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	495355	A. BUILDING _____ B. WING _____	C 04/22/2016

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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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/19/16 through 4/22/16. 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 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents 1 through 17 and 3 supplment 21-23) and 6 closed record reviews (Residents 18-20, and 24 through 26).	F 000	The submission of the Plan of Correction does not constitute agreement on the part of Radford Health & Rehab Center nor do the deficiencies cited within the report represents deficient practices on the part of the center and its staff. The plan represents our on-going pledge to provide quality care rendered in substantial compliance with regulatory requirements.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post the results of the most recent life safety code surveys. The findings included:	F 167	1. Life Safety Code survey results placed in front lobby survey book on 4-20-16 2. Any resident has the potential to be affected if life survey results are not posted for review. 3. Staff will be educated on need for all survey results in current survey cycle to be kept in the survey book in the front lobby. Location of survey results will be discussed with patients in May resident council meeting. Survey ready book to be audited by Administrator or designee weekly x12 weeks to ensure all survey results are in binder. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brittney A Bright	Administrator	05-20-2016

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

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F 167	Continued From page 1 During the entrance to the facility on 4/19/16 at 10:00 a.m., the surveyor observed to the left of the business office window in the front lobby and located on a small table, a sign that indicated the results of the most recent surveys were available in the notebook on the table. The surveyor observed the contents of the notebook. The notebook included the results of the most recent standard survey. The notebook did not include any life safety code survey results. The surveyor toured the facility on 4/20/16 beginning at 10:33 a.m. with the maintenance director. The surveyor confirmed with the maintenance director that the facility had two previous life safety surveys, the first survey completed on 5/12/15 and the second survey (a federal comparative life safety code survey) conducted on 6/29/15. Neither of these surveys were located in the survey results book. The surveyor discussed the location of the life safety surveys with the maintenance director. The maintenance director stated the administrator had them. A second surveyor conducted a goup interview with six (6) of the facility residents on 4/20/16 at 10:00 a.m. None of the six (6) residents in the group knew where the results were located. The administrative team of the facility was notified of the missing life safety code survey results during a meeting with the survey team on 4/20/16 at 5:50 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference on 4/22/16.	F 167	4. committee for review and further analysis of findings. 5. 06-02-16	

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F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a clean, comfort and homelike environment in 25 of 33 air vents and on 2 of 2 units. 1. The air vents in 25 of 33 resident room bathrooms were dirty with lint on the Magnolia unit. 2. The facility staff failed to ensure the facility was clean, comfortable and sanitary on 2 of 2 units. The findings included: 1. The air vents in 25 of 33 resident room bathrooms were dirty with lint on the Magnolia unit. On initial tour of the facility on 4/19/16 at 10 am, the surveyor observed the following resident bathrooms to have dirty air vents: 215, 212, 211, 210, 207, 204, 203, 202, 201, 118, 117, 115, 114, 113, 112, 111, 109, 108, 107, 106, 105, 104, 103, 102 and 101. The unit manager for the Magnolia unit was with the surveyor as the above was observed. The unit manager stated,"Those are dirty" and pointed to the air vent in the resident ' s bathroom. On 4/20/16 at 5:50 pm in the end of the day conference, the administrator, director of nursing	F 252	1. Air vents in rooms 215, 212, 211, 210, 207, 204,203, 202, 201, 118, 117, 115, 114, 113, 112, 111, 109, 108, 107, 106, 105, 104, 103, 102, and 101 were cleaned on 4/20/16. The air vent in the public restroom on Dogwood, the air vents in the Janitor's closet, the vents in the restorative room, the dust on the wheelchair scales, the air vents in the storage area, the air vents in the rehabilitative shower room, the air vents in the community bathroom on Magnolia, the air vents in the Janitor's closet on Magnolia and the dust in the air conditioner unit of Resident #10s room were cleaned on 4/20/16. The chux, gowns, lift straps touching floor, oxygen room clutter was cleaned and/or corrected on 4/20/16. 2. Any resident room, storage room, air conditioner unit has the potential to be affected if air vents are not free of dust or storage room, shower room, closets if there is clutter under shelves or items hanging on floor. Housekeeping Director or designee to inspect vents in the facility to ensure vents are free of dust. Administrator or designee	

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F 252	Continued From page 3 and housekeeping were notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/22/16. 2. The facility staff failed to ensure the facility was clean, comfortable and sanitary on 2 of 2 units. The surveyor and the maintenance director did a walk-through of the facility on 4/20/16 beginning at 10:33 a.m. The surveyor observed in the community restroom on the Dogwood unit an accumulation of dust in the air vent. The dust had the appearance of being "fuzzy" and "feathery." The surveyor also observed a disposable glove in the floor sink. The vents in the janitor's closet were also observed to have an accumulation of dust on the air vents. The linen closet had several gowns and chux that were located underneath the shelves on the floor. Several of the facility lift pad straps were observed to be touching the floor in the linen closet. The surveyor and the maintenance director observed an accumulation of dust on both vents in the restorative room. The restorative room also housed the facility wheelchair scales. The scales had what appeared to be dust on the frame and the rubber on the scale itself was torn in parts. The storage area was also observed to have an accumulation of dust in the air vents. The room where the used/empty oxygen tanks were stored had an accumulation of clutter under the shelves. The rehab shower room on the Magnolia side was observed to have an accumulation of dust in the air vents in the bathroom. The community bathroom on the Magnolia unit also had an accumulation of dust in the air vents. The janitor's closet on the Magnolia side also had an	F 252	to educate Department heads to complete rounds to ensure facility presents in a clean, comfortable, and safe manner. 3. Housekeeping Director or designee will in-service housekeeping staff on cleaning vents when in patient rooms. Department heads will be in-serviced on rounds to identify issues that may not be satisfactory on resident units. 4. Housekeeping Director or designees to audit 10 patient rooms, as well as closets, restrooms, storage areas, oxygen storage areas, etc. weekly x12 weeks to ensure vents are free of dust and facility is clean, comfortable and safe. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 252	Continued From page 4 accumulation of dust in the air vents. In the linen closet, several of the facility lift pad straps were observed to be touching the floor. At the Magnolia nurse's station, the surveyor observed the wall directly across from the nurse's station where wheelchairs have rubbed against the wall. The maintenance director stated the wall had recently been painted and that the facility was always painting. Random checks of the air conditioner units in the resident's rooms were made on both the Dogwood side and the Magnolia side. The air conditioner unit in Resident #10's room had an accumulation of dust in the unit. The surveyor discussed with the maintenance director which department was responsible for cleaning the air vents. The maintenance director stated probably both housekeeping and maintenance should be responsible for their cleaning. The surveyor informed the administrative staff of the above concerns on 4/20/16 at 5:50 p.m. The surveyor requested the facility policy on facility cleaning on 4/21/16 from the assistant director of nursing. The surveyor reviewed the facility policy titled "Miscellaneous Equipment, Daily Cleaning" on 4/22/16. The policy read in part "Equipment used during the day will be cleaned and stored in the proper location each day." No further information was provided prior to the exit conference on 4/22/16.	F 252		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272	1. Assessment for resident #4, #6, and # 8 was already complete and location and date of information unable to be added to assessment. No negative outcome identified for these residents.	

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F 272	Continued From page 5 functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to document the	F 272	2. Any resident has the potential to be affected if section V is not documented on with the date and location for the CAA. Current residents as of May 16th audited to ensure that section V has the date and location of information documented. 3. Regional MDS Consultant or designee will educate staff responsible for completing section V on the MDS to include date and location of information used for the CAA. 4. MDS Coordinator or designee will audit 10 of comprehensive assessments monthly x3 months to ensure that section V completed properly. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 272	Continued From page 6 date and location of clinical record documentation used to complete the comprehensive minimum data set (MDS) assessments for 3 of 26 residents (Resident #4, Resident #6, and Resident #8). The findings included: 1. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the significant change MDS (minimum data set) assessment with an assessment reference date (ARD) of 3/29/16 for Resident #4. The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. A review of the significant change MDS referenced above revealed Resident #4 triggered for the following areas in Section V: Delirium, Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug Use, and Pain. For the triggered areas of Delirium and Cognition there was no documented location and date under the Location and Date column for these triggered areas. The column only contained the words "Delirium" and "Cognition". A review of the CAA	F 272		

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F 272	Continued From page 7 worksheet for delirium and cognition failed to reveal a location and date for information in the clinical record. The date on the CAA worksheet was 4/1/16, the date the social services assistant signed the CAA worksheet. The surveyor interviewed the social services assistant and registered nurse #3 on 4/22/16 at 11:50 a.m. The social services assistant was asked where the location and date of the clinical information that supports the triggered areas of delirium and cognition were located in the clinical record. She stated "I get it from where it triggers on the MDS-the CAA worksheet." The CAA worksheet for delirium read "Resident #4 BIM (brief interview mental) (sic) fluctuates. Resident #4 exhibits no signs of delirium at this time. Will continue to monitor." The CAA worksheet for cognition read "Resident #4 has short term memory loss. Staff to monitor." Neither of the triggered areas had dates or location where the information was found in the clinical record to support the reason the areas were triggered. The surveyor informed the MDS staff of the above finding on 4/22/16. No further information was provided prior to the exit on 4/22/16. 2. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the significant change MDS (minimum data set) assessment, with an assessment reference date (ARD) of 3/10/16 for Resident #6. The clinical record of Resident #6 was reviewed 4/19/16 through 4/22/16. Resident #6 was	F 272		

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admitted to the facility on 5/16/12 and readmitted 3/2/16 with diagnoses that included, but not limited to anxiety, depressive disorder, urinary retention, constipation, pain, hypothyroidism, dementia with behavioral disturbances, Parkinson ' s disease, diabetes mellitus type II, anemia, and enlarged prostate.
Resident #6's significant change in assessment MDS with an assessment reference date (ARD) of 3/10/16 coded the resident with a cognitive summary score of 04 out of 15 in Section C0500.

A review of the significant change MDS referenced above revealed Resident #6 triggered for the following areas in Section V: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dental Care, Pressure Ulcer, and Psychotropic Drug Use. For the triggered area of Cognition there was no documented location and date under the Location and Date column for the triggered area. Only the word "cognition" was written in the column. A review of the CAA worksheet for cognition failed to reveal a location and date for information in the clinical record. The date on the CAA worksheet was 3/10/16, the date the social services assistant signed the CAA worksheet.

The surveyor interviewed the social services assistant and registered nurse #3 on 4/22/16 at 11:50 a.m. The social services assistant was asked where the location and date of the clinical information that supported the triggered area of cognitive was located in the clinical record. She stated "I get it from where it triggers on the MDS-the CAA worksheet." The CAA worksheet for cognition read "Resident #6 has a cognitive impairment due to low BIM (brief interview

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mental) (sic) score. Staff to redirect him as needed. He is assisted with his care daily to ensure that his needs are met."

The triggered area of cognition had no dates or location where the information was found in the clinical record to support the reason the areas were triggered.

The surveyor informed the MDS staff of the above finding on 4/22/16.

No further information was provided prior to the exit on 4/22/16.

3. The facility staff failed to document location and date of the information used to complete Section-V of the CAA (Care Area Assessment) for the significant change MDS (minimum data set) assessment, with an assessment reference date (ARD) of 4/11/16 for Resident #8.

The clinical record of Resident #8 was reviewed 4/19/16 through 4/22/16. Resident #8 was admitted to the facility on 9/25/14 with diagnoses that included, diabetes mellitus type II, hemiplegia, hemiparesis, cerebrovascular disease, hypertension, hypothyroidism, schizophrenia, manic episodes, ocular hypertension, depressive disorder, constipation, overactive bladder, gastroesophageal reflux disease (GERD), recurrent urinary tract infections, postmenopausal atrophic vaginitis, urinary frequency, allergic rhinitis, and anemia. Resident #8's annual MDS assessment with an assessment reference date (ARD) of 4/11/16 coded the resident with a cognitive summary score of 15 out of 15 in Section C0500.

A review of the annual MDS referenced above revealed Resident #8 triggered for the following

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F 272	Continued From page 10 areas in Section V: Visual, ADL Functional/Rehabilitation, Psychosocial Well-Being, Mood State, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcer, Psychotropic Drug Use and Pain. For the triggered areas of Psychosocial Well-Being and Mood State there was no documented location and date under the Location and Date column for these triggered areas. Psychosocial well-being and mood were the only words documented in the column. A review of the CAA worksheet for psychotropic drug use and mood state failed to reveal a location and date for information in the clinical record. The date on the CAA worksheet was 4/14/16, the date the social services assistant signed the CAA worksheet. The surveyor interviewed the social services assistant and registered nurse #3 on 4/22/16 at 11:50 a.m. The social services assistant was asked where the location and date of the clinical information that supports the triggered areas of psychotropic drug use and mood state were located in the clinical record. She stated "I get it from where it triggers on the MDS-the CAA worksheet." The CAA worksheet for psychotropic drug use read "Resident #8 states having little interest or pleasure in doing things. Staff to monitor." The CAA worksheet for mood state read "Resident #8 feeling down and feeling tired. Staff to monitor." Neither of the triggered areas had dates or location where the information was found in the clinical record to support the reason the areas were triggered. The surveyor informed the MDS staff of the above finding on 4/22/16.	F 272		

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F 272	Continued From page 11 No further information was provided prior to the exit on 4/22/16.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a care plan for 1 of 26 residents (Resident #4). The findings included: The facility staff failed to develop a comprehensive care plan for Resident #4. Resident #4 was admitted with a pacemaker. The clinical record of Resident #4 was reviewed	F 279	1. Resident #4's care plan updated to reflect pacemaker. 2. Any resident is at risk if their care plan does not reflect their pacemaker or interventions for care of the pacemaker. An audit of current residents as of May 16th with pacemakers conducted to ensure care plan reflects their pacemaker. 3. Regional MDS consultant or designee to educate MDS staff regarding updating care plans to reflect pacemakers and interventions related to care for pacemakers. 4. Regional MDS Consultant or designee to audit residents with pacemakers monthly x3 months to ensure care plan reflects pace maker and interventions for care of pacemaker. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 279	Continued From page 12 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, pacemaker, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. The clinical record of Resident #4 revealed the resident had a pacemaker documented in the physician notes of 12/28/15, 12/31/15 and 1/8/16, and 1/29/16. The surveyor reviewed the current comprehensive care plan initiated 12/31/15. The current comprehensive care plan had the focus area that read "Resident #4 has diagnosis of hypertension, hyperlipidemia, A. Fib (atrial fibrillation), CAD (coronary artery disease) with stents; at risk for bleeding and excessive bruising dude to ASA (aspirin) use; at risk for dehydration due to diuretic use." A review of the comprehensive care plan dated 12/28/15 did not include the development of a care plan for the cardiac pacemaker or any interventions for the care of the pacemaker. The surveyor informed the administrative staff of the above finding on 4/22/16. No further information was provided prior to the exit conference on 4/22/16.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	1. Care plan for resident #1, #10, #14, #13, #12, #2 updated to reflect non-pharmacological interventions for pain. Care plan for resident #3 updated to reflect	

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F 280	Continued From page 13 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 staff interview, clinical record review and facility document review, the facility staff failed to update the comprehensive care plan for 10 of 26 residents in the survey sample (Resident #'s 2,3,7,12,13,4,6,10,14, and #1). 1. The facility staff failed to update the comprehensive care plan as related to non-pharmacological interventions for pain for Resident #2. 2. The facility staff failed to update the comprehensive care plan as related to non-pharmacological interventions for depression for Resident #3. 3. The facility failed to update the comprehensive care plan related to non-pharmacological interventions as related to falls for Resident #7.	F 280	non-pharmacological interventions for depression. Care plan for resident #7 updated to reflect non-pharmacological interventions related to a fall. Care plan for resident #4 updated to reflect non-pharmacological interventions for pain and anxiety. Care plan for resident #6 updated to reflect non-pharmacological interventions for anxiety. 2. Any resident has the potential to be affected if care plan is not updated with non-pharmacological interventions for pain, anxiety, depression, or falls. Current residents as of May 16th audited to ensure care plans reflective of non-pharmacological interventions for pain, anxiety, depression, and falls if applicable. 3. DON or designee to educate licensed nursing staff on updating care plans with non-pharmacological interventions when residents have new pain, anxiety, depression, or falls. 4. MDS Coordinator or designee to audit 10 of care plans monthly x3 months to ensure care plans are reflective of non-pharmacological interventions for pain, anxiety, depression, and falls. Any discrepancies will be addressed	

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F 280	Continued From page 14 4. The facility staff failed to update the comprehensive care plan as related to non-pharmacological interventions for pain for Resident #12. 5. The facility staff failed to update the comprehensive care plan as related to non-pharmacological interventions for pain for Resident 13. 6. The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for pain and anxiety for Resident #4. 7. The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for anxiety for Resident #6. 8. The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for pain for Resident #10. 9. The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for Resident #14's pain. 10.The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for Resident #1's pain. The findings included: 1). The facility staff failed to update the comprehensive care plan as related to non-pharmacological interventions for pain for Resident #2. Resident #2 was readmitted to the facility on 2/20/16 with the following diagnoses of, but not limited to diabetes, dementia, enlarged prostrate, chronic obstructive pulmonary disease, major depressive disorder, anemia and heart failure.	F 280	promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 280	Continued From page 15 On the resident ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 3/17/16, Resident #2 was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene. Resident #2 is totally dependent on staff for bathing. During the review of the clinical record by the surveyor, it was noted that the comprehensive care plan was not updated with non-pharmacological interventions that staff can use prior to the administration of a pain medication. The most recent updated care plan was dated for 3/4/16 which stated, under the focus of " Non-Cardiac Chest Pain " , the following interventions: " Administer medication for nerve pain as ordered ...Administer pain medication as ordered ...Follow up with Dr. (name of physician) as ordered/needed ...Observe for an increase in pain or unrelieved and report to the physician as needed. " The director of nursing was notified of the above documented findings on 4/21/16 and again on 4/22/16 by the surveyor. The director of nursing stated on 4/22/16 at approximately 2:45 pm, " I didn ' t see any other interventions on the care plan besides medicine. " No further information was provided to the surveyor prior to the exit conference on 4/22/16. 2). The facility staff failed to update the comprehensive care plan as related to non-pharmacological interventions for depression for Resident #3. Resident #3 was admitted to the facility on 2/21/16 with the following diagnoses of, but not limited to heart failure, high blood pressure, arthritis, depression, asthma, respiratory failure,	F 280		

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F 280	Continued From page 16 muscle weakness, difficulty in walking and shortness of breath. The resident was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/28/16 as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance from one staff person for dressing, personal hygiene and bathing. During the review of the clinical record by the surveyor, it was noted that the comprehensive care plan was not updated with non-pharmacological interventions that staff can use prior to the administration of a depression medication. The most recent updated care plan was dated for 3/3/16 which stated, under the focus of " ...uses psychoactive medications related to depression " , the following interventions: " Administer medications as ordered; observe for side effects and effectiveness of medications. Conduct medication regimen reviews monthly by consulting pharmacist. Observe for target behaviors for decrease or escalation that may indicate need for medication review. " The director of nursing was notified of the above documented findings on 4/21/16 and again on 4/22/16 by the surveyor. The director of nursing stated on 4/22/16 at approximately 2:45 pm, " I didn ' t see any other interventions on the care plan besides medicine. " No further information was provided to the surveyor prior to the exit conference on 4/22/16. 3). The facility failed to update the comprehensive care plan related to non-pharmacological interventions as related to falls for Resident #7. Resident #7 was readmitted to the facility on	F 280		

