication administration for insulin.

Resident #5 was admitted to the facility on 3/31/11 with diagnoses including hypertension,

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F 333	Continued From page 44 diabetes mellitus, anxiety, depression, and bipolar disorder. The resident scored 13/15 on the brief interview for mental status on the minimum data set assessment dated 2/5/16, and was assessed without symptoms of delirium, psychosis, or behavior issues. Clinical record review on 3/30/16, revealed that Lantus insulin 30 units twice per day was not documented as administered on the medication administration record (MAR) at 9 AM on 3/26/16. No explanation for the omission was found in the nurse's progress notes. The concern was reported to administrative staff during a summary meeting on 3/30/16. The director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days.	F 333		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure the resident received the physician ordered therapeutic diet for 1 of 24 residents (Resident #16). The findings include: Resident #16 was purchasing coffee with caffeine	F 367	1. Resident #16 now receives her coffee from the kitchen as she wishes. 2. All residents capable of interview have been asked if they prefer caffeinated or decaffeinated coffee to be served to them. Their preferences will be honored.	

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F 367	Continued From page 45 out of her $30 dollar she receives monthly because of being on a Cardiac diet. Resident #16 was admitted to the facility on 10/08/14. Diagnoses included, but were not limited to, seizure disorder, chronic pain, depression, anxiety, heart failure, diabetes and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 03/04/16. Section C (cognitive patterns) of this assessment scored the resident 14 out of a possible 15 points indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood. The current comprehensive care plan dated 3/8/16 revealed the problem/need for therapeutic diet. Approaches included "provided and serve diet as ordered and dietary consult to determine preferred foods. " The surveyor did not find documentation to indicate that a consult related to Resident #16 ' s preference for coffee containing caffeine. The March 2016 physician order sheet was reviewed 3/30/16. Resident #16 was ordered a cardiac low concentrated sweet diet. The surveyor observed Resident #16 on 3/30/16 at 2:35 p.m. Resident #16's over the bed table contained a thermos and a coffee mug. She said it contained her coffee for the day that the nurse brewed for her every morning and filled. She informed the surveyor that she purchased her own coffee monthly because she could not drink the caffeine free dark water the facility severed her. Resident #16 was asked if she knew she was on a cardiac diet. She stated " I ' ve drunk regular coffee for well over 30 years and don ' t	F 367	3. The Dietary manager has been reeducated concerning the contents of the therapeutic diets. Resident preferences will be reviewed quarterly and as a resident brings up an issue. The Dietary Manager will create a list for the Administrator of the latest preference interview with each resident and the date of the next interview. 4. The Administrator will audit 25% the completion of resident preference interviews monthly for 3 months. The Administrator will report the findings of the monitoring to the monthly QAPI committee for the duration of the monitoring period for review and recommendations. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	

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F 367	Continued From page 46 like the other. " The surveyor interviewed licensed practical nurse (LPN) #1 on 3/30/16 at 10:00 a.m. When asked about Resident #16 ' s coffee she said " she told me she didn ' t like decaf. The night shift C.N.A. ' s brew her coffee and fill her thermos. " She was asked why she was receiving the coffee with caffeine she said " It ' s her right to have it. The LPN was asked if the resident ' s physician had been notified. She said " I will. " The dietary manager was asked for a copy of the cardiac therapeutic diet they used at the facility. After the document was provided with the title of Chapter 5:Diets for Cardiovascular Health the surveyor reviewed it and determined that the diet did not restrict caffeine. On the morning of 3/21/16 the dietician was asked about the cardiac therapeutic diet document. She stated. " It does not address caffeine and we do not have a policy and procedure that address it either. It has just been the standard. Some people will develop a tolerance to caffeine and it doesn ' t affect the blood pressure or cardiac rhythm. " The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above finding on 3/31/16 at 3:20 p.m. No further information was provided prior to the exit on 3/31/16.	F 367		
F 371 SS=F	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	F 371	1. The meat in question was discarded as soon as the Director of Nursing was notified. 2. All opened food must be kept in accordance to policy 3. The Dietary Manager and staff have been reeducated concerning the policy and procedure for storage of food after it has been opened.	