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F 280	Continued From page 17 11/17/15 with the following diagnoses of, but not limited to high blood pressure, dementia, anxiety, osteoarthritis and transient ischemic attack. The resident was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/15/16 as having a BIMS (Brief Interview for Mental Status) score of 0 out of a possible score of 15. Resident #7 was also coded as requiring extensive assistance of 1 staff member with bed mobility, toilet use and personal hygiene. During review of Resident # 7 ' s clinical record by the surveyor, it was noted that the comprehensive care plan dated for 2/18/16 was not updated after each of the resident ' s 3 falls that occurred on 1/4/16, 1/24/16 and 2/15/16. There were no new interventions put into place as noted by the surveyor upon review of the care plan on 4/21/16. The director of nursing was interviewed on 4/22/16 at approximately 2:45 pm and stated, " I don ' t see where the staff updated the care plan with interventions after each fall as they were expected to do. " No further information was provided to the surveyor prior to the exit conference on 4/22/16. 4). The facility staff failed to update the comprehensive care plan as related to non-pharmacological interventions for pain for Resident #12. Resident #12 was readmitted to the facility on 12/7/15 with the following diagnoses of, but not limited to: heart failure, anemia, peripheral vascular disease, high cholesterol, anxiety disorder, depression, bilateral amputation of lower extremities, Stage IV kidney disease, and insomnia. Resident #12 was coded on the quarterly MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/1/16 as having a BIMS	F 280		

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F 280	Continued From page 18 (Brief Interview for Mental Status) score of 10 out of a possible score of 15. The resident was also coded as being totally dependent on staff members for dressing, personal hygiene and bathing. During the review of the clinical record by the surveyor on 4/22/16, it was noted that the staff administered pain medication, " Percocet 5 -325 mg " on 4/16/16 at 2043 (8:43 pm) and again on 4/17/16 at 2333 (11:33 pm) as documented on the resident ' s Medication Administration Record (MAR). The surveyor reviewed the nurses ' notes for these dates and times and there were no noted non-pharmacological interventions documented by the staff prior to the administration of Percocet, a pain medication, to Resident #12. The care plan dated for 2/5/16, for Resident #12, was also reviewed by the surveyor on 4/22/16. The resident was care planned for a focus of " Pain " with the following interventions noted on it: " Administer pain medications and medication for phantom pain as ordered ...Observe for an increase in s/s (signs and symptoms) or c/o (complaints of) unrelieved pain and report to the physician as needed. " The director of nursing was notified of the above documented findings on 4/22/16 at 2:30 pm. The director of nursing stated " Let me review the notes myself and then I can get with you about this. " No further information was provided to the surveyor prior to the exit conference on 4/22/16.5. 5). The facility staff failed to update the comprehensive care plan as related to non-pharmacological interventions for pain for Resident 13. Resident #13 was admitted to the facility on	F 280		

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4/11/16 with the following diagnoses of, but not limited to muscle weakness, difficulty in walking, weakness on one side after a stroke affecting the left side, uncontrolled insulin dependent diabetic, and high blood pressure. At the time of the survey on 4/19/16, the only MDS (Minimum Data Set, an assessment protocol) that had been completed was a 5 day admission with only Section A completed.

On the comprehensive care plan with admission date of 4/11/16, the surveyor noted there were no documented non-pharmacological interventions in place to be used by the staff prior to the administration of a pain medication to Resident #13. The focus area of " pain " on the care plan had the following interventions that stated, " Administer pain medication as ordered ...Administer topical pain medication as ordered ...Observe for s/s (signs and symptoms) or c/o (complaints of) increase pain or unrelieved pain. Notify physician as needed. "

The director of nursing was notified of the above documented findings on 4/21/16 and again on 4/22/16 by the surveyor. The director of nursing stated on 4/22/16 at approximately 2:45 pm, " I didn ' t see any other interventions on the care plan besides medicine. "

No further information was provided to the surveyor prior to the exit conference on 4/22/16.

6). The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for pain and anxiety for Resident #4.

The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis,

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BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right lateral foot ulcer.
(a) Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. Resident #4 was assessed to understand others usually and was understood. Resident #4 was assessed to have no behaviors in Section E. Resident #4's pain assessment revealed no scheduled pain medication regimen, did not receive any prn (whenever necessary) medications and did not receive any non-medication interventions for pain. Resident #4 frequently had pain during the look back period. Resident #4 rated his pain level as 8 out of 10.

The April 2016 physician order sheet included an order that read "Norco Tablet 5-325 mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain." The April 2016 medication administration records (MARs) were reviewed. Resident #4 received prn (as needed) pain medications eight (8) times in April 2016 on 4/2/16, 4/5/16, 4/9/16, 4/15/16, 4/18/16, 4/19/16 (x2), and 4/20/16.

The current comprehensive care plan initiated 12/31/15 included a focus area that read "Resident #4 has generalized pain with legs, feet, and buttocks." Interventions: "Administer pain medication as ordered. Nursing to assist with position of comfort. Observe for increase s/s (signs and symptoms) of pain or unrelieved pain. Notify physician as needed."

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The April 2016 progress notes did not reveal non-pharmacological interventions prior to medication administration on 4/2/16 at 21:44 (9:44 p.m.) The 4/13/16 21:30 (9:30 p.m.) note read "Acetaminophen tablet 325 mg Give 1 tablet by mouth every 4 hours as needed for pain back and hips aching, repositioned and gave prn Tylenol." Tylenol was administered at the same time the note was written. The 4/15/16 21:38 (9:38 p.m.) progress note did not include non-pharmacological interventions for Resident #4 when the resident complained of back pain. The 4/18/16 21:37 (9:37 p.m.) progress notes read "C/o (complain of) all over pain." There was no documented non-pharmacological intervention prior to the administration of the pain medication at 21:37 (9:37 p.m.). The 4/19/16 at 10:51 progress note read "RSD (resident) states pain in his sacrum and back 8/10." There were no documented non-pharmacological interventions prior to the administration of the pain medication at 10:51 a.m. The 4/20/16 08:00 progress note read "RSD said he is having pain in his sacral wound." Resident #4 received pain medication at 8:00 a.m. There were no non-pharmacological interventions prior to the administration of the pain medication on 4/20/16.

The surveyor discussed the current comprehensive care plan for pain for Resident #4 with registered nurse #3 on 4/22/16 at 10:00 a.m. The current comprehensive care plan identified one non-pharmacological intervention for pain. R.N. #3 stated the facility wouldn't document "Standards of Practice" on the care plan-- what would normally be tried prior to the use of medication. One example she gave: turning and repositioning. R.N. #3 stated these would be used on each resident prior to giving medications.

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R.N. #3 stated the facility "charted by exception." R.N. #3 stated interventions might be found in other areas of the care plan and stated you have to look at all of the problems. The surveyor asked R.N. #3 if the facility knew what Resident #4's pain management would include besides "position of comfort." No answer was given.

(b) The April 2016 physician order sheet read in part "Xanax tablet 0.25 mg (milligram) (Alprazolam) Give 1 tablet by mouth every 6 hours as needed for anxiety."

The April 2016 progress notes were reviewed. Resident #4 was administered Xanax 0.25 mg (milligrams) six (6) times in April on the following days: 4/2/16, 4/5/16, 4/9/16, 4/15/16, 4/17/16, and 4/18/16.

The current comprehensive care plan initiated 12/31/15 read "Resident #4 receives psychotropic medication for depression with adult failure to thrive, anxiety, and insomnia, at risk for side effects." Interventions "Administer psychotropic medication as ordered. Observe for increase s/s (signs/symptoms) of depression and anxiety. Notify physician as needed."

The current comprehensive care plan did not include any non-pharmacological interventions prior to the use of Xanax.

The 4/5/16 22:15 (10:22 p.m.) progress note read "Anxiety, redirection ineffective. Xanax 1 tablet by mouth every 6 hours as needed for anxiety." Xanax 0.25 mg was administered at 22:15 (10:15 p.m.). There were no non-pharmacological interventions prior to the administration of the

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Xanax.

The progress notes of 4/6/16 8:32 read "Offered snacks, fluids, repositioning, boosting into bed, tv channel changed. Redirection ineffective."

The 4/17/16 22:27 (10:27 p.m.) progress note read "Xanax 0.25 mg Give 1 tablet by mouth every 6 hours as needed for anxiety. Anxiety, hollering help me, help me while nurse is standing @ (at) bedside resident stated he doesn't need anything, increased restlessness with anxiety, denies pain." Resident #4 was administered Xanax 0.25 mg at 22:27 (10:27 p.m.). Resident #4 medicated without the use of a non-medication intervention.

The surveyor informed the administrative staff of the above finding on 4/22/16 at 10:00 a.m.

The surveyor requested the facility policy for pain from the director of nursing on 4/21/16. The policy titled "Pain Management in the Long Term Care Setting" read in part "Procedure:
1. Assess the resident for pain on admission, readmission, quarterly, change of condition, or at other times as appropriate. Use the EMR (electronic medication record) Pain Assessment Form.
2. Document the location, quality, duration, and intensity of pain. a. Some residents will deny pain, however will describe feelings of discomfort b. Assist the resident to describe the quality of pain by cueing with such words as throbbing, stabbing, burning and aching c. Some residents will relate pain or discomfort in connection with certain times of day or specific movement or activity d. Teach the resident to use the intensity scale with which they are most comfortable e.

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For the cognitively impaired resident, the nurse should involve the family as appropriate, or make observations of the resident's behavior and reactions.
3. Document present and past treatments utilized by the resident for the treatment of pain, include: a. medications both prescription and OTC (over the counter) b. alternative treatments such as positioning, heat and cold applications c. specify the treatment by each site of pain d. record the effectiveness of each treatment
4. Develop a specific care plan to address all sites of pain and the appropriate treatment for each.
6. Utilize the pain assessments in interdisciplinary care planning meetings to determine the adequacy of the resident's pain management, and revise the plan of care as appropriate."

No further information was provided prior to the exit conference on 4/22/16.

7). The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for anxiety for Resident #6.
The clinical record of Resident #6 was reviewed 4/19/16 through 4/22/16. Resident #6 was admitted to the facility on 5/16/12 and readmitted 3/2/16 with diagnoses that included, but not limited to anxiety, depressive disorder, urinary retention, left fractured humerus, congestive heart failure, constipation, pain, hypothyroidism, dementia with behavioral disturbances, Parkinson ' s disease, diabetes mellitus type II, anemia, and enlarged prostate.
Resident #6's significant change in assessment MDS with an assessment reference date (ARD)

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of 3/10/16 coded the resident with a cognitive summary score of 04 out of 15 in Section C0500. Resident #6 was assessed with speech clarity, usually understood, and usually understands. There were no issues documented for behaviors in Section E.

Resident #6's current comprehensive care plan initiated 11/29/12 with revisions on 2/8/16 identified cognitive behavior as a focus due to diagnosis of dementia, history of behaviors. Interventions: assist as needed, consult ST (speech therapy) as needed, encourage Resident #6 to make decisions daily regarding care, and provide a consistent environment. Resident #6 also received psychotropic medication due to anxiety and depression; at risk for side effects; dementia with behaviors. Interventions for the focus area: Administer psychotropic medication as ordered, MD (medical doctor) and pharmacy consultant to review meds (medications) regularly, monitor for side effects and attempt GDR (gradual dose reduction) as indicated unless otherwise contraindicated, observe for an increase in reported s/s (signs/symptoms) of depression or anxiety and report to the physician as needed, observe for s/s drug toxicity and report to the physician as needed, observe for side effects and report to the physician as needed, observe for side effects such as dizziness, drowsiness, high BP (blood pressure), rapid heart rate, weight gain, or tardive dyskinesia and report to the physician as needed.

The comprehensive care plan dated 3/15/16 did include interventions for Resident #6's confusion; however, there were no non-pharmacological interventions for anxiety on the current comprehensive care plan.

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The April 2016 physician order sheet read in part "Ativan tablet 0.5 mg (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for agitation/anxiety."

The April 2016 medication administration record identified Resident #6 received Ativan on 4/3/16, 4/4/16, 4/7/16, 4/8/16, 4/10/16, 4/11/16, 4/15/16, 4/17/16, 4/18/16 and 4/20/16-ten (10) times in April.

There was no documentation in any of the April 2016 progress notes that Resident #6 was offered non-pharmacological interventions prior to the administration of Ativan.

The surveyor informed the administrative staff of the above finding on 4/22/16.

No further information was provided prior to the exit conference on 4/22/16.

8). The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for pain for Resident #10.
The clinical record of Resident #10 was reviewed 4/19/16 through 4/22/16. Resident #10 was admitted to the facility 4/3/15 and readmitted 4/9/16 with diagnoses that included but not limited to hypertension, status post pacemaker insertion, chronic kidney disease, atrial fibrillation, hyperlipidemia, osteoarthritis, diabetes mellitus type II, and hypothyroidism.
Resident #10's significant change in MDS (minimum data set) assessment with an assessment reference date (ARD) of 8/17/15 assessed the resident with a cognitive summary

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score of 15 out of 15 in Section C Summary Score. Section J Health Conditions assessed that Resident #10 received scheduled pain medication, received prn (whenever needed) pain medications or was offered and declined, and did not receive any non-medication interventions for pain.

Resident #10's current comprehensive care plan identified the diagnosis of DJD (degenerative joint disease) and DDD (degenerative disc disease); history of fracture to leg with related pain. The care plan was revised 4/16/15.

Interventions/tasks: administer pain medication as ordered; observe for an increase in pain or unrelieved pain and report to the physician as needed and follow-up with MD as ordered/needed.

Resident #10's physician orders for April 2016 read in part "Percocet tablet 10-325 mg (Oxycodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain. Start date: 4/9/16."

The April 2016 medication administration records were reviewed. Resident #10 received Percocet as follows: 4/9/16 (x1), 4/10/16 (x3), 4/11/16 (x3), 4/12/16 (x2), 4/13/16 (x1), 4/14/16 (x3), 4/15/16 (x2), 4/16/16 (x1), 4/17/16 (x1), 4/18/16 (x1), 4/19/16 (x1) and 4/20/16 (x2).

The progress notes reviewed from 4/9/16 through 4/20/16 did not identify non-medications prior to the administration of Percocet.

The current care plan was not reviewed and updated to reflect Resident #10's recent surgical procedure of pacemaker insertion in April 2016.

The surveyor interviewed the assistant director of nursing on 4/21/16 regarding no care plan revision for Resident #10's surgical procedure.

The surveyor requested the facility policy for pain from the director of nursing on 4/21/16. The

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F 280	Continued From page 28 policy titled "Pain Management in the Long Term Care Setting" read in part "Procedure: 1. Assess the resident for pain on admission, readmission, quarterly, change of condition, or at other times as appropriate. Use the EMR (electronic medication record) Pain Assessment Form. 2. Document the location, quality, duration, and intensity of pain. a. Some residents will deny pain, however will describe feelings of discomfort b. Assist the resident to describe the quality of pain by cueing with such words as throbbing, stabbing, burning and aching c. Some residents will relate pain or discomfort in connection with certain times of day or specific movement or activity d. Teach the resident to use the intensity scale with which they are most comfortable e. For the cognitively impaired resident, the nurse should involve the family as appropriate, or make observations of the resident's behavior and reactions. 3. Document present and past treatments utilized by the resident for the treatment of pain, include: a. medications both prescription and OTC (over the counter) b. alternative treatments such as positioning, heat and cold applications c. specify the treatment by each site of pain d. record the effectiveness of each treatment 4. Develop a specific care plan to address all sites of pain and the appropriate treatment for each. 6. Utilize the pain assessments in interdisciplinary care planning meetings to determine the adequacy of the resident's pain management, and revise the plan of care as appropriate." No further information was provided prior to the exit conference on 4/22/16. 9). The facility staff failed to review and revise	F 280		

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the current comprehensive care plan to include non-pharmacological interventions for Resident #14's pain.
Resident #14's clinical record was reviewed 4/21/16 through 4/22/16. Resident #14 was admitted to the facility 3/24/14 and readmitted 7/17/15 with diagnoses that included but not limited to osteoarthritis, hypertension, hyperlipidemia, depression, anxiety, anemia, gastroesophageal reflux disease, enlarged prostate, insomnia, and spondylosis.
Resident #14's significant change in MDS assessment with an assessment reference date (ARD) of 7/29/15 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Summary Score.
The current comprehensive care plan dated 2/10/16 identified that Resident #14 assistance needs varied with ADLs (activities of daily living) due to osteoarthritis (OA); joint replacements. A second focus area read "Resident #14 has diagnosis of OA and chronic pain syndrome, immobility." Interventions/tasks: administer arthritic medication as ordered, administer muscle relaxant as ordered, administer pain medication as ordered, encourage use of brace as ordered, observe for an increase in pain or unrelieved pain and notify the physician as needed.
The current comprehensive care plan did not identify any non-medication interventions prior to the administration of pain medications.
The April 2016 physician orders included the following: Oxycodone HCL (hydrochloride) tablet 5 mg Give 1 tablet by mouth every 4 hours as needed for pain.
The surveyor observed a medication pass and pour on 4/19/16 at 4:50 p.m. with licensed practical nurse #1. Resident #14 complained of

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stomach "belly" pain and rated the pain an 8 out of 10. L.P.N. #1 proceeded to administer Resident #14 oxycodone 5 mg at this time. There were no non-medication interventions offered prior to the administration of the medication. Resident #14 did however, have a care plan for constipation revised 4/14/16 with 7 interventions identified.

The surveyor discussed the issue of Resident #14's pain medications with the assistant director of nursing on 4/21/16 at 7:20 a.m.

The surveyor requested the facility policy for pain from the director of nursing on 4/21/16. The policy titled "Pain Management in the Long Term Care Setting" read in part "Procedure:

1. Assess the resident for pain on admission, readmission, quarterly, change of condition, or at other times as appropriate. Use the EMR (electronic medication record) Pain Assessment Form.

2. Document the location, quality, duration, and intensity of pain. a. Some residents will deny pain, however will describe feelings of discomfort b. Assist the resident to describe the quality of pain by cueing with such words as throbbing, stabbing, burning and aching c. Some residents will relate pain or discomfort in connection with certain times of day or specific movement or activity d. Teach the resident to use the intensity scale with which they are most comfortable e. For the cognitively impaired resident, the nurse should involve the family as appropriate, or make observations of the resident's behavior and reactions.