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This Requirement is not met as evidenced by:
Based on observation and staff interview, facility staff failed to label and date stored ready to eat food and ensure it was discarded by its use-by date.

During initial tour of the kitchen at approximately 6:15 on 3/29/16, the surveyor observed 2 foil-wrapped packages of a pink meat. One was unlabeled. The second was labeled "layed 3/16". The surveyor asked the dietary staff member conducting the tour what "layed 3/16" meant. She said that the packages were ham and that it had been taken from the freezer on 3/16. She put the unlabeled package in a Ziploc bag and labeled it 3/23. She said she knew it was opened 3/23 because that was the last time they had served ham.

On 3/30/16 at 9 AM, the surveyor interviewed the dietary manager. The ham dated 3/16 was no longer in the refrigerator. The dietary manager said it was gone. She stated that the 3/23 date on the ham in the refrigerator should be accurate. When asked how long ham should be kept before it was discarded, she said she would check the policy. The policy she offered from The Academy of Nutrition and Dietetics listed, Under Use By Guide Reference highlighted Potentially Hazardous Foods- 3 day rule-meats. She stated that the ham would be discarded after 3 days.

The surveyor calculated that the ham dated 3/16 had been kept in the refrigerator for 13 days (29-16=13) and the ham labeled 3/23 would have been in the refrigerator for 7 days at the time of the interview (30-23=7).

4. The Administrator will inspect the kitchen to identify any variance from the policy and procedure for the storage of food after it is open. The administrator will address any violation.
   This inspection will be documented 3 days a week for 2 weeks and then weekly x 6 weeks.
   The Administrator will report the findings of the inspection to the QAPI committee monthly meeting for the duration of the monitoring period for review and recommendations.
5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016

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F 371	Continued From page 48 The administrator and director of nursing were notified of the concern during a summary meeting on 3/30/16.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This Requirement is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure the controlled medication Ativan was available for administration for 1 of 24 residents, Residents #16 and failed to ensure scopolamine was available for 1 of 24 residents Resident # 8. The findings included: 1. The facility staff failed to ensure the resident's	F 425	1. The physician was notified of the medication availability issues for Residents # 16 and #8. No new orders were given at that time. 2. All residents receiving medication are at risk for this issue. 3. Licensed nursing staff have been reeducated concerning the facility policy for Unavailable Medications. The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.	

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F 425	Continued From page 49 physician ordered Ativan was available for administration on 3/18/16 at 2:00 p.m. and on 3/19/16 at 6 a.m. and again at 2 p.m. Resident #16 was admitted to the facility on 10/08/14. Diagnoses included, but were not limited to, seizure disorder, chronic pain, depression, anxiety, heart failure, diabetes and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 03/04/16. Section C (cognitive patterns) of this assessment scored the resident 14 out of a possible 15 points indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood. Resident #16 ' s physicians summary of orders signed and dated 3/4/16 had the order for Ativan 0.5 mg one every eight hours for seizures. When reviewing the current MAR's (medication administration records) it was noted that the facility nursing staff had circled their initials on 3/18/16 at 2:00 p.m. and on 3/19/16 at 6 a.m. and again at 2 p.m.in the administration blocks for the medication Ativan. On the back of the MAR, LPN #1 had written on 3/18/16, " need hard script NP (nurse practitioner) aware not available from pharmacy. " The Ativan was not available for 3 doses. On 3/31/16 at approximately 2:30 p.m., LPN #1 was asked why the Ativan was not available for administration; she said " I wrote that (referring to the note on the back of the MAR) the pharmacy would not send it without a hard script. " She was then asked why the prescription and	F 425	4. The Director of Nursing or designee will monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 weeks, 3 days a week for 4 weeks, and then weekly for 4 weeks. The Director of Nursing or designee will review the MARs for each resident and document their findings weekly for 12 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the monitoring process. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	

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medication was not obtained at an earlier by the nurse the day before and she stated I don ' t know.