3. Document present and past treatments utilized by the resident for the treatment of pain, include: a. medications both prescription and OTC (over the counter) b. alternative treatments such as positioning, heat and cold applications c. specify

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F 280	Continued From page 31 the treatment by each site of pain d. record the effectiveness of each treatment 4. Develop a specific care plan to address all sites of pain and the appropriate treatment for each. 6. Utilize the pain assessments in interdisciplinary care planning meetings to determine the adequacy of the resident's pain management, and revise the plan of care as appropriate." No further information was provided prior to the exit conference on 4/22/16. 10). The facility staff failed to review and revise the current comprehensive care plan to include non-pharmacological interventions for anxiety for Resident #1. The clinical record of Resident #1 was reviewed 4/19/16 through 4/22/16. Resident #1 was admitted to the facility on 5/15/14 and readmitted on 12/1/14 with diagnoses that included, but not limited to anemia, high blood pressure, dementia, anxiety, depression, asthma, and osteoarthritis. Resident #1 most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 02/22/16. 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. In section N she was coded to have received antianxiety medication. The March and April 2016 physician order sheet read in part "Xanax tablet 0.5 mg (milligram) Give 1 tablet by mouth every 24 hours as needed for anxiety." The March and April 2016 medication	F 280		

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F 280	Continued From page 32 administration records were reviewed. Resident #1 was administered Xanax 0.5 mg on Wednesday 3/23/16 and on Monday 4/18/16 for anxiety. The current comprehensive care plan initiated 12/31/15 read "Resident #1 receives psychotropic medication for anxiety and depression; at risk for side effects: Interventions; Administer psychotropic medication as ordered. Observe for increase s/s (signs/symptoms) of depression and anxiety. Notify physician as needed." The current comprehensive care plan did not include any non-pharmacological interventions prior to the use of Xanax. The progress notes for March and April did not have any documentation related to the administration of the xanax. There were no non-pharmacological interventions prior to the administration of the Xanax documented. The surveyor informed the administrative staff of the above finding on 4/22/16 at 10:00 a.m. No further information was provided to the surveyor prior to the 4/22/16 exit related to the non- pharmacological interventions.	F 280		
F 281 SS=D	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:	F 281	1. Labs for residents #4 and #14 had already been obtained without order. No negative outcome identified. 2. Any resident is at risk if a lab is obtained without a physician's order. DON or designee to audit labs for current residents obtained as of May 16th to ensure physicians order.	

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F 281	Continued From page 33 Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of nursing practice for writing physician orders for 2 of 26 residents (Resident #4 and Resident #14). The findings included: 1. The facility staff failed to write a physician order for a BMP obtained 3/21/16 for Resident #4. The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. The surveyor found the results of a BMP obtained 3/21/16 in the electronic clinical record. The surveyor reviewed the physician orders for March 2016 but was unable to locate the physician order. The surveyor informed the director of nursing and registered nurse #3 of the BMP obtained 3/21/16 and that the surveyor was unable to locate the physician order for the 3/21/16 lab test on 4/20/16 at 4:00 p.m. The director of nursing stated the BMP obtained was requested by the pharmacy when Resident #4 received Gentamycin. The surveyor informed the administrative staff of the failure of the staff to write the order for the BMP on 4/21/16 at 4:20 p.m. and asked the nursing staff in the meeting if writing a physician	F 281	3. DON or designee to educate licensed nursing staff of the need to obtain a physician's order prior to obtaining a lab. 4. Unit Manager or designee to audit labs that are obtained daily (M-F) x4 weeks and weekly x8 weeks to ensure physicians order was obtained prior to obtaining the lab. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 281	Continued From page 34 order was a standard of practice when physician orders are conveyed to a nurse. The corporate nurse registered nurse #4 stated yes nurses should write an order when orders are given to them. The surveyor reviewed the facility's standard of practice with regard to physician orders. The policy titled "Physician's Verbal Orders" read "Verbal orders can be taken by licensed nurse, pharmacist, or physician. All physician ' s verbal and telephone orders are recorded in the medical record immediately by the licensed nurse. These orders will be countersigned by the physician as soon as his/her signature can be obtained." No further information was provided prior to the exit conference on 4/22/16. 2. The facility staff failed to write a physician order when a urinalysis and a urine bilirubin were obtained on 4/18/16 for Resident #14. Resident #14's clinical record was reviewed 4/21/16 through 4/22/16. Resident #14 was admitted to the facility 3/24/14 and readmitted 7/17/15 with diagnoses that included but not limited to osteoarthritis, hypertension, hyperlipidemia, depression, anxiety, anemia, gastroesophageal reflux disease, enlarged prostate, insomnia, and spondylosis. Resident #14's significant change in MDS assessment with an assessment reference date (ARD) of 7/29/15 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Summary Score. The surveyor reviewed the miscellaneous section of the electronic clinical record. The clinical record revealed the results of a urinalysis and a urine bilirubin obtained 4/18/16. The surveyor reviewed the April 2016 physician orders but was unable to locate physician orders for the two aforementioned laboratory tests.	F 281		

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F 281	Continued From page 35 The surveyor requested the assistance of the assistant director of nursing on 4/22/16 at 8:20 a.m. The ADON stated when urinalyses are obtained and the tube has no sex or birthday, the lab will automatically do a urine bilirubin to determine the sex of the resident. ADON stated "The nurse documented Resident #14 was having burning upon urination in the progress note of 4/18/16. The nurse needed to write the order for the urinalysis. The nurse took the order from the routine standing orders." The surveyor reviewed the facility's standard of practice with regard to physician orders on 4/22/16. The policy titled "Physician's Verbal Orders" read "Verbal orders can be taken by licensed nurse, pharmacist, or physician. All physician's verbal and telephone orders are recorded in the medical record immediately by the licensed nurse. These orders will be countersigned by the physician as soon as his/her signature can be obtained." During the end of the day meeting with the administrative staff on 4/21/16 at 4:20 p.m., the corporate nurse registered nurse #4 stated yes nurses should write an order when orders are given to them. No further information was provided prior to the exit conference on 4/22/16.	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.	F 309	1. Resident #1, #3, and #6 had no negative outcome identified after not having a bowel movement for more than 3 days. Residents #15, #12, #4, #14, had no negative outcome identified due to non-pharmacological interventions not being provided prior to the administration of pain medications.	

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F 309	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to provide non- pharmacological interventions for pain and failed follow established bowel protocol for 7 of 26 Residents, Residents #1, #15, #3, #12, #6, #4, and #14. The findings included: 1). The facility staff failed to provide non-pharmacological interventions for pain for Resident #1. The clinical record of Resident #1 was reviewed 4/19/16 through 4/22/16. Resident #1 was admitted to the facility on 5/15/14 and readmitted on 12/1/14 with diagnoses that included, but not limited to anemia, high blood pressure, dementia, anxiety, depression, asthma, and osteoarthritis. Resident #1 most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 02/22/16. 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. In section N she was coded to have received antianxiety medication. In section G she was coded to require extensive assistance with toilet use. On 4/20/16 review of Resident #1 electronic clinical record revealed her bowel movement (BM) record. The record revealed she did not	F 309	2. Any resident is at risk if physician's standing orders are not followed when a patient has gone greater than 3 days without having a bowel movement. Current residents as of May 16th audited to ensure that physician's standing orders followed if resident has gone greater than 3 days without a bowl movement in the last 30 days. Any resident is at risk if non-pharmacological interventions are not used prior to administering pain medications. DON or designee to audit current patients to ensure non-pharmacological interventions are documented prior to administering pain meds. 3. DON or designee to educate licensed staff on following facility protocol for patients who have gone greater than 3 days without a bowel movement and on documenting non-pharmacological interventions prior to administering pain medications. 4. DON or designee will audit 10 patients weekly x12 weeks to ensure patients going longer than 3 days without a bowel movement have proper interventions. DON or designee will audit 24 hour clinical report	

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

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F 309	Continued From page 37 have a BM from 4/3/16 through 4/10/16 and again through 4/15/16 through 4/20/16. During a conversation with Resident #1 she was asked if her bowels moved regularly. She said " No, they don ' t I can ' t remember when I had my last BM. " Resident #1's current comprehensive care plan reviewed 2/26/16 identified that Resident #1 to receive medication to prevent constipation. Interventions listed in part read "Administer laxative as ordered, follow RSO (routine standing orders) for no BM (bowel movement) in 3+ days, and keep accurate record of bowel movements." The April 2016 electronic physician orders read in part "Milk of Magnesia Suspension 400 mg (milligrams)/5 ml (milliliter) (Magnesium Hydroxide) Give 30 ml by mouth every 24 hours as needed for constipation Start date 9/14/15." The April 2016 electronic medication administration records (eMARs) were reviewed. The eMARs had no documentation that the physician ordered medication MOM had been administered any in April 2016. The surveyor reviewed the facility protocol titled Record of Bowel Movement on 4/22/16. The policy read in part: "Provide a record of, and monitor, each resident's bowel movements to prevent constipation. Procedure: 1. Bowel movement activity/inactivity is to be documented each shift in the CCR software program by the CNAs (certified nursing assistants). 2. When a resident does not have a bowel movement during the shift, it is documented in	F 309	daily (M-F) x4 weeks, then weekly x8 weeks to ensure non-pharmacological interventions are documented prior to administering pain medications. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 309	Continued From page 38 the CCR software program that one did not occur. 3. Each time a resident has a bowel movement, the results are documented in the CCR software program. Documentation to include: a. Size of bowel movements (small, medium, large). 4. The charge nurse checks the bowel movement status alerts from the dashboard view of the CCR software program for any residents that were triggered for not having had a bowel movement in the last three days. The charge nurse will create a laxative /suppository list accordingly. 5. If the resident has not had a bowel movement by the third day, the charge nurse checks the resident's orders to make sure there is a laxative or suppository order. If not, the nurse will obtain further orders from the resident ' s physician. If indicated, the resident may be given a laxative or suppository per physician ' s orders. If given, it will be documented on the resident ' s EMAR accordingly." No further information was provided prior to the exit conference on 4/22/16 related to the bowel protocal not followed. 2). For Resident # 15 the facility staff failed to ensure the non- pharmacological interventions were provided prior the administration of pain medications. The April 2016 physician order sheet included an order that read "Norco Tablet 5-325 mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed (PRN) for pain." The April 2016 medication administration records (MARs) were reviewed.	F 309		

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The current comprehensive care plan initiated 4/11/16 included a focus area that read "Resident #15 has pain; index finger injured during activity. Has diagnosis indicating possible presence of pain: End stage renal disease, diabetes. Hypertension, anemia. "Interventions: "Administer pain medication as ordered. Encourage position changes as possible relief. Encourage hand up on a pillow as ordered. Apply ice and elevated to left hand as ordered and as needed. Observe for increase s/s (signs and symptoms) of pain or unrelieved pain. Notify physician as needed."

A 4/13/16, 15:41 progress note did not include non-pharmacological interventions for Resident #15 nor did it indicate where the Residents pain was. The next note read pain was effective at 16:52. On 4/14/16 8:35 the residents progress note read: " resident states pain is in his back " the next note at 9:12 read; Norco tablet 5-325 mg, Give 1 tablet every 6 hours as needed for pain. PRN medication was effective. Again on 4/14/16 16.25 : " resident states pain is in his back " the next note at 16:57 read; Norco tablet 5-325 mg, Give 1 tablet every 6 hours as needed for pain. PRN medication was ineffective

On 4/15/16 :8:25 " resident states pain is in his back " the next note at 9:32 read; Norco tablet 5-325 mg (milligram), Give 1 tablet every 6 hours as needed for pain. PRN medication was ineffective.

On 4/16/16 16:38: " :Norco tablet 5-325 mg, Give 1 tablet every 6 hours as needed for pain C/O (complain of pain) in his back. " the next note at 17:38 read; Norco tablet 5-325 mg, Give 1 tablet

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F 309	Continued From page 40 every 6 hours as needed for pain. PRN medication was effective. On 4/17/16 16:06: " resident states pain is in his back " the next note at 9:12 read; Norco tablet 5-325 mg, Give 1 tablet every 6 hours as needed for pain. PRN medication was effective. 4/19/16 10:57 progress notes read: " resident states pain is in his back " the next note at 12:24 read; Norco tablet 5-325 mg, Give 1 tablet every 6 hours as needed for pain. PRN medication was ineffective There was no documented non-pharmacological intervention prior to the administration of the pain medication for any of the above dates and time when Resident #15 complained of pain. The surveyor discussed the issue of Resident #15's pain medications with the assistant director of nursing on 4/22/16 at 11:20 a.m. The surveyor requested the facility policy for pain from the director of nursing on 4/21/16. The policy titled "Pain Management in the Long Term Care Setting" read in part "Procedure: 1. Assess the resident for pain on admission, readmission, quarterly, change of condition, or at other times as appropriate. Use the EMR (electronic medication record) Pain Assessment Form. 2. Document the location, quality, duration, and intensity of pain. a. Some residents will deny pain; however will describe feelings of discomfort b. Assist the resident to describe the quality of pain by cueing with such words as throbbing, stabbing, burning and aching -c. Some residents will relate pain or discomfort in connection with certain times of day or specific movement or	F 309		

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activity d. Teach the resident to use the intensity scale with which they are most comfortable e. For the cognitively impaired resident, the nurse should involve the family as appropriate, or make observations of the resident's behavior and reactions.
3. Document present and past treatments utilized by the resident for the treatment of pain, include: a. medications both prescription and OTC (over the counter) b. alternative treatments such as positioning, heat and cold applications c. specify the treatment by each site of pain d. record the effectiveness of each treatment
4. Develop a specific care plan to address all sites of pain and the appropriate treatment for each.
6. Utilize the pain assessments in interdisciplinary care planning meetings to determine the adequacy of the resident ' s pain management, and revise the plan of care as appropriate."

The failure of the facility to provide non pharmacological interventions for resident complaints of pain was discussed with the administrative staff on 4/22/16 prior to exit. No further information was provided prior to the exit conference on 4/22/16.

3). The facility staff failed to follow physician standing orders when Resident #3 had no bowel movements for 3 days.
Resident #3 was admitted to the facility on 2/21/16 with the following diagnoses of, but not limited to heart failure, high blood pressure, arthritis, depression, asthma, respiratory failure, muscle weakness, difficulty in walking and shortness of breath. The resident was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference

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Date) of 2/28/16 as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance from one staff person for dressing, personal hygiene and bathing.

During the review of the clinical record on 4/19/16 by the surveyor, it was noted that Resident #3 had no bowel movements documented from 4/12/16 through 4/15/16. The surveyor asked Unit 2 Manager for the protocol for a resident that has no bowel movement for 3 days. The Unit 2 Manager gave the surveyor a copy of the physician ' s standing orders on 4/20/16 at 8:10 am. The standing order sheet titled " ...Routine Standing Order " stated the following ... " Constipation (No BM for 3 days) A. Give MOM (Milk of Magnesium) 30 cc by mouth x (times) 1 dose. B. If no results in 8 hours, give Dulcolax rectal suppository x 1 dose. C. Check for presence of stool in rectum. Remove manually if indicated. D. If no results in 8 hours, give fleets enema x 1 enema. E. If no results, notify the physician for further orders. " The surveyor reviewed the nurses ' notes and the resident ' s medication administration record for April, 2016 and there were no documentation or entries made by the staff in the clinical record as any of the above interventions being given to the resident for no bowel movements noted for 3 days.

On 4/20 16 at 7:45 am, Administrative staff #4 was asked to review resident ' s clinical record to see if there were any bowel movements documented for 412/16 through 4/15/16. The administrative staff #4 stated, " I looked through the record and I could not find any bowel movements documented or any interventions that the staff used during this time to help the resident

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F 309	Continued From page 43 to have a bowel movement. " The director of nursing and administrator were notified of the above documented findings on Resident #3 on 4/20/16 in the end of the day conference. No further information was provided to the surveyor prior to the exit conference on 4/22/16. 4). The facility staff failed to implement non-pharmacological interventions for pain prior to the administration of pain medication to Resident #12. Resident #12 was readmitted to the facility on 12/7/15 with the following diagnoses of, but not limited to: heart failure, anemia, peripheral vascular disease, high cholesterol, and anxiety disorder, and depression, bilateral amputation of lower extremities, Stage IV kidney disease, and insomnia. Resident #12 was coded on the quarterly MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/1/16 as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. The resident was also coded as being totally dependent on staff members for dressing, personal hygiene and bathing. During the review of the clinical record by the surveyor on 4/22/16, it was noted that the staff administered pain medication, " Percocet 5 -325 mg " on 4/16/16 at 2043 (8:43 pm) and again on 4/17/16 at 2333 (11:33 pm) as documented on the resident ' s Medication Administration Record (MAR). The surveyor reviewed the nurses ' notes for these dates and times and there were no noted non-pharmacological interventions documented by the staff prior to the administration of Percocet, a pain medication, to Resident #12.	F 309		

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F 309	Continued From page 44 The care plan dated for 2/5/16, for Resident #12, was also reviewed by the surveyor on 4/22/16. The resident was care planned for a focus of " Pain " with the following interventions noted on it: " Administer pain medications and medication for phantom pain as ordered ...Observe for an increase in s/s (signs and symptoms) or c/o (complaints of) unrelieved pain and report to the physician as needed. " The director of nursing was notified of the above documented findings on 4/22/16 at 2:30 pm. The director of nursing stated " Let me review the notes myself and then I can get with you about this. " No further information was provided to the surveyor prior to the exit conference on 4/22/16. 5). The facility staff failed to follow the physician's orders for bowel protocol [Milk of Magnesia 30 ml (milliliters) every 24 hours as needed for constipation] for Resident #6. The clinical record of Resident #6 was reviewed 4/19/16 through 4/22/16. Resident #6 was admitted to the facility on 5/16/12 and readmitted 3/2/16 with diagnoses that included, but not limited to anxiety, depressive disorder, urinary retention, left fractured humerus, congestive heart failure, constipation, pain, hypothyroidism, dementia with behavioral disturbances, Parkinson ' s disease, diabetes mellitus type II, anemia, and enlarged prostate. Resident #6's significant change in assessment MDS with an assessment reference date (ARD) of 3/10/16 coded the resident with a cognitive summary score of 04 out of 15 in Section C0500. Resident #6 was assessed with speech clarity, usually understood, and usually understands. Section G Functional Status assessed Resident #6 to need extensive assistance of two persons	F 309		

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for toileting needs. Section H Bladder and Bowel assessed Resident #6 to be always incontinent of bowel.

Resident #6's current comprehensive care plan initiated 11/29/12 with revisions on 3/15/16 identified that Resident #6 received a laxative for constipation. Interventions listed in part read "Administer laxative as ordered, administer supplement as ordered for diarrhea, encourage fluids unless otherwise indicated, follow RSO (routine standing orders) for no BM (bowel movement) in 3+ days, and keep accurate record of bowel movements."

The April 2016 electronic physician orders read in part "Milk of Magnesia Suspension 1200 mg (milligrams)/15 ml (milliliter) (Magnesium Hydroxide) Give 30 ml by mouth every 24 hours as needed for constipation Start date 4/6/16."

The surveyor reviewed the March 2016 and April 2016 bowel movement records in the electronic clinical record. The surveyor was only able to review the past 30 days. The surveyor requested the past two months BM documentation from licensed practical nurse #3 on 4/21/16 at 9:45 a.m. L.P.N. #3 printed the BM documentation used for MDS (minimum data set) assessments for March 2016 and April 2016.

The March 2016 BM documentation revealed Resident #6 had no bowel movements from 3/4/16 through 3/8/16, 3/13/16 through 3/16/16, and 3/19/16 through 3/27/16. The April 2016 BM documentation revealed Resident #6 had no bowel movements from 4/9/16 through 4/18/16.

The March 2016 and April 2016 electronic

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medication administration records (eMARs) were reviewed. The eMARs had no documentation that the physician ordered medication MOM had been administered any in April 2016. There were no medications for constipation administered in March 2016 as well.

L.P.N. #3 stated that was an issue. She stated Resident #6 had C. Diff (Clostridium difficile) recently with diarrhea.

The surveyor requested the facility's policy for bowel movements and the facility protocol from licensed practical nurse #3.

The surveyor informed the administrative staff of the above finding on 4/21/16 at 4:20 p.m.