At 3:20pm the administration team was notified of the medication that was not available for administration.

Prior to exit no further information was provided related to the unavailable Ativan.

2. The facility staff failed to ensure medication of Scopolamine was available for administration for Resident #8.

Resident #8 was admitted to the facility on 2/25/15 with diagnoses of respiratory failure, anemia, pressure ulcer, malnutrition, anxiety, myocardial infarction, hypertension, post-polio syndrome, stroke, atrial fibrillation, and coronary artery disease.

The current quarterly Minimum Data Set (MDS) with a reference date of 12/9/15 assessed the resident with a cognitive score of " 15 " of " 15 " . The resident was assessed requiring total assistance of 2 persons for bed mobility, transfers, dressing, toileting, bathing, and hygiene.

The clinical record was reviewed. The physician had written a telephone order dated 1/29/16 for Scopolamine 1.5mg patch-apply 1 patch behind ear q 72 hours (change every 72 hours).

The February 2016 medication administration record (MAR) was reviewed. The nurses had circled their initials for the Scopolamine patch on 2/9/16 and 2/15/16 indicating the medication was not administered. The nurses documented on the back of the MAR for both days that the Scopolamine patch was not available and pharmacy was aware.

The unit manager (RN#3) was informed of the finding on 3/30/16 at 10:00 a.m. The director of

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F 425	Continued From page 51 nursing (DON) was also informed and stated that insurance did not cover the medication. There was no documentation in the clinical record regarding this information. The DON provided the facility policy for Unavailable Medications. The policy stated if the medication was not covered then the facility should collaborate with the pharmacy and physician to determine a suitable alternative. The administrator, DON, assistant DON, unit manager, and corporate nurse were informed of the findings during a meeting with the survey team on 3/30/16 at 4:40 p.m.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	1. The bottle of medication was discarded prior to any further dose of this medication to the resident. 2. All residents receiving liquid medication are at risk for this issue. 3. Licensed Nursing staff has been reeducated concerning the appropriate wasting of liquid medication. 4. The Director of Nursing or designee will randomly observe and document the observation of one medication administration pass to ensure proper wasting 3 days weekly for 4 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for the duration of the monitoring for review and recommendations. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	

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controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This Requirement is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to properly discard wasted medications for 1 of 24 residents (Resident #18). The findings included:
The facility staff failed to properly discard wasted medication during a medication pass and pour observation on 3/30/16 for Resident #18. The registered nurse poured the unused liquid medication Ergocalciferol back into the original bottle.
Resident #18 was admitted to the facility 5/22/13 and readmitted 12/6/15 with diagnoses that included but not limited to acute respiratory failure with tracheostomy, osteoporosis, aphasia, type 2 diabetes mellitus, morbid obesity, epilepsy, depression, anxiety, anoxic brain damage, encephalopathy, hypertension, chronic obstructive pulmonary disease, and bariatric surgery.
Resident #18's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/5/16 had dash marks for short and long term memory and severely impaired cognitive skills for decision making.
The surveyor observed a medication pass with registered nurse #1 on 3/30/16 at 8:10 a.m. R.N. #1 prepared the following medications for Resident #18: Ferrous sulfate 5 milliliters [220