The surveyor reviewed the facility protocol titled "Record of Bowel Movements" on 4/22/16. The policy read in part "Provide a record of, and monitor, each resident's bowel movements to prevent constipation. Procedure:
1. Bowel movement activity/inactivity is to be documented each shift in the CCR software program by the CNAs (certified nursing assistants).
2. When a resident does not have a bowel movement during the shift, it is documented in the CCR software program that one did not occur.
3. Each time a resident has a bowel movement, the results are documented in the CCR software program. Documentation to include: a. Size of bowel movements (small, medium, large).
4. The charge nurse checks the bowel movement status alerts from the dashboard view of the CCR software program for any residents that were triggered for not having had a bowel

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movement in the last three days. The charge nurse will create a laxative /suppository list accordingly.
5. If the resident has not had a bowel movement by the third day, the charge nurse checks the resident's orders to make sure there is a laxative or suppository order. If not, the nurse will obtain further orders from the resident ' s physician. If indicated, the resident may be given a laxative or suppository per physician ' s orders. If given, it will be documented on the resident ' s EMAR accordingly."

No further information was provided prior to the exit conference on 4/22/16.

6). The facility staff failed to complete a pain assessment with non-pharmacological interventions for pain for Resident #4.
The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right lateral foot ulcer.
(a) Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. Resident #4 was assessed to understand others usually and was understood. Resident #4 was assessed to have no behaviors in Section E. Resident #4's pain assessment revealed no scheduled pain medication regimen,

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did not receive any prn (whenever necessary) medications and did not receive any non-medication interventions for pain. Resident #4 frequently had pain during the look back period. Resident #4 rated his pain level as 8 out of 10.

The April 2016 physician order sheet included an order that read "Norco Tablet 5-325 mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain." The April 2016 medication administration records (MARs) were reviewed. Resident #4 received prn (as needed) pain medications eight (8) times in April 2016 on 4/2/16, 4/5/16, 4/9/16, 4/15/16, 4/18/16, 4/19/16 (x2), and 4/20/16.

The current comprehensive care plan initiated 12/31/15 included a focus area that read "Resident #4 has generalized pain with legs, feet, and buttocks." Interventions: "Administer pain medication as ordered. Nursing to assist with position of comfort. Observe for increase s/s (signs and symptoms) of pain or unrelieved pain. Notify physician as needed."

The April 2016 progress notes did not reveal non-pharmacological interventions prior to medication administration on 4/2/16 at 21:44 (9:44 p.m.). The note read " c/o (complained of) back and BLE (bilateral lower extremities). " The next entry dated 4/3/16 05:41 read " PRN medication was effective. " Resident #4 had received Hydrocodone 5-Acetaminophen 325 mg at 21:44 (9:44 p.m.).

The 4/13/16 21:30 (9:30 p.m.) note read "Acetaminophen tablet 325 mg Give 1 tablet by mouth every 4 hours as needed for pain back and

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hips aching, repositioned and gave prn Tylenol." Tylenol was administered at the same time the note was written.

The 4/15/16 21:38 (9:38 p.m.) progress note did not include non-pharmacological interventions for Resident #4 when the resident complained of back pain.

The 4/18/16 21:37 (9:37 p.m.) progress notes read "C/o (complain of) all over pain." There was no documented non-pharmacological intervention prior to the administration of the pain medication at 21:37 (9:37 p.m.).

The 4/19/16 at 10:51 progress note read "RSD, (resident) states pain in his sacrum and back 8/10." There were no documented non-pharmacological interventions prior to the administration of the pain medication at 10:51 a.m.

The 4/20/16 08:00 progress note read "RSD said he is having pain in his sacral wound." Resident #4 received pain medication at 8:00 a.m. " There were no non-pharmacological interventions prior to the administration of the pain medication on 4/20/16.

The surveyor discussed the current comprehensive care plan for pain for Resident #4 with registered nurse #3 on 4/22/16 at 10:00 a.m. The current comprehensive care plan identified one non-pharmacological intervention for pain. R.N. #3 stated the facility wouldn't document "Standards of Practice" on the care plan-- what would normally be tried prior to the use of medication. One example she gave: turning and repositioning. R.N. #3 stated these would be

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used on each resident prior to giving medications. R.N. #3 stated the facility "charted by exception." R.N. #3 stated interventions might be found in other areas of the care plan and stated you have to look at all of the problems. The surveyor asked R.N. #3 if the facility knew what Resident #4's pain management would include besides "position of comfort." No answer was given.

The surveyor requested the facility policy for pain from the director of nursing on 4/21/16. The policy titled "Pain Management in the Long Term Care Setting" read in part "Procedure:
1. Assess the resident for pain on admission, readmission, quarterly, change of condition, or at other times as appropriate. Use the EMR (electronic medication record) Pain Assessment Form.
2. Document the location, quality, duration, and intensity of pain. a. Some residents will deny pain; however will describe feelings of discomfort b. Assist the resident to describe the quality of pain by cueing with such words as throbbing, stabbing, burning and aching c. Some residents will relate pain or discomfort in connection with certain times of day or specific movement or activity d. Teach the resident to use the intensity scale with which they are most comfortable e. For the cognitively impaired resident, the nurse should involve the family as appropriate, or make observations of the resident ' s behavior and reactions.
3. Document present and past treatments utilized by the resident for the treatment of pain, include: a. medications both prescription and OTC (over the counter) b. alternative treatments such as positioning, heat and cold applications c. specify the treatment by each site of pain d. record the effectiveness of each treatment

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F 309	Continued From page 51 4. Develop a specific care plan to address all sites of pain and the appropriate treatment for each. 6. Utilize the pain assessments in interdisciplinary care planning meetings to determine the adequacy of the resident ' s pain management, and revise the plan of care as appropriate." The failure of the facility to not offer/use non pharmacological interventions for resident complaints of pain was discussed with the administrative staff on 4/21/16 at 4:20 p.m. No further information was provided prior to the exit conference on 4/22/16. 7). The facility staff failed to complete a pain assessment with non-pharmacological interventions for Resident #14's pain. Resident #14's clinical record was reviewed 4/21/16 through 4/22/16. Resident #14 was admitted to the facility 3/24/14 and readmitted 7/17/15 with diagnoses that included but not limited to osteoarthritis, hypertension, hyperlipidemia, depression, anxiety, anemia, gastroesophageal reflux disease, enlarged prostate, insomnia, and spondylosis. Resident #14's significant change in MDS assessment with an assessment reference date (ARD) of 7/29/15 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Summary Score. The current comprehensive care plan dated 2/10/16 identified that Resident #14 assistance needs varied with ADLs (activities of-daily living) due to osteoarthritis (OA): joint replacements. A second focus area read "Resident #14 has	F 309		

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diagnosis of OA and chronic pain syndrome, immobility." Interventions/tasks: administer arthritic medication as ordered, administer muscle relaxant as ordered, administer pain medication as ordered, encourage use of brace as ordered, observe for an increase in pain or unrelieved pain and notify the physician as needed.

The current comprehensive care plan did not identify any non-medication interventions prior to the administration of pain medications.

The April 2016 physician orders included the following: Oxycodone HCL (hydrochloride) tablet 5 mg Give 1 tablet by mouth every 4 hours as needed for pain.

The surveyor observed a medication pass and pour on 4/19/16 at 4:50 p.m. with licensed practical nurse #1. Resident #14 complained of stomach "belly" pain and rated the pain an 8 out of 10. L.P.N. #1 proceeded to administer Resident #14 oxycodone 5 mg at this time. There were no non-medication interventions offered prior to the administration of the medication. Resident #14 did however, have a care plan for constipation revised 4/14/16 with 7 interventions identified.

The surveyor discussed the issue of Resident #14's pain medications with the assistant director of nursing on 4/21/16 at 7:20 a.m.

The surveyor requested the facility policy for pain from the director of nursing on 4/21/16. The policy titled "Pain Management in the Long Term Care Setting" read in part "Procedure:

1. Assess the resident for pain on admission, readmission, quarterly, change of condition, or at other times as appropriate. Use the EMR (electronic medication record) Pain Assessment Form.

2. Document the location, quality, duration, and

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F 309	Continued From page 53 intensity of pain. a. Some residents will deny pain; however will describe feelings of discomfort b. Assist the resident to describe the quality of pain by cueing with such words as throbbing, stabbing, burning and aching c. Some residents will relate pain or discomfort in connection with certain times of day or specific movement or activity d. Teach the resident to use the intensity scale with which they are most comfortable e. For the cognitively impaired resident, the nurse should involve the family as appropriate, or make observations of the resident's behavior and reactions. 3. Document present and past treatments utilized by the resident for the treatment of pain, include: a. medications both prescription and OTC (over the counter) b. alternative treatments such as positioning, heat and cold applications c. specify the treatment by each site of pain d. record the effectiveness of each treatment 4. Develop a specific care plan to address all sites of pain and the appropriate treatment for each. 6. Utilize the pain assessments in interdisciplinary care planning meetings to determine the adequacy of the resident ' s pain management, and revise the plan of care as appropriate." The failure of the facility to not offer/use non pharmacological interventions for resident complaints of pain was discussed with the administrative staff on 4/21/16 at 4:20 p.m. No further information was provided prior to the exit conference on 4/22/16.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	1. Nurse who disposed of lancet improperly was educated on 4-20-16 regarding proper sharps disposal.	

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F 323	Continued From page 54 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to dispose of sharps in a sharps container during a medication pass that affected 1 of 26 residents (Resident #22). The findings included: The facility staff failed to dispose of a lancet used to obtain an accucheck on Resident #22 during a medication pass and pour observation. The surveyor observed a medication pass on 4/19/16 at 4:28 p.m. with registered nurse #1. Resident #22's signed physician orders for April 2016 read in part "Accuchecks ac (before meals) & HS (bedtime) for DM (diabetes mellitus)." R.N. #1 prepared Resident #22's medication then removed the community glucometer from the medication cart. R.N. #1 pricked Resident #22's finger with the lancet, obtained the blood sugar results, then placed the lancet in the gloves and then put the gloves in the water cup. R.N. #1 then disposed of the cup with the lancet in the trash can attached to the medication cart. The surveyor interviewed R.N. #1 immediately upon completion of Resident #22's medication administration. The surveyor asked R.N. #1 where lancets should be disposed. R.N. #1 stated "In the sharps container." The surveyor informed the administrative staff of	F 323	2. Any resident/staff has the potential to be affected if lancets or sharps are not disposed of properly. 3. DON or designee to educate licensed nursing staff on proper disposal of lancets/sharps. 4. Unit Manager or designee to randomly observe 5 nurses a week x12 weeks disposing of lancets/sharps to ensure proper disposal of lancet/sharps. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 323	Continued From page 55 the above finding on 4/20/16 at 5:50 p.m. The surveyor requested the facility policy for disposal of sharps on 4/21/16. The surveyor reviewed the facility policy titled "Sharps Disposal" on 4/22/16. The policy read in part under POLICY: "A. NO sharps (needles, sharp instruments, razors, broken glass, etc.) are to be discarded in waste baskets, anywhere." Resident #22 was admitted to the facility 4/11/16 with diagnoses that included but not limited to muscle weakness, lack of coordination, diabetes mellitus, hypertension, hyperlipidemia, constipation, and hypothyroidism. Resident #22's admission minimum data set (MDS) assessment had not yet been completed. No further information was provided prior to the exit conference on 4/22/16.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and clinical record review, the facility staff failed to ensure physician's orders for respiratory care were followed for 2 of 26	F 328	1. Oxygen sats for resident #6 were unable to be obtained as they were missed in March. No negative outcome identified. Oxygen adjusted to 2 l/min for resident #2 as soon as it was identified that the oxygen was not on the correct setting. No negative outcome identified. 2. Any resident has the potential to be affected if O2 sats are not obtained per physician order. DON or designee will audit current patients on oxygen as of May 16th to ensure O2 sats have been documented as ordered for the last 30 days. Any resident has the potential to be affected if	

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F 328	Continued From page 56 residents (Resident #6 and Resident #2). The findings included: 1. The facility staff failed to obtain oxygen saturation (O2 sats) levels as ordered by the physician for Resident #6. The clinical record of Resident #6 was reviewed 4/19/16 through 4/22/16. Resident #6 was admitted to the facility on 5/16/12 and readmitted 3/2/16 with diagnoses that included, but not limited to anxiety, depressive disorder, urinary retention, constipation, pain, hypothyroidism, dementia with behavioral disturbances, Parkinson's disease, diabetes mellitus type II, anemia, and enlarged prostate. Resident #6's significant change in assessment MDS with an assessment reference date (ARD) of 3/10/16 coded the resident with a cognitive summary score of 04 out of 15 in Section C0500. The April 2016 signed physician orders read "Apply O2 @ (at) 2L (liters) when O2 stats (sic) below 90% per standing orders every shift for low O2. Start date 3/21/16." The surveyor reviewed the "Weights and Vitals Summary Report" for March 2016 and April 2016 and the electronic medication administration records for March 2016 and April 2016. The surveyor was unable to locate oxygen saturation levels for 7:00 p.m.-7:00 a.m. shift for 3/21/16, 3/22/16, and 3/23/16. The surveyor requested the assistance of licensed practical nurse #3 on 4/21/16 at 9:15 a.m. for the results of the oxygen saturation levels for 3/21/16, 3/22/16, and 3/23/16. The director of nursing stated on 4/22/16 at 7:50 a.m. that the facility staff was still looking for the	F 328	their oxygen is not on the correct setting. Unit Manager or designee to check current patients as of May 16th to ensure oxygen is on correct setting. 3. DON or designee will educate licensed nursing staff on documenting O2 sats per physician order and on properly setting patient O2 on the correct setting. 4. Unit manager or designee will audit patients on oxygen daily (M-F) x4 weeks, then weekly x8 weeks to ensure oxygen is documented per physician order. Unit Manager or designee will randomly check 5 patients on oxygen weekly x12 weeks to ensure oxygen is set to correct setting. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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O2 saturation levels. The director of nursing stated the staff will sometimes document the results on the eMAR or the vitals signs sheet, sometimes in the nurses notes and then sometimes on the 24 hour sheet.

No further oxygen saturation levels were provided prior to the exit conference on 4/22/16.

2. The facility staff failed to administer oxygen by nasal cannula at the prescribed rate of 2 liters per minute (l/min) for Resident #2.

The findings included:

2. The facility staff failed to administer oxygen by nasal cannula at the prescribed rate of 2 liters per minute (l/min) for Resident #2.

Resident #2 was readmitted to the facility on 2/20/16 with the following diagnoses of, but not limited to diabetes, dementia, enlarged prostrate, chronic obstructive pulmonary disease, major depressive disorder, anemia and heart failure.

On the resident ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 3/17/16, Resident #2 was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene. Resident #2 is totally dependent on staff for bathing.

Resident #2 was sitting at the nurses ' station on 4/20/16 at 2 pm, at which time the surveyor observed the Resident ' s oxygen setting at 1.5 l/min by nasal cannula.

According to the clinical record review performed by the surveyor on 4/20/16, it was noted that a physician ' s order dated on 3/16/16 stated, " O2 (oxygen) at 2 l/min via (by) nasal cannula continuously every shift. "

Licensed practical nurse (LPN) #2 was asked by

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F 328	Continued From page 58 the surveyor on 4/20/16 at 2:10 pm to look and make sure the oxygen setting was right for Resident #2. LPN #2 went over to the resident ' s portable oxygen tank and stated, " No, it should be at 2 l/min. " LPN #2 proceeded to increase the oxygen setting to 2 l/min. The administrator and director of nursing were notified of the above documented findings on 4/20/16 at the end of the day conference. No further information was provided to the surveyor prior to the exit conference on 4/22/16.	F 328		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1. Medication had already been administered for resident #4, #6, #1, #9, and #7, no negative outcome identified. 2. Any resident is at risk of behaviors are not monitored and non-pharmacological interventions attempted prior to administering anxiolytic medications. DON or designee will audit current patients as of May 16th on anxiolytic medications to ensure behaviors are monitored and non-pharmacological interventions attempted prior to administering the medication. 3. DON or designee will educate licensed nursing staff on center policy for behavior monitoring and attempting non-pharmacological interventions prior to administering anxiolytic medications.	

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F 329	Continued From page 59 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 5 of 26 residents were free of unnecessary drugs (Resident #4, Resident #6, Resident #1, Resident #9, and Resident #7). The findings included: 1. The facility staff failed to monitor Resident #4's behavior prior to the administration of an anxiolytic medication Xanax. Resident #4 was administered PRN (as needed) Xanax without any indication of the attempt to use non-pharmacological interventions prior to the administration. The facility staff failed to identify the targeted behavior for the use of the prn Xanax and failed to provide evidence of monitoring when the anxiolytic was administered. The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, and sacral ulcer and right lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. Resident #4 was assessed to understand others usually and was understood. Resident #4 was assessed to have no behaviors in Section E during the look back period.	F 329	4. DON or designee will audit 24 hour clinical report daily (M-F) x4 weeks, then weekly x8 weeks to ensure behavior monitoring and non-pharmacological interventions are attempted prior to administering anxiolytic medications. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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The April 2016 physician order sheet read in part "Xanax tablet 0.25 mg (milligram) (Alprazolam) Give 1 tablet by mouth every 6 hours as needed for anxiety."

The April 2016 progress notes were reviewed. Resident #4 was administered Xanax 0.25 mg (milligrams) six (6) times in April on the following days: 4/2/16, 4/5/16, 4/9/16, 4/15/16, 4/17/16, and 4/18/16.

The current comprehensive care plan initiated 12/31/15 read "Resident #4 receives psychotropic medication for depression with adult failure to thrive, anxiety, and insomnia, at risk for side effects." Interventions "Administer psychotropic medication as ordered. Observe for increase s/s (signs/symptoms) of depression and anxiety. Notify physician as needed."

The current comprehensive care plan did not include any non-pharmacological interventions prior to the use of Xanax.

The 4/5/16 22:15 (10:22 p.m.) progress note read "Anxiety, redirection ineffective. Xanax 1 tablet by mouth every 6 hours as needed for anxiety." Xanax 0.25 mg was administered at 22:15 (10:15 p.m.). There were no non-pharmacological interventions prior to the administration of the Xanax.

The progress notes of 4/6/16 8:32 read "Offered snacks, fluids, repositioning, boosting into bed, tv channel changed. Redirection ineffective."

The 4/17/16 22:27 (10:27 p.m.) progress note read "Xanax 0.25 mg Give 1 tablet by mouth every 6 hours as needed for anxiety. Anxiety,

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hollering help me, help me while nurse is standing @ (at) bedside resident stated he doesn't need anything, increased restlessness with anxiety, denies pain." Resident #4 was administered Xanax 0.25 mg at 22:27 (10:27 p.m.). Resident #4 medicated without the use of a non-medication intervention.

The surveyor reviewed the clinical record for monitoring of Resident #4's behavior. The clinical record did contain monitoring for Resident #4's antidepressant medication but the surveyor found no monitoring for the use of the prn medication Xanax-an antianxiety medication.

The facility staff failed to identify the targeted behavior for Resident #4's Xanax use, failed to monitor the behavior and failed to incorporate non-pharmacological interventions prior to the administration of Xanax.

The surveyor informed the administrative staff of the above finding on 4/21/16 at 4:20 p.m. The surveyor requested the facility policy on anxiolytic medications.

The surveyor reviewed the facility policy titled "Anxiolytics" on 4/22/16. The policy read in part "Residents receive anxiolytic medications only when medically necessary. Every effort is made to ensure that residents who use anxiolytics receive the intended benefit of the medications and the potential for unwanted effects is minimized. Procedure 1. The reason for the medication is documented in the resident's medical record and included in the care planning for the resident. 3. Monitoring: When anxiolytic therapy is initiated, the resident is monitored to determine the effectiveness of the medication

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and the presence of adverse effects. C. Non-pharmacologic behavioral modification activities and their effects, as well as the effect of pharmacologic behavior modifiers, are addressed in nursing notes in the resident's chart and in the resident care planning. These records are reviewed by the physician in the process of assessing the resident ' s response to therapy. 5. Anxiolytic medications ordered on a "prn" basis are administered only at the request of the resident or, if nursing judgement indicates it is warranted, in the case of a non-communicative resident or other situation where its use is in the resident's best interest."

No further information was provided prior to the exit conference on 4/22/16.

2. The facility staff failed to monitor Resident #6's behavior prior to the administration of an anxiolytic medication Ativan. Resident #6 was administered PRN (as needed) Ativan without any indication of the attempt to use non-pharmacological interventions prior to the administration. The facility staff failed to identify the targeted behavior for the use of the prn Ativan and failed to provide evidence of monitoring when the anxiolytic was administered.
The clinical record of Resident #6 was reviewed 4/19/16 through 4/22/16. Resident #6 was admitted to the facility on 5/16/12 and readmitted 3/2/16 with diagnoses that included, but not limited to anxiety, depressive disorder, urinary retention, left fractured humerus, congestive heart failure, constipation, pain, hypothyroidism, dementia with behavioral disturbances, Parkinson's disease, diabetes mellitus type II, anemia, and enlarged prostate.
Resident #6's significant change in assessment

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F 329	Continued From page 63 MDS with an assessment reference date (ARD) of 3/10/16 coded the resident with a cognitive summary score of 04 out of 15 in Section C0500. Resident #6 was assessed with speech clarity, usually understood, and usually understands. There were no issues documented for behaviors in Section E. Resident #6's current comprehensive care plan initiated 11/29/12 with revisions on 2/8/16 identified cognitive behavior as a focus due to diagnosis of dementia, history of behaviors. Interventions: assist as needed, consult ST (speech therapy) as needed, encourage Resident #6 to make decisions daily regarding care, and provide a consistent environment. Resident #6 also received psychotropic medications due to anxiety and depression; at risk for side effects; dementia with behaviors. Interventions for the focus area: Administer psychotropic medication as ordered, MD (medical doctor) and pharmacy consultant to review meds (medications) regularly, monitor for side effects and attempt GDR (gradual dose reduction) as indicated unless otherwise contraindicated, observe for an increase in reported s/s (signs/symptoms) of depression or anxiety and report to the physician as needed, observe for s/s drug toxicity and report to the physician as needed, observe for side effects and report to the physician as needed, observe for side effects such as dizziness, drowsiness, high BP (blood pressure), rapid heart rate, weight gain, or tardive dyskinesia and report to the physician as needed. The comprehensive care plan dated 3/15/16 did include interventions for Resident #6's confusion; however, there were no non-pharmacological interventions for anxiety.	F 329		

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The April 2016 physician order sheet read in part "Ativan tablet 0.5 mg (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for agitation/anxiety."

The April 2016 medication administration record identified Resident #6 received Ativan on 4/3/16, 4/4/16, 4/7/16, 4/8/16, 4/10/16, 4/11/16, 4/15/16, 4/17/16, 4/18/16 and 4/20/16-ten (10) times in April.

There was no documentation in the April 2016 progress notes that identified the targeted behavior that Resident #6 exhibited prior to the administration of the Ativan. There was no documentation in any of the April 2016 progress notes that Resident #6 was offered non-pharmacological interventions prior to the administration of Ativan.

The April 2016 eMAR (electronic medication administration record) had an entry for behaviors that read "Behaviors-Monitor for the following: (specify) anxiety/depression Document "Y" if monitored and resident is free of above. "N" If monitored and resident is not free of above, select chart code "Other/See Nurses Notes" and must document findings. Every shift -Start Date-03/25/16 1900 (7:00 p.m.)." The surveyor reviewed all entries on the April 2016 eMAR and found check marks and initials in each of the boxes for both the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift; however, Ativan 0.5 mg was administered-ten (10) times in April 2016.

There was no evidence in the progress notes to support the use of Ativan. There was no

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evidence in the clinical record of any targeted behaviors the Ativan had been administered to control, no non-medication intervention prior to the use of the Ativan, and no follow-up after the Ativan had been administered.

The surveyor informed the administrative staff of the above finding on 4/21/16 at 4:20 p.m. The surveyor requested the facility policy on anxiolytic medications.

The surveyor reviewed the facility policy titled "Anxiolytics" on 4/22/16. The policy read in part "Residents receive anxiolytic medications only when medically necessary. Every effort is made to ensure that residents who use anxiolytics receive the intended benefit of the medications and the potential for unwanted effects is minimized. Procedure 1. The reason for the medication is documented in the resident's medical record and included in the care planning for the resident. 3. Monitoring: When anxiolytic therapy is initiated, the resident is monitored to determine the effectiveness of the medication and the presence of adverse effects. C. Non-pharmacologic behavioral modification activities and their effects, as well as the effect of pharmacologic behavior modifiers, are addressed in nursing notes in the resident ' s chart and in the resident care planning. These records are reviewed by the physician in the process of assessing the resident ' s response to therapy. 5. Anxiolytic medications ordered on a "prn" basis are administered only at the request of the resident or, if nursing judgement indicates it is warranted, in the case of a non-communicative resident or other situation where its use is in the resident's best interest."

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No further information was provided prior to the exit conference on 4/22/16.

3. The facility staff failed to provide non-pharmacological interventions for anxiety for Resident #1.

The clinical record of Resident #1 was reviewed 4/19/16 through 4/22/16. Resident #1 was admitted to the facility on 5/15/14 and readmitted on 12/1/14 with diagnoses that included, but not limited to anemia, high blood pressure, dementia, anxiety, depression, asthma, and osteoarthritis. Resident #1 most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 02/22/16. 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. In section N she was coded to have received antianxiety medication.

The March and April 2016 physician order sheet read in part "Xanax tablet 0.5 mg (milligram) (Alprazolam) Give 1 tablet by mouth every 24 hours as needed for anxiety."

The March and April 2016 medication administration records were reviewed. Resident #1 was administered Xanax 0.5 mg on Wednesday 3/23/16 and on Monday 4/18/16 for anxiety.

The current comprehensive care plan initiated 12/31/15 read "Resident #1 receives psychotropic medication for anxiety and depression; at risk for side effects." Interventions "Administer psychotropic medication as ordered. -Observe for increase s/s (signs/symptoms) of depression and

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F 329	Continued From page 67 anxiety. Notify physician as needed." The current comprehensive care plan did not include any non-pharmacological interventions prior to the use of Xanax. The progress notes for March and April did not have any documentation related to the administration of the xanax. There were no non-pharmacological interventions prior to the administration of the Xanax documented. The surveyor informed the administrative staff of the above finding on 4/22/16 at 10:00 a.m. The surveyor reviewed the facility policy titled "Anxiolytics" on 4/22/16. The policy read in part "Residents receive anxiolytic medications only when medically necessary. Every effort is made to ensure that residents who use anxiolytics receive the intended benefit of the medications and the potential for unwanted effects is minimized. Procedure 1. The reason for the medication is documented in the resident's medical record and included in the care planning for the resident. 3. Monitoring: When anxiolytic therapy is initiated, the resident is monitored to determine the effectiveness of the medication and the presence of adverse effects. C. Non-pharmacologic behavioral modification activities and their effects, as well as the effect of pharmacologic behavior modifiers, are addressed in nursing notes in the resident's chart and in the resident care planning. These records are reviewed by the physician in the process of assessing the resident's response to therapy. 5. Anxiolytic medications ordered on a "prn" basis are administered only at the request of the resident or, if nursing judgement indicates it is	F 329		

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F 329	Continued From page 68 warranted, in the case of a non-communicative resident or other situation where its use is in the resident's best interest." No further information was provided to the surveyor prior to the 4/22/16 exit related to the non- pharmacological interventions. 4. The facility staff failed to use non-pharmacological interventions prior to the administration of Ativan for Resident #9. Resident #9 was readmitted to the facility on 5/27/15 with the following diagnoses of, but not limited to heart failure, coronary artery disease, diabetes, high blood pressure, anxiety, depression, high cholesterol and muscle weakness. On the annual MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/22/16, Resident #9 was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. The resident was also coded as requiring the extensive assistance of 1 or more staff members for dressing, toilet use, personal hygiene and bathing. During the review of the April 2016, Medication Administration Record of Resident #9, the surveyor noted that the resident was given "Ativan 0.5 mg (milligram) Give 1 tablet by mouth every 24 hours as needed for anxiety " on 4/13/16 at 1702 (5:02 pm). The resident was given the scheduled, "Ativan 0.5 mg (milligram) Give 1 tablet by mouth two times a day " at 8 am and 8 pm on 4/13/16 as ordered by the physician. The surveyor reviewed the nurses' notes of Resident #9 for 4/13/16 and there were no non-pharmacological interventions documented as being used before the administration of the "prn" (as needed) Ativan dose on this date at	F 329		

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F 329	Continued From page 69 1702. The surveyor also reviewed the most recent updated care plan dated for 2/26/16 on Resident #9 on 4/19/16. The care plan listed " Anxiety " as one of the focus areas with the following interventions to be followed, " Administer psychotropic medications and sleep medication as ordered. Observe for an increase in symptoms of or complaints of anxiety ...Observe for side effects related to psychotropic medications ...and report to the physician as needed. Physician and Pharmacy consultants as needed to review medications regularly ... " There were no non-pharmacological interventions noted on the care plan as well. On 4/19/16 at the end of the day conference, the administrator and director of nursing were notified of the above documented findings. The surveyor asked the director of nursing what non-pharmacological interventions were used by the staff prior to the administration of the " prn " Ativan that was given to Resident #9 on 4/13/16 at 1702. The director of nursing stated, " I 'll have to review the notes myself and get back to you about this. " No further information was provided to the surveyor prior to the exit conference on 4/22/16. 5. The facility staff failed to use non-pharmacological interventions prior to the administration of Ativan for Resident #7. Resident #7 was readmitted to the facility on 11/17/15 with the following diagnoses of, but not limited to high blood pressure, dementia, anxiety, osteoarthritis and transient ischemic attack. The resident was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/15/16 as having a BIMS (Brief Interview for Mental Status) score of 0 out of a possible score of 15. Resident	F 329		

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F 329	Continued From page 70 #7 was also coded as requiring extensive assistance of 1 staff member with bed mobility, toilet use and personal hygiene. During the review of the April 2016, Medication Administration Record of Resident #7, the surveyor noted that the resident was given " Ativan 0.5 mg (milligram) Give 1 tablet by mouth every 6 hours as needed for anxiety " . The resident was given the Ativan on the following dates and times, as documented on the MAR, " 4/6/16 at 1931 (7:31 pm), 4/7/16 at 2046 (8:46 pm), 4/9/16 at 1609 (4:09 pm), 4/10/16 at 2024 (8:24 pm), 4/13/16 at 2014 (8:14 pm), 4/14/16 at 2035 (8:35 pm), 4/15/16 at 2045 (8:45 pm) and 4/18/16 at 1900 (7 pm). " The surveyor reviewed the nurses ' notes of Resident #7 for the above documented dates and times that the Ativan was given. There were no non-pharmacological interventions documented as being used before the administration of the " prn " (as needed) Ativan dose on these dates and times by the staff. On 4/20/16 at the end of the day conference, the administrator and director of nursing were notified of the above documented findings. The surveyor asked the director of nursing what non-pharmacological interventions were used by the staff prior to the administration of the " prn " Ativan that was given to Resident #9 on above documented dates and times. The director of nursing stated, " I ' ll have to review the notes myself and get back to you about this. " No further information was provided to the surveyor prior to the exit conference on 4/22/16.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332	1. No negative outcome identified for resident #21, #22, #23 when medication was administered without food. No negative	

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F 332	Continued From page 71 medication error rates of five percent or greater. 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 a medication error rate of less than 5%. There were 7 errors out of 33 opportunities for a medication error rate of 21.21% that affected 4 of 26 residents (Resident #21, Resident #22, Resident #23, and Resident #8). The findings included: 1. The facility staff failed to administer Resident #21's medication with meals. Resident #21 was administered Metformin 1000 mg (milligram) without food. R.N. #1 failed to administer Metformin per the manufacturer ' s instructions to administer with food. The surveyor observed a medication pass and pour observation with registered nurse #1 on 4/19/16 at 4:18 p.m. R.N. #1 prepared four (4) medications for Resident #21 on 4/19/16. Medications administered at 4:25 p.m. were: Metformin 1000mg, Glimperide 2 mg tablet, Prilosec 40 mg, and Midodrine 2.5 mg. The medications were administered with a cup of water. The surveyor reconciled the medications administered with the physician's signed orders for April 2016. The surveyor requested the manufacturer's product information from the director of nursing on 4/20/16 at 10:10 a.m. The manufacturer's product information for Metformin, received from the facility's contract pharmacist, read in part "For treatment of type 2 diabetes mellitus - for monotherapy or for use in	F 332	outcome was identified for resident #8 when residents eye was not held shut after administration of eye drops or when Voltaren gel was not applied per physician orders. No negative outcome identified for resident #6 when resident was not instructed to blow nose prior to administration of Nasacort. 2. Any resident is at risk of medications are not administered per physicians order 3. DON or designee will educate licensed nursing staff regarding following physicians orders when administering medications. 4. Unit Manager or designee will randomly observe 5 nurses medication passes weekly x12 weeks to ensure that medications are administered per physician order. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 332	Continued From page 72 combination with an insulin secretogue (e.g., sulfonylurea) or insulin: Oral dose (regular-release tablets or oral solution): Adults: Initially, 500 mg (milligrams) po (by mouth) twice daily or 850 mg po once daily, given with meals." The evening meal on the skilled unit had not been served by 4:25 p.m. on 4/19/16. R.N. #1 stated in an interview on 4/20/16 that the package labeling had not been read. The package the medications were removed from read to administer Metformin with food. The surveyor interviewed other #4 (one of the facility's contract pharmacist) on 4/20/16 at 10:03 a.m. Other #4 stated the manufacturer's recommendations state "Give with food." The surveyor informed the administrative staff of the med error during the medication observation on 4/19/16 and 4/20/16 on 4/20/16 at 5:50 p.m. Resident #21 was admitted to the facility 3/29/16 with diagnoses that included but not limited to systolic heart failure, diabetes mellitus type 2, hypertension, atrial fibrillation, gastroesophageal reflux disease, and chronic kidney disease Stage 3. No further information was provided prior to the exit conference on 4/22/16. 2. The facility staff failed to administer Resident #22's medication with meals. Resident #22 was administered Metformin 1000 mg (milligram) without food. R.N. #1 failed to administer Metformin per the manufacturer ' s instructions to administer with food. The surveyor observed a medication pass and pour observation with registered nurse #1 on 4/19/16 at 4:28 p.m. R.N. #1 prepared one (1) medication for Resident #22 on 4/19/16 and performed an accucheck. The medication was administered at 4:32 p.m. The medication was administered with a cup of water.	F 332		

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The surveyor reconciled the medications administered with the physician's signed orders for April 2016. The surveyor requested the manufacturer's product information from the director of nursing on 4/20/16 at 10:10 a.m.
The manufacturer's product information for Metformin, received from the facility's contract pharmacist, read in part "For treatment of type 2 diabetes mellitus · for monotherapy or for use in combination with an insulin secretogue (e.g., sulfonylurea) or insulin: Oral dose (regular-release tablets or oral solution): Adults: Initially, 500 mg (milligrams) po (by mouth) twice daily or 850 mg po once daily, given with meals."
The evening meal on the skilled unit had not been served by 4:32 p.m. on 4/19/16.
R.N. #1 stated in an interview on 4/20/16 that the package labeling had not been read. The package the medications were removed from read to administer Metformin with food.
The surveyor interviewed other #4 (one of the facility's contract pharmacist) on 4/20/16 at 10:03 a.m. Other #4 stated the manufacturer ' s recommendations state "Give with food."
The surveyor informed the administrative staff of the med error during the medication observation on 4/19/16 and 4/20/16 on 4/20/16 at 5:50 p.m.
Resident #22 was admitted to the facility 4/11/16 with diagnoses that included but not limited to muscle weakness, lack of coordination, diabetes mellitus, hypertension, hyperlipidemia, constipation, and hypothyroidism. Resident #22's admission minimum data set (MDS) assessment had not yet been completed.
No further information was provided prior to the exit conference on 4/22/16.
3. The facility staff failed to administer Resident #23's with meals. Resident #23 was administered Metformin 1000 mg (milligram)

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without food. R.N. #2 failed to administer Metformin per the manufacturer ' s instructions to administer with food.
The surveyor observed a medication pass and pour observation with registered nurse #2 on 4/19/16 at 4:40 p.m. R.N. #2 prepared three (3) medications for Resident #23. The medications were Metformin 500 mg, Vitamin D3 1000 units, and Glimperide 2 mg. The medication was administered at 4:48 p.m. The medication was administered with a cup of water.
The surveyor reconciled the medications administered with the physician's signed orders for April 2016. The surveyor requested the manufacturer's product information from the director of nursing on 4/20/16 at 10:10 a.m.
The manufacturer's product information for Metformin, received from the facility ' s contract pharmacist, read in part "For treatment of type 2 diabetes mellitus · for monotherapy or for use in combination with an insulin secretogue (e.g., sulfonylurea) or insulin: Oral dose (regular-release tablets or oral solution): Adults: Initially, 500 mg (milligrams) po (by mouth) twice daily or 850 mg po once daily, given with meals."
The evening meal on the skilled unit had not been served by 4:40 p.m. on 4/19/16.
R.N. #2 was not available for an interview on 4/20/16.
The surveyor interviewed other #4 (one of the facility ' s contract pharmacist) on 4/20/16 at 10:03 a.m. Other #4 stated the manufacturer ' s recommendations state "Give with food."
The surveyor informed the administrative staff of the med error during the medication observation on 4/19/16 and 4/20/16 on 4/20/16 at 5:50 p.m.
Resident #23 was admitted to the facility 2/18/16 with diagnoses that included but not limited to muscle weakness, diabetes mellitus,

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F 332	Continued From page 75 hypertension, hyperlipidemia, and hypothyroidism. No further information was provided prior to the exit conference on 4/22/16. 4. (a) The facility staff failed to instruct Resident #8 in the use of Nasacort nasal spray. (b) The facility staff failed to compress the tear duct after eye drops were administered for one minute or to keep the eyelids gently closed for three minutes to Resident #8. (c) The facility staff failed to apply Voltaren gel to the physician ordered location for Resident #8. (d) The facility staff failed to administer physician ordered Ocean Nasal Spray to Resident #8. The surveyor observed a medication pass and pour observation with licensed practical nurse #6 on 4/20/16 beginning at 8:10 a.m. L.P.N. #6 prepared the following medications for Resident #8: Escitalopram 10 mg (Lexapro), Nitrofurantoin 50 mg, Tamsulosin (Flomax) 0.4 mg, Metoprolol 25 mg, Ativan 0.5 mg, Levemir flex pen 35 units, Nasacort nasal spray, Sodium Chloride ophthalmic (hypertonic) eye drops (Muro 128) 5%, and Voltaren gel 1%. L.P.N. #6 administered the medications to Resident #8 at 8:28 a.m. L.P.N. #6 administered 2 sprays of the Nasacort nasal spray into each of Resident #8 ' s nostrils. Prior to the administration of the Nasacort, L.P.N. #6 failed to instruct Resident #8 to blow her nose as recommended from the manufacturer's recommendations. The manufacturer's recommendations for Nasacort nasal spray, requested from the director of nursing 4/20/16, read in part "Patient Instructions for Use: Using the Spray: 6. Gently blow your nose to clear it, if needed." L.P.N. #6 failed to instruct Resident #8 to blow the nose prior to the use of Nasacort.	F 332		

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(b) The facility staff failed to compress the tear duct after eye drops were administered for one minute or instructed Resident #8 to keep her eyelids closed for three minutes.
L.P.N. #6 applied one (1) drop of Sodium Chloride ophthalmic (hypertonic) eye drops (Muro 128) 5% to each of Resident #8's eyes. After the eye drops had been administered to Resident #8, L.P.N. #6 took a tissue and dabbed the corners of each eye near the tear duct briefly. L.P.N. #6 failed to press the tear duct for 1 minute after the medications were administered or instruct Resident #8 to keep eyes closed for approximately three minutes.
Information provided by the facility's contract pharmacist received 4/22/16 read "If the medication has the potential to produce systemic effects, gentle pressure should be applied to the nasolacrimal duct for 30-60 seconds."
The following information was obtained from the State Operations Manual and read under medication administration: "Eye Contact: The eye drop, but not the dropper, must make full contact with the conjunctival sac and then be washed over the eye when the resident closes the eyelid; and Sufficient Contact Time: The eye drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes. (It should be encouraged that when the procedures are possible, systemic effects of eye medications can be reduced by pressing the tear duct for one minute after eye drop administration or by gentle eye closing for approximately three minutes after the administration.)"