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F 431	Continued From page 53 mg (milligrams)], Zantac 10 ml (150 mg), and Ergocalciferol 1 ml. R.N. #1 poured the Ferrous Sulfate and Zantac at eye level into plastic medication cups. R.N. #1 used a syringe to measure 1 ml of the Ergocalciferol; however, the syringe was not long enough to draw the medication into the barrel of the syringe. R.N. #1 then poured an un-measured amount of Ergocalciferol into a plastic medication cup and proceeded to draw up 1 ml of the medication. R.N. #1 then returned the unused or "wasted" Ergocalciferol back to the original bottle. R.N. #1 mixed all the liquid medications together and administered them to Resident #18. The surveyor requested the facility policy on discarding unused medications from the director of nursing on 3/30/16 at 12:30 p.m. The director of nursing stated medications should not be poured back into the bottle but discarded. The surveyor interviewed R.N. #1 on 3/30/16 at 4:00 p.m. R.N. #1 stated she was not aware that unused medications could not be returned to the original bottle. The surveyor informed the administrative staff of the above concern on 3/30/16 at 4:40 p.m. The director of nursing informed the surveyor on 3/31/16 at 7:45 a.m. that the remainder of the Ergocalciferol had been tossed and a new bottle had been ordered. The facility policy titled "Return Medications to the Pharmacy and Credits" read in part "13. "Wasted medications" are defined as medications contaminated or refused that require disposal. Facility should not place "wasted medications" back in their original containers." No further information was provided prior to the exit conference on 3/31/16.	F 431		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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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, facility document review, and clinical record review, the facility staff failed to ensure complete and accurate clinical records for 6 of 24 residents in the sample survey (Resident #11, Resident #16, Resident #20, Resident #5, Resident #3 and Resident #15).
The findings included:
1. Resident #11's March 2016 medication administration record (MAR) contained "holes", times when there was no documentation that the ordered medications had been given.
The clinical record was reviewed 3/30/16 and 3/31/16. Resident #11 was admitted to the facility 4/25/14 with diagnoses that included but not limited to rectocele/cystocele without uterine prolapse, diabetes mellitus type 2, urine retention, senile dementia, nephritis and nephropathy, diabetic retinopathy, hypertension, congestive heart failure, pain, and osteoporosis.
Resident #11's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/1/16 assessed the resident with a cognitive summary score of 12 out of 15.
The March 2016 physician orders were reviewed

1. There is no remedy for the past mistakes of documentation that have been found in the clinical records of Residents' #11, #16, #20, #5, #3, and #15.
2. All residents are at risk for this issue.
3. Licensed nursing staff have been reeducated concerning the medication administration/documentation policy. This includes when to notify the physician and responsible party of an issue.
The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.

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F 514	Continued From page 55 3/30/16. Two insulin orders were written and read: "Lantus 100 units/1 ml (milliliter) vl (vial) Inject 10 units subcutaneously twice daily" and "Humalog 100 units/1 ml vl Inject subcutaneously before meals and at bedtime per sliding scale for blood sugar: 0-50=0 units, house protocol and call MD (medical doctor); 51-70=0 units & house protocol; 71-150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units for DM (diabetes mellitus)." The surveyor reviewed the March 2016 medication administration records (MARs). There were blanks for the administration of Lantus insulin on 3/3/16 and 3/4/16 at 9:00 p.m., blanks on 3/15/16 at 9:00 p.m., blanks on 3/17/16 at 9:00 p.m., blanks on 3/20/16 and 3/21/16 at 9:00 a.m., blanks on 3/23/16 at 9:00 a.m., blanks on 3/26/16 at 9:00 a.m., and blanks on 3/30/16 at 9:00 p.m. The sliding scale insulin entry had no evidence the blood sugar was obtained on 3/23/16 at 6:00 a.m. The surveyor reviewed the reverse side of the March 2016 medication administration records. There was no documentation as to the reason why the insulins were not administered or the blood sugar obtained. The March 2016 progress notes were reviewed as well. There was no evidence why Resident #11 did not receive insulin as ordered or blood sugar as ordered. The surveyor interviewed licensed practical nurse #2 on 3/30/16 at 3:03 p.m. The surveyor showed L.P.N. #2 the March 2016 MAR and specifically the scheduled and sliding scale insulin documentation. The surveyor asked L.P.N. #2 what nurses do when medications are administered. L.P.N. #2 stated when medications are administered they are initialed. L.P.N. #2 stated there were blanks on the March 2016	F 514	4. The Director of Nursing or designee will monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 weeks, 3 days a week for 4 weeks, and then weekly for 4 weeks. The Director of Nursing or designee will review the MARs for each resident and document their findings weekly for 12 weeks. The Director of Nursing will report results of the monitoring to the monthly QAPI committee for review and recommendations. 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016	