(c) The facility staff failed to apply Voltaren gel to the physician ordered location for Resident #8.

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During the medication pass and pour observation with licensed practical nurse #6 on 4/20/16 at 8:10 a.m., L.P.N. #6 asked Resident #8 where she wanted the Voltaren Gel applied. Resident #8 stated left knee. L.P.N. #6 applied Voltaren gel 1% to Resident #8 ' s left knee and both elbows.

The surveyor reconciled the medications administered with the signed April 2016 physician orders. Resident #8's physician orders read for Voltaren: "Voltaren Gel 1% Apply 1 application transdermally two times a day to elbows. Administer 2 grn (grams) topically to elbows bid (twice a day) and Voltaren Gel 1%-Apply 1 application transdermally two times a day for pain Apply to right leg."

Voltaren Gel 1% was applied to the left knee and not the right leg during the medication pass.

The surveyor interviewed licensed practical nurse #6 when the medication pass had been completed at 9:35 a.m. She reviewed the order and stated she would let the physician know and get the order clarified.

(d) The facility staff failed to administer Ocean Nasal Spray to Resident #8 on 4/20/16 during the medication pass and pour observation.

During the reconciliation of the medications administered with the medications ordered, the surveyor identified a physician order for nasal spray that read " Ocean Ultra saline Mist Solution (Nasal Moisturizer Combination) 2 spray in both nostrils three times a day related to Allergic Rhinitis) Start date 1/20/2016. "

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F 332	Continued From page 78 L.P.N. #6 failed to administer the Ocean Nasal Spray during the medication pass and pour when the surveyor observed. The surveyor interviewed L.P.N. #6 on 4/20/16 at 9:35 a.m. L.P.N. #6 stated she realized she didn't give them, went back and gave them after the surveyor left. The surveyor did not observe L.P.N. #6 administer the ocean nasal spray during the medication pass and pour. The surveyor informed the administrative staff of the medication pass and pour concerns during the end of the day meeting on 4/20/16 at 5:50 p.m. The surveyor requested the facility policy on medication administration. The policy titled "General Guidelines for Medication Administration" read in part: "4. Open the medication administration book/eMAR to the appropriate resident and note the first medication to administer. The nurse is responsible for noting: a. Any changes on the Medication Administration record (MAR). 5. Read the label three times before preparing the medication. If the medication is discontinued or outdated, remove medication for proper disposal." No further information was provided prior to the exit conference on 4/22/16.	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	1. The air vents in the kitchen were cleaned on 4-20-16. Boxes and	

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F 371	Continued From page 79 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and a facility document review, the facility's staff failed to store, prepare and serve food in a safe and sanitary manner in the kitchen and on 3 of 3 units in the pantry refrigerators. The findings include: 1. The initial tour of the kitchen was conducted on 4/19/16 at 10:10 am. The dietary manager gave a tour of the kitchen. Upon entrance it was noted that the ceiling air vents were very dusty. The refrigerators and freezers were then observed. In the walk-in-freezer boxes with food in them were sitting on the floor. The walk in refrigerator had a carton of milk sitting under one of the shelves on the floor. Multiple pans were observed on a rack. The dietary manager stated that the pans were on a storage rack. The pans were stacked one on another. The surveyor asked the dietary manager to pick up the individual pans from the stack as she did water ran from inside and off the pans. Also observed at the end of the food preparation	F 371	carton of milk on freezer floor were removed on 4-19-16. The pan that was wet was removed from the clean dishes and placed back for cleaning on 4-19-16. The trash can at the end of the tray line had a lid placed on it on 4-19-16. Expired hotdog buns were removed on 4-19-16. The refrigerators that were identified as dirty were cleaned on 4-20-16. Applesauce that was not labeled was removed from the refrigerator on 4-20-16. 2. Any resident is at risk if food is not cooked and stored in a sanitary manner. Dietary manager audited refrigerators in the center to ensure they are clean and food prepared by the kitchen is labeled with its contents. 3. Dietary manager or designee to educate dietary staff on center policy for food storage, clean dish storage, and sanitation practices in the kitchen. 4. Administrator or designee to inspect the kitchen weekly x12 weeks to ensure that food is labeled and stored properly, clean dishes are stored properly, and proper sanitation is being practiced. Dietary manager or designee to audit common area refrigerators daily (M-F) x4 weeks, then weekly x8 weeks to	

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F 371	Continued From page 80 table was a large black trash can without a lid. The dietary manager took the surveyor to the dry storage area. Lying on the floor was paper and an individual package of crackers. There were no dates listed on the powdered cake icing, turkey gravy mix or brownie mix. The surveyor asked how the rotation of the dry food was done without a date. She said as the supplies came in they were rotated back to front. However, there were no dates to determine if this process was being followed by the staff. It was also noted on the bread rack there were 2 packages of hot dog buns that had expired dates of use on them. On 4/20/16 at 11:25 am, the surveyor returned to the kitchen and asked the cook to check the tray line temperatures. The temperatures on the tray line were maintained at 140 degrees and greater. However, the cook leaned the food thermometer against the wall of the pan that contained pork chops and quickly removed it as the surveyor stepped closer to the tray line. As the cook served the food on to the plates she let the gravy ladle touch the pork chops and she used the ladle to mash the potatoes down and then poured the gravy over the top. The surveyor also noted that the cook spilled gravy into a bowl of corn sitting on a plate then using her gloved hand wiped the gravy off the dish edge. The bowl still had gravy mixed in the corn. The surveyor informed the dietary manager who had the bowl replaced. On 4/21/16 at 4:20 pm, the administrator, director of nurse and other administrative staff were informed of the issues and concerns found in the kitchen. The surveyor reviewed the facility policy titled	F 371	ensure refrigerators are clean and the food placed in them is labeled properly. . Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings 5. 06-02-16	

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"Food and Supply Storage" on 4/21/16. The policy read in part "Food and supplies will be stored under sanitary and secure conditions according to approved State and Federal standards. Procedure 1. Food service products will be placed in appropriate storage areas that have been designated for each product. All storage areas should be well-lit, well ventilated, clean, dry and organized. Appropriate temperatures must be maintained. Attachment a Food and Supply Storage Guidelines for Leftovers 1. Leftovers must be labeled, dated, and stored in NSF (National Sanitation Foundation) approved containers, zip lock bags or wrapped in plastic wrap. They can be frozen or refrigerated."

Prior to exit on 4/22/16 the surveyor was not provided further information related to the above issues.

2. The facility staff failed to ensure food delivered from the kitchen to the "Resident Designated Refrigerators" was labeled and the refrigerators in all three designated "resident refrigerators" were clean.

The surveyor observed the refrigerator in the "The Parlor" on 4/19/16 at 3:40 p.m. The surveyor noted an accumulation of liquids on the bottom shelves just above the pull-out drawers. The surveyor toured the facility with the maintenance director on 4/20/16 beginning at10:33 a.m. "The Parlor"s resident designated refrigerator was checked. The surveyor observed fourteen (14) covered bowls of food. The bowls were dated but none contained a label that identified the contents of the bowl. The cover on the bowls was not clear; therefore, the contents of the bowls could not be seen. The surveyor also observed an accumulation of liquids in the same

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F 371	Continued From page 82 area on the bottom shelf of the refrigerator. The surveyor and maintenance director observed the "Resident Designated Refrigerator" in the Twelve Oaks day room. The refrigerator also contained twelve (12) bowls of covered food but no label on the bowls. The cover on the bowls was not clear; therefore, the contents of the bowls could not be seen. The surveyor and the maintenance director observed the refrigerator in the rehab unit designated for the residents. The refrigerator had an accumulation of liquids on the bottom of the shelf. The surveyor asked the maintenance director which department was responsible for cleaning the refrigerator. The maintenance director stated "dietary." The surveyor interviewed the dietary manager (other #5) on 4/20/16 at 2:00 p.m. The dietary manager stated staff were to label and date food items that came from the kitchen. The dietary manager stated the refrigerators were cleaned daily. The dietary manager stated the residents often spilled food and drinks when they got them out of the refrigerator. The surveyor asked for the dietary policy on labeling and dating food items and the cleaning of the refrigerators. The surveyor reviewed the facility policy titled "Food and Supply Storage" on 4/21/16. The policy read in part "Food and supplies will be stored under sanitary and secure conditions according to approved State and Federal standards. Procedure 1. Food service products will be placed in appropriate storage areas that have been designated for each product. All storage areas should be well-lit, well ventilated, clean, dry and organized. Appropriate temperatures must be maintained. Attachment A Food and Supply Storage Guidelines for	F 371		

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F 371	Continued From page 83 Leftovers 1. Leftovers must be labeled, dated, and stored in NSF (National Sanitation Foundation) approved containers, zip lock bags or wrapped in plastic wrap. They can be frozen or refrigerated." The surveyor informed the administrative staff of the above findings on 4/21/16 at 4:20 p.m. No further information was provided prior to the exit conference on 4/22/16.	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the physician visited at least every 30 days for the first 90 days as required for 1 of 26 residents (Resident #4). The findings included: The facility staff failed to ensure Resident #4 was seen by the physician every 30 days for the first 90 days as required. The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without	F 387	1. Resident #4's missed physician visit was in March, unable to correct. No negative outcome identified. 2. Any resident is at risk of not seen by the physician every 30 days for the first 90 days as required. DON or designees to audit current patients as of May 16th to ensure patients have been seen every 30 days for the first 90 days. 3. DON or designee to educate licensed nursing staff and medical records on patients needing to be seen by a physician every 30 days for the first 90 days. 4. Medical records or designee to audit new admissions monthly x3 months to ensure patients are seen by physician every 30 days for first 90 days. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance	

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F 387	Continued From page 84 complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. Resident #4 was assessed to understand others usually and was understood. Resident #4 was assessed to have no behaviors in Section E. Resident #4's pain assessment revealed no scheduled pain medication regimen, did not receive any prn (whenever necessary) medications and did not receive any non-medication interventions for pain. Resident #4 frequently had pain during the look back period. Resident #4 rated his pain level as 8 out of 10. The surveyor reviewed Resident #4's physician progress notes. Resident #4 was seen by the physician on 12/28/15, 12/31/15, 1/8/16, and 1/29/16. The next physician progress note was 3/21/16. The surveyor discussed the progress note visits with the minimum data set nurse (L.P.N. #2) on 4/20/16 at 3:30 p.m. L.P.N. #2 reviewed the progress notes and stated she would research the concern. She stated when Resident #4 was no longer skilled, the progress notes were not done every 30 days. "I can't believe he wasn't seen. The doctors are in here all the time." The surveyor informed the administrative staff of the above finding on 4/22/16 prior to the exit conference on 4/22/16. No further information was provided prior to the exit conference on 4/22/16.	F 387	committee for review and further analysis of findings. 5. 06-02-16	

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F 425 F 425 SS=E	Continued From page 85 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to dispose of expired medications and laboratory tubes on 2 of 2 units. The findings included: The surveyor toured the Dogwood unit with the assistant director of nursing (ADON) on 4/19/16 at 10:00 a.m. Upon completion of the resident rooms, the surveyor checked the medication room on the Dogwood unit with the ADON. The surveyor observed the following: • Four (4) purple top laboratory tubes with an	F 425 F 425	1. Expired medications, open insulin pens that were not dated, and laboratory tubes were discarded on 4-19-16 2. Any patient is at risk of expired meds and laboratory tubes are not discarded properly and timely. DON or designee to audit medication rooms and carts to ensure that there are no expired medications, opened insulin pens with no date, or laboratory tubes. 3. DON or designee to educate licensed nursing staff regarding proper disposal of expired medications and laboratory tubes promptly after they expire and dating insulin pens when they have been opened. 4. Unit Manager or designee to audit medication rooms and carts weekly x12 weeks to ensure there are no expired medications or laboratory tubes and that insulin pens have been dated once opened. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 425	Continued From page 86 expiration date of 12/15 - Two (2) green top laboratory tubes with an expiration date of 1/16 The contents of the refrigerator observed included the following: - One vial of opened Influenza vaccine dated 11/13/15 - Unsampled resident #1--2 IV (intravenous) bags of Cefazolin 2 GM (gram) with an expiration date of 3/11/16 - Vancomyin 50 powder for Resident #6 with an expired date of 3/13/16 The surveyor observed the medication carts on the Dogwood unit. The following concerns were identified: - Levemir insulin dated 3/4/16 - Resident #8's Novolog 100 unit/1 milliliter insulin vial-dated 3/5/16 - Lantus insulin vial/box/package-No date when opened - Lantus solostar 100 units-No date when opened on vial /box/package - Humalog insulin-No date when opened on vial/box/package - Novolog 100 units dated 3/3/16 - Resident #4's Novolog insulin 100 units/1 ml-dated 3/7/16 - Five insulin pens [Novolog, Humalog, Levemir (x2) and Lantus]-No dates when opened The assistant director of nursing stated the insulin vials should be dated when opened and stated Levemir and Lantus when opened could be used for 42 days. The ADON stated Humalog and Novolog when opened could be used for 28 days. She stated the insulins should be discarded.	F 425		

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F 425	Continued From page 87	F 425		

The surveyor observed the medication room on the Magnolia unit with the unit manager registered nurse #5 on 4/19/16 at 11:35 a.m. The following issues were observed:

- Vancomycin 1 GM (gram) with expiration date of 4/14/16
- Gabapentin 250 mg (milligram) / 5 ml (milliliter) bottle No date when opened

The unit manager registered nurse #5 stated she tried to check the refrigerator for expired medications every day.

The surveyor informed the administrative staff of the above concerns and requested the facility policy on medication storage on 4/20/16 at 5:50 p.m.

The surveyor reviewed the facility policy titled "General Guidelines for Medication Storage" on 4/20/16. The policy read in part "Policy The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members authorized to administer medications. Procedure 11. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the Pharmacy, if replacements are needed."

A second facility policy titled "Discontinuation and Disposal of Controlled Substances C11-V" read "Procedure 6. Nursing staff is responsible for removing all discontinued medications from the cart and/or storage areas."

Special Expiration Dating Requirements: Insulin

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F 425	Continued From page 88 · Humalog-When opened, 28 days · Lantus-When opened, 28 days · Levemir-When opened, 42 days · Novolog-When opened, 28 days Special Expiration Dating Requirements: Misc (miscellaneous) · Multidose vials with preservative-30 days after opening Guidelines to follow with these items: 1. The date of opening should be documented on the container/vial 2. If the date of opening is not documented or cannot be determined, the date dispensed may be considered the date after opening for stability purposes. No further information was provided prior to the exit conference on 4/22/16.	F 425		
F 431 SS=E	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.	F 431	1. Ointment was removed from bedside on 4-19-16. The Voltaren gel was re-ordered from the pharmacy so the correct instructions were on the medication. Refrigerator on Dogwood and Magnolia had locked boxes that could not be removed from the refrigerator placed in them for the storage of narcotics. 2. Any resident is at risk if ointments are left at the bedside. Unit Manager or designee to audit patient rooms to ensure no medicated ointments are at the bedside. Any resident is at risk if	

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F 431	Continued From page 89 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 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, and facility document review the facility staff failed to ensure safe and secure storage of medication and failed to provide separately locked, permanently affixed compartments for storage of controlled drugs on 2 of 2 units. The facility staff also failed to ensure the medication label was accurate with correct instructions for application. 1. The facility staff failed to store a medication (Calmoseptine Ointment) in a safe and secure area for Resident #3. The findings included: Resident #3 was admitted to the facility on 2/21/16 with the following diagnoses of, but not limited to heart failure, high blood pressure, arthritis, depression, asthma, respiratory failure, muscle weakness, difficulty in walking and	F 431	their Volteran gel does not have the proper instructions on the label. Unit Manager or designee to audit patients on Volteran gel to ensure that proper instructions are on the label. Any patient is at risk if narcotics are not secured properly. Unit manager or designee to audit medication room refrigerators to ensure that narcotics are secured in lock boxes properly. 3. DON or designee to educate licensed staff on keeping medicated ointment in their medication cart, on ensuring Volteran Gel has the proper instructions on the label, and that narcotics are secured properly per center policy. 4. Unit Manager or designee to audit 10 patient rooms daily (M-F) x4 weeks, then weekly x8 weeks to ensure medicated ointments are not left at the bedside. Unit Manager or designee to audit patients on Volteran gel weekly x12 weeks to ensure proper instructions are on the label. Unit Manager or designee to audit medication rooms daily (M-F) x4 weeks then weekly x8 weeks to ensure that	

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F 431	Continued From page 90 shortness of breath. The resident was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/28/16 as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance from one staff person for dressing, personal hygiene and bathing. During the initial tour of the facility on 4/19 /16 at 10:20 am, the surveyor observed that a tube of " Calmoseptine Ointment " was in the resident ' s bathroom laying on the counter beside the sink. The Unit 2 Manager was with the surveyor on initial tour when this was observed. The surveyor asked if this was the proper place for this ointment to be kept. The Unit 2 Manager stated, " No, it really shouldn ' t be in here. It should be locked up with the other medications for this resident. " The Unit Manager took the tube of ointment out to the medication cart and placed it in the resident ' s bin with the other medications for this resident. The administrator and director of nursing were notified of the above documented findings on 4/20/16 at the end of the day conference. The director of nursing was asked by the surveyor where storage medications or ointments should be kept for the residents. The corporate wound care nurse stated, " If the ointment was a barrier cream, then it can be kept at the bedside. " The surveyor asked the corporate wound care nurse to let the surveyor know if the cream was a barrier or medicated cream. On 4/21/16 at the end of the day conference, the corporate wound care nurse stated to the surveyor when asked, that the ointment found in the bathroom on initial tour was considered a medicated ointment and should have been locked	F 431	narcotics are secured per center policy. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 431	Continued From page 91	F 431		

up with the resident ' s other medications.
No further information was provided to the surveyor prior to the exit conference on 4/22/16.

2. The facility staff failed to ensure the medication label on Resident #8's Voltaren gel was
accurate with correct instructions for application. The surveyor observed a medication pass and pour observation with licensed practical nurse #6 on 4/20/16 beginning at 8:10 a.m. L.P.N. #6 prepared the following medications for Resident #8: Escitalopram 10 mg (Lexapro), Nitrofurantoin 50 mg, Tamsulosin (Flomax) 0.4 mg, Metoprolol 25 mg, Ativan 0.5 mg, Levemir flex pen 35 units, Nasacort nasal spray, Sodium Chloride ophthalmic (hypertonic) eye drops (Muro 128) 5%, and Voltaren gel 1%.
During the medication pass and pour observation with licensed practical nurse #6 on 4/20/16 at 8:10 a.m., L.P.N. #6 asked Resident #8 where she wanted the Voltaren Gel applied. Resident #8 stated left knee. L.P.N. #6 applied Voltaren Gel 1% to Resident #8's left knee and both elbows.

The surveyor reconciled the medications administered with the signed April 2016 physician orders. Resident #8's physician orders read for Voltaren: "Voltaren Gel 1% Apply 1 application transdermally two times a day to elbows. Administer 2 gm (grams) topically to elbows bid (twice a day) and Voltaren Gel 1% Apply 1 application transdermally two times a day for pain Apply to right leg."

Voltaren Gel 1% was applied to the left knee and not the right leg during the medication pass.

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F 431	Continued From page 92 The surveyor interviewed licensed practical nurse #6 when the medication pass had been completed at 9:35 a.m. The surveyor and licensed practical nurse #6 reviewed the label on the Voltaren Gel package. The label read "Resident #8's name, Voltaren Gel 1%, physician's name, resident's room number, DEA (drug enforcement agency number) account number, and with the following instructions for use: Apply topically to right leg and right knee two times a day." The label did not include instructions to apply to the elbows. She reviewed the order and stated she would let the physician know and get the order clarified. The surveyor informed the administrative staff of the above concern with medication labeling in the end of the day meeting on 4/20/16 at 5:50 p.m. The surveyor requested the facility policy on medication labeling. The policy titled "Medication Labeling" read in part "Policy Remedi labels medications dispensed in accordance with State and Federal regulations. Procedure 1. Resident medications will have at least the following information printed on the package or label in accordance with State and Federal regulations. o. Directions as required by regulation. 2. When appropriate, cautionary or warning information will be printed or added by auxiliary sticker. 6. Any item improperly labeled, sealed, damaged, or appearing to be tampered with or soiled should be rejected and the pharmacy should be notified immediately. 7. The nurse verifies the direction and administers medication based on the Medication	F 431		

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Administration Record: a. If directions are printed on the label and the directions change to a dose that can be administered from the existing supply, the nurse will affix an auxiliary sticker to the product indicating "See MAR" or comparable to indicate that directions have changed."

No further information was provided prior to the exit conference on 4/22/16.

3. The facility failed to provide separately locked, permanently affixed compartments for storage of controlled drugs on 2 of 2 units.

During the initial tour of both of the facility's resident units, the surveyor observed both medication rooms.

The surveyor observed the medication room on the Dogwood unit with the assistant director of nursing on 4/19/16 at 10:00 a.m. The surveyor observed a locked refrigerator. The locked refrigerator contained three (3) vials of Ativan injectable (2 mg/1 ml) in a plastic bag, 8 syringes of AHBR gel (Ativan, Haldol, Benadryl, and Reglan) for an unsampled resident , six (6) syringes of AHBR gel for an unsampled resident, and sixteen (16) syringes of Ativan gel 1 mg/1 ml for an unsampled resident. The refrigerator was not securely attached to the floor and was able to be moved. The controlled medications were not locked in a separate compartment.

The surveyor observed the medication room on the Magnolia unit with the unit manager registered nurse #5 on 4/19/16 at 11:35 a.m. The refrigerator contained a separately locked narcotic box; however, the shelf the medication box was attached to could be removed from the

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F 431	Continued From page 94 refrigerator. The surveyor informed the administrative staff of the above finding on 4/20/16 at 5:50 p.m. and requested the facility policy on medication storage. The policy titled "General Guidelines for Medication Storage" read in part "Policy The medication supply is accessible only to licensed personnel, pharmacy personnel or staff members authorized to administer. Procedure 7. Schedule II medications are stored in a separate, permanently affixed area and are double lock. Schedule III-V (3-5) medications may be stored along with non-controlled drugs, but may be under more strict storage controls at the Facility's discretion." No further information was provided prior to the exit conference on 4/22/16.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	1. Infection control log has been updated to reflect if infection was community acquired or facility acquired, identify of the organism/culture results, or if the infection has been resolved or is ongoing. The nurse who failed to clean the bell of her stethoscope prior to obtaining a blood pressure was educated on proper cleaning of equipment. The nurse who failed to clean the	

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F 441	Continued From page 95 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure an effective infection control program regarding surveillance documentation; failed to follow infection control guidelines for 2 of 26 Residents (Resident #8 and Resident #22); and failed to ensure each of the three ice machines in the dayrooms in the facility were maintained in a manner which promoted infection control practices. The ice machines in each of the resident ' s dayrooms did not have proper air gaps. The findings included:	F 441	glucometer before and after use was educated on proper cleaning of equipment. The ice machines were fixed to have the proper air gaps. 2. Any resident is at risk if infections are not logged and tracked properly. DON to audit May infection control log to ensure infections are being tracked and logged properly. Any patient is at risk if staff do not clean equipment properly before and/or after use. Any resident is at risk if ice machines do not have proper air gaps in them. Maintenance director to check facility ice machines to ensure proper air gaps. 3. DON or designee to educate infection control nurse on properly logging and tracking infections. DON or designee to educate nursing staff on proper cleaning of equipment before and/or after use. Administrator or designee to educate Maintenance Director on ensuring ice machines have proper air gap in them. 4. DON or designee to audit infection control log monthly x3 months to ensure infections are logged and tracked properly. Unit Manager or designee to audit 5	

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F 441	Continued From page 96 1. During the entrance conference on 4/19/16, the surveyor requested the infection control line list (tracking form for facility infections) for the past year from the administrator. When the infection control line listing was provided to the surveyor by the director of nurses (DON) and the infection control registered nurse, the form was incomplete. The infection control line listing form titled Residents Illness Log did not provide information if the infection was community acquired or facility acquired, the identity of the organism/culture results or if the infection had been resolved or was ongoing. The surveyor requested the facility infection control policy from the DON on 4/20/16. The surveyor interviewed the DON and the infection control registered nurse on 4/22/16. The infection control nurse informed the surveyor on how the documentation was done. The surveyor showed the DON and the infection control nurse their tracking form and pointed out the form did not provide information if the infection was community acquired or facility acquired, the identity of the organism/culture results or if the infection had been resolved or was ongoing. The surveyor informed the administrator, the director of nursing and other administration staff above finding on 4/22/16 at 10:20 a.m. The facility provided the following policy and procedure titled Infection control Program that read in part: The facility has developed and infection control program that provides a safe, sanitary, and comfortable environment to help prevent/ control the development and transmission of infection and/or outbreaks. The program emphasizes the prevention and management of infections including oversight for establishing goals and priorities with strategies to achieve the goals through monitoring and	F 441	staff members randomly using equipment weekly x12 weeks to ensure equipment is cleaned before and/or after use. Maintenance director or designee to audit ice machines monthly x3 months to ensure proper air gaps. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings 5. 06-02-16	

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responding to identified problems or issues including the interdisciplinary team ' s infection control practices.
No further information was provided prior to the exit conference on 4/22/16.
2. The facility staff failed to follow infection control guidelines during a medication pass and pour observation that affected Resident #8. The licensed practical nurse failed to clean the bell of the stethoscope prior to obtaining the blood pressure of Resident #8 and failed to clean the bell of the stethoscope after taking the blood pressure of Resident #8.
The surveyor observed a medication pass and pour observation with licensed practical nurse #6 on 4/20/16 beginning at 8:10 a.m. L.P.N. #6 prepared the following medications for Resident #8: Escitalopram 10 mg (Lexapro), Nitrofurantoin 50 mg, Tamsulosin (Flomax) 0.4 mg, Metoprolol 25 mg, Ativan 0.5 mg, Levemir flex pen 35 units, Nasacort nasal spray, Sodium Chloride ophthalmic (hypertonic) eye drops (Muro 128) 5%, and Voltaren gel 1%.
After licensed practical nurse #6 prepared Resident #8's medication, she stated she needed to check the blood pressure. She checked the medication cart but was unable to locate the stethoscope. She locked the medication cart and walked toward the nurse ' s station. L.P.N. #6 returned with a stethoscope and proceeded to check resident #8 ' s blood pressure. L.P.N. #6 informed the surveyor of the blood pressure result and proceeded to administer Resident #8's medications.
L.P.N. #6 did not clean the bell of the stethoscope before it was used on resident #8 or after the blood pressure had been taken.
The surveyor discussed the above issue with the director of nursing and the assistant director of

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nursing on 4/21/16 at 1:30 p.m. The director of nursing stated she would expect staff to clean the stethoscope after use. She would expect anything that touches a resident to be cleaned.
The surveyor requested the facility policy on cleaning equipment on 4/21/16.
No further information was provided prior to the exit conference on 4/22/16.

3. The facility staff failed to clean the glucometer before and after use during a medication pass and pour observation on 4/19/16 that affected Resident #22.
The surveyor observed a medication pass and pour observation with registered nurse #1 on 4/19/16 at 4:28 p.m. R.N. #1 prepared one (1) medication for Resident #22 on 4/19/16 and performed an accucheck. The medication was administered at 4:32 p.m. The medication was administered with a cup of water.
The surveyor removed the community accucheck and performed an accucheck on Resident #22. When R.N. #1 returned to the medication cart, the glucometer was cleaned with an alcohol pad and placed back in the medication drawer. The glucometer was not cleaned before use with a disinfectant.
The surveyor informed the administrative staff of the above finding and requested the manufacturer's product information for cleaning the glucometer in the end of the day meeting on 4/20/16 at 5:50 p.m. The infection control nurse/assistant director of nursing was asked how she would expect the glucometer to be cleaned. She stated "Use disinfectant wipes in between residents -before and after each resident." The surveyor requested the facility policy on cleaning glucometers.
The manufacturer's user instruction manual for the blood glucose monitoring system named

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GLUCOCARD ® Vital TM was reviewed 4/21/16. The product information titled "Caring for your GLUCOCARD ® Vital TM Blood Glucose Meter" read: "Cleaning the Meter The GLUCOCARD ® Vital TM Blood Glucose Meter is a precise instrument. Please handle with care. Clean the outside of the meter with a damp cloth only. Dirt, dust, blood, control solution, or water entering the meter could cause damage. Your GLUCOCARD ® Vital TM Blood Glucose Meter should not need decontamination as no blood or control solution should come into contact with the meter if the instructions are followed correctly."

The surveyor interviewed the director of nursing and the assistant director of nursing/Infection Control nurse on 4/21/16 at 1:15 p.m. The surveyor asked about the policy on cleaning the glucometer. The ADON stated the glucometers used between patients needed to be cleaned in between the residents-before and after use with alcohol or disinfectant towelettes. The glucometers then would be stored in the medication cart. The ADON stated the facility would follow the CDC (Centers for Disease Control) guidelines.

The surveyor reviewed the Infection Control Program policy on 4/21/16. The policy read in part "The program develops and implements appropriate infection control policies and procedures and the training of staff that reflects the current Centers for Disease Control (CDC) Guidelines." The surveyor reviewed the facility policy titled "Blood Glucose Monitoring, Fingerstick " on 4/22/16. The policy read in part "12. Cleanse glucometer monitor between residents by wiping off outside case with alcohol wipe."

The CDC guidelines accessed 4/21/16 read in part "Blood Glucose Meters Blood glucose

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meters are devices that measure blood glucose levels. Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. A simple rule for safe care: If shared, blood glucose meters should be cleaned and disinfected after every use."

Resident #22 was admitted to the facility 4/11/16 with diagnoses that included but not limited to muscle weakness, lack of coordination, diabetes mellitus, hypertension, hyperlipidemia, constipation, and hypothyroidism. Resident #22's admission minimum data set (MDS) assessment had not yet been completed.

No further information was provided prior to the exit conference on 4/22/16.

4. The facility staff failed to ensure each of the three ice machines in the dayrooms in the facility were maintained in a manner which promoted infection control practices. The ice machines in each of the resident ' s dayrooms did not have proper air gaps.

The surveyor and the maintenance director toured the facility on 4/20/16 at 10:33 a.m. Each day room contained an ice machine. The pipe that drained the ice machine (potable water line) was observed to be in close proximity to the waste line pipe. This did not allow for an air gap between the ice machine drainage pipe and the main drainage system.

The surveyor asked the maintenance director if there was a back-up in the waste line, what the circumstances might be for contamination of the

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F 441	Continued From page 101 ice machine-the potential for the water to flow backwards possibly mixing and contaminating the drinking water/ice machine. The maintenance director stated the potential would be a concern. The maintenance director stated he could adjust the length of the pipe and correct the problem identified. At the time of the surveyor, the three ice machines were functioning and providing ice to the residents. US Food and Drug Administration accessed at www.fda.gov <http://www.fda.gov> described air gaps as: An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). The surveyor informed the administrative staff of the above finding on 4/20/16 at 5:50 p.m. No further information was provided prior to the exit conference on 4/22/16.	F 441		
F 504 SS=E	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician 's order prior to obtaining the laboratory test for 4 of 26 residents, Residents #11, #12, #4 #14.	F 504	1. Labs for resident #11, #12, #4, and #14 had already been obtained. No negative outcome identified. 2. Any resident is at risk if a lab is obtained without a physician's order. DON or designee to audit labs for current residents obtained as of May 16th to ensure physicians order in place prior to obtaining lab. Any resident is at risk if a lab is not drawn timely per physicians order. DON or designee to audit	

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F 504	Continued From page 102 The finding included: 1. For Resident #11 the facility staff failed to obtain physicians orders for laboratory test: a complete blood count (CBC). Resident #11 was admitted to the facility 6/25/15 with diagnoses that included but not limited to dementia, high blood pressure, heart failure, seizure disorder, and esophageal reflux disorder. A review of Resident #11's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 2/8/16, the facility staff assessed the resident to understand and to be understood. She was assessed to have a cognitive summary score of 15. Resident #11's clinical record was reviewed 4/20/16 and revealed the results of a CBC done on 10/8/15. However, the surveyor could not locate a corresponding order. On 4/20/16 at 2:15pm the assistant director of nurses was asked to assist in locating the orders for the labs. On 4/21/16 at 3:15pm, the assistant director of nurses informed the survey team she did not have the order. On 4/21/16 at approximately 4:20 pm, the administrative staff was made aware of the CBC obtained without an order. Prior to exit no further information was provided related to the lab test CBC without an order. 2. The facility staff failed to obtain a laboratory testing in a timely manner as ordered by the physician for Resident #2. Resident #2 was readmitted to the facility on	F 504	current residents labs obtained as of May 16th to ensure labs obtained timely per physician order. 3. DON or designee to educate licensed nursing staff the need to obtain a physician's order prior to obtaining a lab and on obtaining labs timely per physician order. 4. Unit Manager or designee to audit labs that are obtained daily (M-F) x4 weeks and weekly x8 weeks to ensure physicians order was obtained prior to obtaining the lab and that labs are obtained timely per physician order. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	

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F 504	Continued From page 103 2/20/16 with the following diagnoses of, but not limited to diabetes, dementia, enlarged prostrate, chronic obstructive pulmonary disease, major depressive disorder, anemia and heart failure. On the resident ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 3/17/16, Resident #2 was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene. Resident #2 is totally dependent on staff for bathing. During the clinical record review, the surveyor noted that Resident #2 had the following physician " Draw a Gent (Gentamycin, which is an antibiotic) peak 1 hour after the fourth dose at 0600 (6 am) on 11/4/15. Draw a Gent trough 30 minutes before fourth dose at 0430 (4:30 am) on 11/4/15. " The results for a Gent peak and trough for 11/4/15 could not be found in the clinical record. However, the surveyor noted laboratory results, that were found in the clinical record, for the above documented physician order with a date of 11/5/15. On 4/21/16, the assistant director of nursing (ADON) was asked by the surveyor to find the results of the above documented physician order for 11/4/15. The ADON stated, " I found results for these labs dated for 11/5/15 instead of 11/4/15. They were drawn on 11/5/15 instead of 11/4/15. " The administrator and director of nursing were notified of the above documented findings on 4/21/16 in the end of the day conference. No further information was provided to the surveyor prior to the exit conference on 4/22/16. 3. The facility staff failed to obtain a physician order prior to obtaining a BMP (basic metabolic	F 504		

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panel) on 3/21/16 for Resident #4.
The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, and sacral ulcer and right lateral foot ulcer.
Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500.
The surveyor found the results of a BMP obtained 3/21/16 in the electronic clinical record. The surveyor reviewed the physician orders for March 2016 but was unable to locate the physician order.
The surveyor informed the director of nursing and registered nurse #3 of the BMP obtained 3/21/16 and that the surveyor was unable to locate the physician order for the 3/21/16 lab test on 4/20/16 at 4:00 p.m. The director of nursing stated the BMP obtained was requested by the pharmacy when Resident #4 received Gentamycin.
The director of nursing stated to the surveyor on 4/22/16 at 8:03 a.m. that the staff was unable to locate the physician order for the BMP obtained on 3/21/16.
No further information was provided prior to the exit conference on 4/22/16.
4. The facility staff failed to obtain a physician order prior to obtaining a urinalysis and a urine bilirubin on 4/18/16 for Resident #14.
Resident #14's clinical record was reviewed 4/21/16 through 4/22/16. Resident #14 was

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F 504	Continued From page 105 admitted to the facility 3/24/14 and readmitted 7/17/15 with diagnoses that included but not limited to osteoarthritis, hypertension, hyperlipidemia, depression, anxiety, anemia, gastroesophageal reflux disease, enlarged prostate, insomnia, and spondylosis. Resident #14's significant change in MDS assessment with an assessment reference date (ARD) of 7/29/15 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Summary Score. The surveyor reviewed the miscellaneous section of the electronic clinical record. The clinical record revealed the results of a urinalysis and a urine bilirubin obtained 4/18/16. The surveyor reviewed the April 2016 physician orders but was unable to locate physician orders for the two aforementioned laboratory tests. The surveyor requested the assistance of the assistant director of nursing on 4/22/16 at 8:20 a.m. The ADON stated when urinalyses are obtained and the tube has no sex or birthday, the lab will automatically do a urine bilirubin to determine the sex of the resident. ADON stated "The nurse documented Resident #14 was having burning upon urination in the progress note of 4/18/16. The nurse needed to write the order for the urinalysis. The nurse took the order from the routine standing orders." No further information was provided prior to the exit conference on 4/22/16.	F 504		
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	F 507	1. Lab result placed in resident #2's chart on 4/21/16 2. Any resident is at risk if lab results are not in the clinical record. DON or designee to audit labs obtained for current patients as of May 16th to ensure lab results are in the clinical record	