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MAR.
The surveyor interviewed the director of nursing on 3/31/16 at 1:20 p.m. The surveyor asked the DON when medications aren't administered, what would the standard of practice be. The DON stated to circle the medication and put the reasons the medications weren't administered on the reverse side of the MAR or chart in the nurse's notes. The surveyor requested the facility policy on standard of nursing practice for medication administration.
The surveyor reviewed the facility standard of nursing practice for medication administration titled "6.0 General Dose Preparation and Medication Administration" on 3/31/16. The policy read in part "Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure: 6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information [e.g., (that is) when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever necessary) medications, application sight] on appropriate forms."
During the interview with the DON, the surveyor asked what "appropriate forms" were. The DON stated "on the reverse side of the MAR or in the chart."
The surveyor informed the administrative staff of the above finding on 3/31/16 at 3:20 p.m.
No further information was made available prior to the exit conference on 3/31/16.
2.The facility staff failed to document the reasons medication was not administered to Resident #16.

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Resident #16 was admitted to the facility on 10/08/14. Diagnoses included, but were not limited to, seizure disorder, chronic pain, depression, anxiety, heart failure, diabetes and COPD (chronic obstructive pulmonary disease).

The most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 03/04/16. Section C (cognitive patterns) of this assessment scored the resident 14 out of a possible 15 points indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood.

The comprehensive care plan was reviewed on 3/9/16. The care plan contained a focus area the resident was an insulin dependent diabetic. The interventions included to administer insulin and /or oral medication as ordered, obtain blood sugars as ordered report to physician any BS (blood sugar outside parameters.

The clinical record was reviewed on 3/31/16. The physician orders dated 12/19/15 included an order for administration of sliding scale insulin as follows: "Novolog 100 Unit/ML vial inject subcutaneously per slicing scale before meals and bedtime as follows:
"If blood sugar is 0-150=0 units
151-200 =2 units
201-250=4 units
251-300=6 units
301-350= 8 units
Over 351=10 units"

The medication administration record (MAR) for March 2016, was also reviewed. On 3/21/16 there was no documentation for a blood sugar.

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The nursing notes were reviewed and did not contain any documentation to provide a reason as to why the blood sugar was not obtained/documented.

Continued review of the MAR revealed the following order Novolog Mix 70-30 units/ml vial inject 25 units subcutaneously twice daily with breakfast and dinner (6am and 5pm).

The MAR revealed on the following dates and times no documentation to support that the insulin was given: 3/4/16 at 5pm, 3/6/16 at 6am, 3/20/16 at 6am, and on 3/26/16 at 5pm.

On 3/31/16, at 1:25 p.m., LPN #1 was asked to look at the MAR and tell the surveyor if the insulin had been administered after looking she said "I can't speak to that they aren't mine."

In the afternoon of 3/31/16 the administrator and director of nurses were informed of the insulin medication errors.

No further information was provided to the surveyors related to the staff failure to document completely and accurately.
3. For Resident #20, facility staff failed to accurately document medication administration.

Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension, gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment

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reference date 3/12/16.

During clinical record review on 3/31/16, the surveyor noted on the medication administration record (MAR) for March 2016 that the signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units / 1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0; 141-180=1 units; 181-220=2units; 221-260=3units; 261-300= 4units; 301-340= 5units; 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23. 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered.

4 For Resident #20, facility staff failed to accurately document medication administration for insulin and antibiotics.

Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension, gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment reference date 3/12/16.