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F 507	Continued From page 106 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that a laboratory test result was available in the clinical record (Resident #2). The findings included: Resident #2 was readmitted to the facility on 2/20/16 with the following diagnoses of, but not limited to diabetes, dementia, enlarged prostrate, chronic obstructive pulmonary disease, major depressive disorder, anemia and heart failure. On the resident ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 3/17/16, Resident #2 was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene. Resident #2 is totally dependent on staff for bathing. During the clinical record review on 4/20/16, the surveyor noted the following physicians ' order dated for 4/8/16 which stated " ...INR recheck 4/11/16. " The surveyor could not find the results of this laboratory testing in the clinical record. On 4/21/16 at 8:05 am, the assistant director of nursing (ADON) was asked to find the results of the above ordered INR on Resident #2. The ADON stated, " It should be in the nurses ' notes or on the MAR (Medication Administration Record). " The ADON could not find the results in either of these two places in the clinical record. The ADON stated " it may be in the unit ' s Coumadin Review Log ". At 8:15 am, the ADON provided the surveyor a copy of the Coumadin Review Log that was on	F 507	3. DON or designee to educate licensed nursing staff and medical records to ensure that lab results are placed in the clinical record. 4. Unit Manager or designee to audit patient labs daily x4 weeks, then weekly x8 weeks to ensure that lab results are filed in the clinical record. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review. 5. 06-02-16	

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F 507	Continued From page 107 the nursing unit for Resident #2. On this log, there was no INR result for 4/11/16. However, there was noted by the surveyor, a notation that stated " 4 mg re (with check mark) 4/15/16. " The ADON stated " it was in the log book but not in the nurses ' notes or on the MAR for April. " The administrator and director of nursing were notified of the above documented findings on 4/21/16 in the end of the day conference. No further information was provided to the surveyor prior to the exit conference on 4/22/16.	F 507		
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure physician ordered diagnostic studies were maintained in the clinical record for 1 of 26 residents (Resident #4). The findings included: The facility staff failed to ensure that the results of a physician ordered Doppler study was contained in the clinical record for Resident #4. The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right	F 513	1. Diagnostic study result placed in resident #4's chart on 4/21/16 2. Any resident is at risk if diagnostic study results are not in the clinical record. DON or designee to audit diagnostic studies completed for current patients as of May 16th to ensure study results are in the clinical record 3. DON or designee to educate licensed nursing staff and medical records to ensure that diagnostic study results are placed in the clinical record. 4. Unit Manager or designee to audit patient diagnostic study results daily (M-F) x4 weeks, then weekly x8 weeks to ensure that lab results are filed in the clinical record. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review. 5. 06-02-16	

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F 513	Continued From page 108 lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. The clinical record revealed a signed physician order dated 1/6/16 that read "Doppler of left arm-r/o (rule out) DVT (deep vein thrombosis), CBC (complete blood count), BMP (basic metabolic panel), BNP (B-type natriuretic peptide) in am (morning)." The surveyor reviewed the electronic medical record and was unable to locate the results of the Doppler. The physician visit progress note dated 1/8/16 read in part "Doppler of left arm was negative for DVT." The surveyor informed the administrative staff of the above concern on 4/21/16 at 4:20 p.m. On 4/22/16, the surveyor was provided the results of the Doppler study done 1/6/16. The assistant director of nursing stated the report wasn ' t found in the chart. No further information was provided prior to the exit conference on 4/22/16.	F 513		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	1. Resident # 11's bowel movements that were not documented were from March, unable to correct in medical record. No negative outcome identified. Resident #10's progress notes were corrected and wrong note removed from the chart by the nurse on 4/21/16. Resident #4's missing output documentation was from February and was unable to be	

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F 514	Continued From page 109 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 6 out of 27 Resident's (Residents # 11, #10, #4. #6,# 2 and # 7). 1. The facility staff failed to maintain accurate documentation to indicate that facility staff was monitoring Resident #11 ' s bowel movements. Resident #11 was admitted to the facility 6/25/15 with diagnoses that included but not limited to dementia, high blood pressure, heart failure, seizure disorder, and esophageal reflux disorder. A review of Resident #11's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 2/8/16, the facility staff assessed the resident to understand and to be understood. She was assessed to have a cognitive summary score of 15. Resident #11 was interviewed on 4/22/16; she was asked how often her bowels moved. Resident #11 said, "About every few days." Further review of the resident's clinical record revealed her physician's orders showed she had scheduled Colace 1 capsule 100 mg (milligram) twice a day as a stool softener. The facility standing orders read as follows: Constipation or	F 514	corrected. No negative outcome identified. Resident #6's missing O2 sat documentation was from March and was unable to be corrected. No negative outcome identified. Resident # 3's missing intake and output documentation was from February and was unable to be corrected. No negative outcome identified. Resident #3's missing behavior monitoring was from March and April and was unable to be corrected, no negative outcome identified. Resident # 7's falls that did not have proper documentation occurred in January and February and was unable to be corrected. No negative outcome identified. 2. Any resident is at risk if bowel movements are not documented in the clinical record. DON or designee to audit current patients as of May 16th to ensure bowel movements documented in medical record. Any resident is at risk if the wrong progress note is placed in his or her medical record. DON or designee to audit current patients as of May 16th to ensure correct progress notes are in patient charts. Any resident is at risk if output is not documented in the medical	

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F 514	Continued From page 110 no BM (bowel movement) for 3 days. Give 30 ml (milliliters) MOM (milk of magnesia) by mouth, x 1 dose; if no results Dulcolax rectal suppository x 1 dose check for presence of stool in rectum. Remove manually if indicated. If no results in 8 hours give fleets enema x1 enema. If no results, notify MD for further orders. The surveyor did not find documentation in the clinical record to show if the resident had bowel movements. The surveyor asked the unit manager if there was documentation in the clinical record for bowel movements. She said " the CNA's document in the electronic clinical record and showed the surveyors the area of documentation for all ADL (activity of daily living). Review of the ADL (activity of daily living) work sheets for the dates 3/5/16 through 3/12/16, showed no BM documentation. For the dates 3/21/16 through 3/25/16 there was no documentation related to BM ' s. The following dates 3/30/16 through 4/5/16 showed no related documentation for BM's. The absence of documentation to indicate that the facility staff were monitoring and treating concerns related to Resident #11's bowel function was discussed with the facility's administrator and director of nursing. During an end of the day meeting with the administrative staff they were notified that Resident #11 did not have a documented BM for extended periods in March and April 2016. The survey team requested the facility policy/procedure on documentation in regards to BM's.	F 514	record. DON or designee to audit current patients as of May 16th with output monitoring to ensure output is documented in the chart. Any resident is at risk if O2 sats are not documented in the medical record. DON or designee to audit current patients as of May 16th on oxygen to ensure O2 sats documented in the medical record. Any resident is at risk if intake and output is not documented in the medical record. DON or designee to audit current patients as of May 16th with intake and output monitoring to ensure intake and output is documented in the medical record. Any resident at risk if behavior monitoring is not documented in the medical record. DON or designee to audit current patients as of May 16th with behavior monitoring to ensure behavior monitoring is documented in the medical record. Any resident is at risk if falls are not properly documented in the chart. DON or designee will audit current patients as of May 16th who have had falls in the last 30 days to ensure proper falls	

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F 514	Continued From page 111 The policy and procedure read as follows in part: 1. Bowel movement activity/inactivity is to be documented each shift in the CCR software program by the CNA ' s. 2. When a resident does not have a bowel movement, during the shift it is documented in the CCR software program that one did not occur. Prior to exit on 4/22/16, no further information was provided to the survey team. 2. The facility staff failed to ensure Resident #10's progress notes were accurate in the clinical record. The clinical record of Resident #10 was reviewed 4/19/16 through 4/22/16. Resident #10 was admitted to the facility 4/3/15 and readmitted 4/9/16 with diagnoses that included but not limited to hypertension, status post pacemaker insertion, chronic kidney disease, atrial fibrillation, hyperlipidemia, osteoarthritis, diabetes mellitus type II, and hypothyroidism. Resident #10's significant change in MDS (minimum data set) assessment with an assessment reference date (ARD) of 8/17/15 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Summary Score. Section J Health Conditions assessed that Resident #10 received scheduled pain medication, received prn (whenever needed) pain medications or was offered and declined, and did not receive any non-medication interventions for pain. The progress note of 4/21/2016 01:55 (1:55 a.m.) read "Resident is resting in bed with eyes closed. Took all meds as ordered. Fluids offered often and accepted. Has tried to walk while sitting at the desk with staff. We encourage him to stay seated and remind him of the fall he had that	F 514	documentation is in the medical record. 3. DON or designee to educate licensed staff on proper documentation of bowel movements, progress notes, output, O2 sats, intake and output, behavior monitoring, and falls. 4. Unit Manager or designee to audit 10 patients daily (M-F) x4 weeks then weekly x8 weeks to ensure bowl movements are documented properly, progress notes, output, O2 sats, intake and output, behavior monitoring, and falls are documented properly. Any discrepancies will be addressed promptly and findings will be reported to Quality. 5. 06-02-16	

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made him to have surgery. Lungs are clear and abd (abdomen) soft and non-tender. Call light is in reach."

The above note found in Resident #10's clinical record was information describing Resident #6.

The surveyor informed the assistant director of nursing of the above concern on 4/21/16 at 3:00 p.m. The ADON stated the nurse who wrote the note was the only person who can strike out the information. The ADON stated the information was password protected. She stated she would inform the nurse of the concern.

The surveyor interviewed licensed practical nurse #5 on 4/22/16 at 7:00 a.m. L.P.N. #6 stated the note was corrected. L.P.N. #5 stated she wrote the note on the correct resident when she was told the documentation was incorrect.

No further information was provided prior to the exit conference on 4/22/16.

3. The facility staff failed to ensure Resident #4's output was accurately documented in the clinical record.
The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right lateral foot ulcer.
Resident #4's significant change in assessment MDS with an assessment reference date (ARD)

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of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500.

The April 2016 physician orders were reviewed. Resident #4 had orders for urinary output every shift that started 12/21/15. The surveyor reviewed the electronic treatment administration record (eTAR) for February 2016. The eTARs contained "holes", times when there was no documentation that the ordered treatments had been completed.

The February 2016 eTAR had holes for the 7:00 p.m.-7:00 a.m. shift on 2/8/16.

The surveyor informed the administrative staff of the lack of documented output for Resident #4 on 2/8/16 on 4/21/16 at 4:20 p.m.

The director of nursing stated the staff will document on assignment sheets that are not part of the clinical record. The director of nursing provided the surveyor on 4/22/16 with the output total for 2/8/16. The surveyor asked if the worksheet was part of the clinical record and she responded no.

No further information was provided prior to the exit conference on 4/22/16.

4. The facility staff failed to ensure Resident #6's oxygen saturation levels were documented in the clinical record.
The clinical record of Resident #6 was reviewed 4/19/16 through 4/22/16. Resident #6 was admitted to the facility on 5/16/12 and readmitted 3/2/16 with diagnoses that included, but not limited to anxiety, depressive disorder, urinary retention, constipation, pain, hypothyroidism,

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dementia with behavioral disturbances, Parkinson's disease, diabetes mellitus type II, anemia, and enlarged prostate.
Resident #6's significant change in assessment MDS with an assessment reference date (ARD) of 3/10/16 coded the resident with a cognitive summary score of 04 out of 15 in Section C0500.

The April 2016 signed physician orders read "Apply O2 @ (at) 2L (liters) when O2 stats (sic) below 90% per standing order every shift for low O2. Start date 3/21/16."

The surveyor reviewed the "Weights and Vitals Summary Report" for March 2016 and April 2016 and the electronic medication administration records for March 2016 and April 2016. The surveyor was unable to locate oxygen saturation levels for 3/21/16, 3/22/16, and 3/23/16.

The surveyor requested the assistance of licensed practical nurse #3 on 4/21/16 at 9:15 a.m. for the results of the oxygen saturation levels for 3/21/16, 3/22/16, and 3/23/16.

The director of nursing was able to locate the oxygen saturation levels for 3/21/16, 3/22/16, and 3/23/16 7:00 a.m. to 7:00 p.m. shift.

The director of nursing stated on 4/21/16 at 11:00 a.m. that the facility staff were still looking for the O2 saturation levels for 3/21/16, 3/22/16, and 3/23/16 7:00 p.m. to 7:00 a.m. shift. The director of nursing stated the oxygen saturation levels for 3/22/16 and 3/23/16 were found on assignment sheets the staff use daily. The director-of nursing was asked if these were a part of the clinical record. She responded that the worksheets were not.

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No further oxygen saturation levels were provided prior to the exit conference on 4/22/16.

5. The facility staff failed to document Intake and Outputs in the clinical record of Resident #3. The facility staff failed to document the specific behavior that was being monitored in the clinical record of Resident #3.

5a. The facility staff failed to document Intake and Outputs in the clinical record for Resident #3. Resident #3 was admitted to the facility on 2/21/16 with the following diagnoses of, but not limited to heart failure, high blood pressure, arthritis, depression, asthma, respiratory failure, muscle weakness, difficulty in walking and shortness of breath. The resident was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/28/16 as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance from one staff person for dressing, personal hygiene and bathing.

During the clinical record review, the surveyor noted that on 2/25/16 7 am-7 pm shift there was no output documented on the resident ' s TAR (Treatment Administration Record). The physician ordered I&O (intake and outputs) each shift for the resident on 2/11/16 due to being placed on fluid restrictions.

The administrator and director of nursing were notified of the above documented findings on 4/21/16 in the end of the day conference.

No further information was provided to the surveyor prior to the exit conference on 4/22/16.

5b. The facility staff failed to document the specific behavior that was being monitored in

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the clinical record of Resident #3.

Resident #3 was admitted to the facility on 2/21/16 with the following diagnoses of, but not limited to heart failure, high blood pressure, arthritis, depression, asthma, respiratory failure, muscle weakness, difficulty in walking and shortness of breath. The resident was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/28/16 as having a BIMS (Brief interview for Mental Status) score of 15 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance from one staff person for dressing, personal hygiene and bathing.

During the clinical record review, the surveyor noted that on the March and April, 2016 MARs (Medication Administration Record) the following was left blank: " Behaviors- Monitor for the following: (specify) _____. "

The administrator and director of nursing were notified of the above documented findings on 4/20/16 in the end of the day conference.

The director of nursing was interviewed on 4/22/16 at 2 pm by the surveyor, and the surveyor asked the director of nursing what behavior was the staff supposed to be monitoring for the months of March and April 2016 on Resident #3. The director of nursing stated, " The blank there should be filled in with the specific behavior that we are monitoring. This one is left blank. "

No further information was provided to the surveyor prior to the exit conference on 4/22/16.

6. The facility staff failed to accurately document 2 falls in the nurses' note of Resident #7.

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Resident #7 was readmitted to the facility on 11/17/15 with the following diagnoses of, but not limited to high blood pressure, dementia, anxiety, osteoarthritis and transient ischemic attack. The resident was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/15/16 as having a BIMS (Brief Interview for Mental Status) score of 0 out of a possible score of 15. Resident #7 was also coded as requiring extensive assistance of 1 staff member with bed mobility, toilet use and personal hygiene.

During the clinical record review by the surveyor, the surveyor noted that Resident #7 had 3 falls since January, 2016. The surveyor asked the director of nursing to provide a copy of the Policy on Falls for the facility. The surveyor received this documentation from the director of nursing on 4/21/16 at approximately 2:30 pm. The policy titled " SAFETY FALLS-INITIAL STEPS TO FOLLOW IF A RESIDENT FALLS OR IS FOUND ON THE FLOOR " . Under the Section STEPS, it stated, " ...6. The fall must be documented thoroughly in the EMR (electronic medical record) system under Interdisciplinary Notes. Include all details of the fall, not just resident found on the floor or resident eased to the floor by the CNA (Certified Nursing Assistant). Also include the results of the full body assessment, not just not apparent injury .... "

A nurses' note dated and timed for 1/24/16 at 16:13 (4:13 pm) that was reviewed by the surveyor in the clinical record stated the following: " RSD (Resident) found on the floor after another RSD reported to the nurses desk about this incidence. CCP was called and made aware. MD (Medical Doctor) also made aware ... " Another nurses' note dated and timed for 2/15/16 vat 19:30 (7:30) pm was reviewed by the

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surveyor in the clinical record which stated " Resident found sitting in the floor beside her bed. Stated she was trying to get into the bed. No injuries noted. Denied any pain ... "

On 4/22/16 at approximately 2:30 pm, the director of nursing was notified of the above documented findings. The director of nursing reviewed the documentation and stated, " No, this documentation is not complete in what is supposed to be written in the nurses ' notes regarding a fall. It doesn ' t give you a clear picture of what happened to the resident. "

No further information was given to the surveyor prior to the exit conference on 4/22/16.

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F 000	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure inspection was conducted 4/19/16 through 4/22/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents 1 through 17 and 3 supplment 21-23) and 6 closed record reviews (Residents 18-20, and 24 through 26).

The submission of the Plan of Correction does not constitute agreement on the part of Radford Health & Rehab Center nor do the deficiencies cited within the report represents deficient practices on the part of the center and its staff. The plan represents our on-going pledge to provide quality care rendered in substantial compliance with regulatory requirements.

F 001 Non Compliance F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12 VAC 5-371-300. Pharmacy Services.
12 VAC 5-371-300 (J.3) Cross reference to F-431.

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

12 VAC 5-371-370. Physical Environment.
12 VAC 5-371-370 (b) Cross reference to F-456.
12 VAC 5-371-360. Clinical Records
12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514
12 VAC 5-371-340. Dietary Services.
12 VAC 5-371-340 (A) Cross reference to F-371.

12 VAC 5-371-220. Quality of Care.

12 VAC 5-371-300. Pharmacy services.
12 VAC 5-371-180 (ABC) Cross Reference to F-431, pages 89-91

12 VAC 5-371-180. Infection Control.
12 VAC 5-371-180 (A,B,C) Cross reference to F-441, see pages 95-97

12 VAC-5-371-370. Physical Environment
12 VAC 5-371-370 (b) Cross reference to 252, see pages page3-4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495355	A. BUILDING _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RADFORD HEALTH AND REHAB CENTER	700 RANDOLPH STREET RADFORD, VA 24141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 1	F 001		

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

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (B) Cross reference to F-329.
12 VAC 5-371-250. Resident assessment and care planning.
12 VAC 5-371-250 (F, H, I) Cross Reference to F-280

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

12 VAC 5-371-360. Clinical Records
12 VAC 5-371-360 (A,E, f, j) Cross Reference to F-514, see pages 109-112

12 VAC 5-371-340 Dietary Services
12 VAC 5-371-340 (A) Cross reference to F-371, see pages 79-81

12 VAC 5-371-220. Quality of Care
12 VAC 5-371-220 (A,B) Cross reference to F-328, see pages 56-57

12 VAC 5-371-220 Quality of Care
12-VAC-371-220 (B) Cross reference to F-329, see pages 59-60

12 VAC 5-371-250. Resident assessment and care planning.
12 VAC 5-371-250 (F,H,I) Cross Refernece to F-280, see pages 13-15

12 VAC-5-371-220. Quality of Care
12 VAC 5-371-220 (A THRU G) Cross reference to F-309, see pages 36-38