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F 514	Continued From page 60 During clinical record review on 3/31/16, the surveyor reviewed the medication administration record (MAR) for March 2016. Bactrim DS 1 tab PO (by mouth) BID (by mouth) X 5 days ordered 3/24/16. Two times per day for 5 days required 10 doses. The MAR had only 9 spaces indicated for documentation of administration of Bactrim, with staff documenting 2 doses on 3/25, 26, 27, and 28. Only one dose was documented on 3/29/16. The space for the second dose on 3/29 was X'd out. There was no documentation to indicate that a 10th dose of Bactrim had been administered. The signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units / 1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0; 141-180=1 units; 181-220=2units; 221-260=3units; 261-300= 4units; 301-340= 5units; 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23. 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered.. On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. Both counted the doses of Bactrim administered and agreed that only 9 had been administered. They acknowledged that the insulin had not been documented administered as ordered.	F 514		

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F 514	Continued From page 61 During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days. On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. The unit manager indicated that the resident had been refusing insulin for years because he thought his blood sugar went too low between the effects of the insulin and the hemodialysis. On 3/31/16, at approximately 12:30 PM, the DON reported discussing the Lantus insulin with the physician and obtaining an order to discontinue the medication. She stated that the record indicated that the resident had not received Lantus insulin in 4 months. Staff were accustomed to the resident refusing the medication and had stopped mentioning it to the physician. During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days. 5. For Resident #5, facility staff failed to follow accurately document medication administration	F 514		

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for insulin.

Resident #5 was admitted to the facility on 3/31/11 with diagnoses including hypertension, diabetes mellitus, anxiety, depression, and bipolar disorder. The resident scored 13/15 on the brief interview for mental status on the minimum data set assessment dated 2/5/16, and was assessed without symptoms of delirium, psychosis, or behavior issues.

Clinical record review on 3/30/16, revealed that Lantus insulin 30 units twice per day was not documented as administered on the medication administration record (MAR) at 9 AM on 3/26/16. No explanation for the omission was found in the nurse's progress notes.

The concern was reported to administrative staff during a summary meeting on 3/30/16. The director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most days.

6. The facility staff failed to ensure a complete and accurate clinical record for Resident #3. Resident #3 was admitted to the facility on 8/31/12 with diagnoses of subarachnoid hemorrhage, hepatitis C, cirrhosis, traumatic brain injury, paraplegia, malnutrition, depression, epilepsy and pressure ulcer.

The Minimum Data Set (MDS) with a reference date of 1/20/16 assessed the resident with a cognitive score of " 15 " of " 15 " . The resident was assessed requiring total assistance of 2

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F 514	Continued From page 63 persons for bed mobility, dressing, toileting, bathing, and hygiene. The current physician recertification orders signed 3/4/16 contained orders to, " Apply Duoderm to sacrum change every 5-7 days until healed " . A second order stated to, " Apply Collagen to sacral wound every day " . The unit manager (RN#3) was asked about the wound care on 3/30/16 at 9:00 a.m. and stated she would find out. A telephone order dated 2/8/16 noted to discontinue the duoderm to the sacrum. The facility failed to remove the order from the current physician recertification orders. The administrator, DON, assistant DON, unit manager, and corporate nurse were informed of the findings during a meeting with the survey team on 3/30/16 at 4:40 p.m. 7. The facility staff failed to ensure a complete clinical record for Resident #15. Resident #15 was admitted to the facility on 1/5/14 with diagnoses of fracture pubis, skin cancer, dysphagia, anemia, hypertension, Gastro-esophageal reflux disease, chronic obstructive pulmonary disease, dementia, anxiety, coronary artery disease, and arthritis. The significant change Minimum Data Set (MDS) with a reference date of 11/23/15 assessed the resident with a cognitive score of " 9 " of " 15 " . The resident was assessed requiring total assistance of 2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene. The medication administration record (MAR) for March 2016 was reviewed. The nurses had documented on the front of the MAR the resident had refused the suppository every evening from 3/1/16 through 3/16/16. There was no documentation the physician/ RP had been notified of the refusal. The nurses also circled their initials from 3/18/16	F 514		

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F 514	Continued From page 64 through 3/29/16 indicating the medication was not given. There was no documentation the physician/ RP had been notified of the refusal. There was no documentation on the back of the MAR for reason the medication was not given. The nursing notes were reviewed and no documentation was evidenced the physician/ RP were notified of the medication not administered.	F 514		