STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENT	3615 WEST MAIN STREET SALEM, VA 24153

(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 7/31/17 through 8/2/17. A 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 315 certified bed facility was 252 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Resident #1 through Resident #27) and 3 closed record reviews (Residents #29 through 30).	F 000		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to provide dignity during the dining room experience for 1 of 30 residents in the survey sample (Resident #5). The findings included: The facility staff failed to provide dignity to Resident #5 during breakfast on 8/1/17 and 8/2/17. Resident #5 was admitted to the facility on	F 241	F241 1. Resident #5 will be provided dignity during the dining room experience. 2. Residents who have had a unit transfer have the potential to be affected when the receiving unit does not have the tray available in the meal tray delivery cart. 3. a) Staff on 3W have been re-educated to provide dignity during the dining room experience by ensuring the trays are available and residents are served in a consecutive order.	9/16/17

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

Electronically Signed | 08/25/2017

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

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F 241	Continued From page 1 3/13/17 with the following diagnosis of, but not limited to high blood pressure, stroke, seizure disorder, muscle weakness and above the knee amputee. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/16/17 the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #5 also requires extensive assistance from 1 staff member for dressing, personal hygiene and bathing. The resident was also coded as requiring limited assistance with oversight and cueing by staff for eating. On 8/1/17 at 8:00 am on the 3rd floor dining room, Resident #5 self-propelled herself to this area for breakfast. This surveyor accompanied the resident to the dining area to make an observation of this resident eating breakfast. On the way to the dining area, Resident #5 had stated to the surveyor, "I hope my tray comes up this morning with the rest of them. They had to go looking for it last night and I didn't get it until 7 pm. I'm hungry this morning so I hope it's there." The resident went on to explain to the surveyor that she had recently been transferred to this floor from the 2nd floor and that was why the staff had said that her supper was late last night. Resident #5 wheeled herself to her table and began talking to the staff members and the other 2 ladies that were sitting at the table with her. At 8:05 am, a CNA brought a breakfast tray to the resident sitting to the left side of Resident #5 and began helping this resident setting up her tray and cutting up her breakfast for the resident. The resident began eating her breakfast as soon as the tray was properly set up for her. Resident #5 asked the CNA if she saw a tray with her name	F 241	b) When a resident is transferred to another unit, the Unit Secretary/designee will notify the kitchen staff by completing the relocation form and submitting to dietary. Nursing staff will complete a diet slip with the unit change and location for dining. The dietary staff will update dining location assignment in PCC to ensure the meal tray is delivered to the appropriate unit. c) UM/designee will complete an audit of residents, who have transferred to a new unit, to ensure dignity was provided in the dining room experience, every week for 4 weeks, every other week for 4 weeks and every month for 4 months. 4. Results of the observations will be reported to QA for review, analysis, and recommendations.	

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on it, and the CNA replied "It's not on this one. We will check the next cart that comes up from the kitchen and see if it's on that one."

Resident #5 stated to the CNA "I'm hungry when will they have the next cart up here." The CNA stated to the resident "It should be soon."
At 8:12 am, the resident sitting to the right side of Resident #5 received her breakfast tray and the CNA began helping this resident with her tray, setting it up for the resident and cutting up her waffle that she had for breakfast. This resident began eating her breakfast while Resident #5 watched the resident eat her breakfast. Resident #5 stated to the surveyor, "It looks like to me that they could find mine for me. I'm hungry and this is making me hungrier to watch the ladies eat."

The surveyor went to the unit manager on unit 3 at 8:15 am and notified her of the above documented observations. The surveyor asked if it was the practice of the facility to have residents at the same table not to be served their meals together. The unit manager stated "The residents at the same table are to be served at the same time or within reason so no one resident is eating in front of another resident that hasn't gotten their meal yet." The unit manager stated, "I will go myself and find out where the resident's tray is at and make sure she gets it."

At 8:20 am, the unit manager came to the surveyor and stated, "I had the CNA go and get the resident her breakfast."

On 8/2/17 at 8 am, the surveyor observed residents being brought into the day room on 3 west for breakfast. There were 14 residents and 2 CNAs present.

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At 8:05 am, the surveyor noted that the breakfast trays had not been arrived in the day room.

At 8:20 am, the surveyor observed breakfast trays arriving in the day room on 3 West. There were 3 more CNAs that came into the day room at this time to help pass out breakfast trays to the residents.

At 8:22 am, the resident sitting to the left of Resident #5 was served her breakfast tray, helped with the setup of her tray and the resident began eating breakfast.

At 8:25 am, the resident sitting directly across from Resident #5 received her breakfast tray with the CNA helping the resident set up her tray and the resident began eating her breakfast.

At 8:30 am, the second breakfast cart arrived on the 3 west day room. Resident #5 stated "I hope mine is in there. I'm hungry watching the others eat at the table." Resident #5 spotted her breakfast tray on the bottom shelf of the cart and asked the CNA "Can you hand me my tray that's on the bottom there." The CNA replied to the resident that she would in just a minute.

At 8:37 am, the resident sitting to the right of Resident #5 received her breakfast tray and the CANA assisted the resident with setting up her tray for breakfast. This resident began to eat her breakfast as soon as the tray had been set up for her.

At 8:39 am, Resident #5 received her breakfast tray and the CNA asked Resident #5 if she needed her to help her with getting her breakfast

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F 241	Continued From page 4 tray ready. The resident replied to the CNA, "I believe I can get this myself." On 8/2/17 at approximately 1 pm, the administrative team was notified of the above documented observations made by the surveyor concerning Resident #5's dining experiences for breakfast on 8/1 and 8/2/17. No further information was provided to the surveyor prior to the exit conference on 8/2/17.	F 241		
F 252 SS=E	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 252		9/16/17

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F 252	Continued From page 5 or theft. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to ensure a clean, comfortable and homelike environment on 3 of 9 units of the facility and 1 of 30 Residents in the sample survey, Resident #20. The Findings Included: 1. On August 1, 2017 at 2:45 p.m. the surveyor made an initial tour of the facility. The surveyor toured the 200 hallway. The surveyor noted that the doorways and crevices where the floor met with the wall were soiled with a blackish-gray debris. The surveyor also noted that the hallways at the elevators on the second floor, third floor and the fourth floor were dirty. The surveyor noted that the crevices on the floor where the floor meets the wall were soiled with a blackish-gray debris. On August 2, 2017 at 11:15 a.m. the surveyor made a tour of the facility with the Maintenance Director (MD) and Maintenance Supervisor (MS). The surveyor, MD and MS walked to the elevator and took the elevator up to the second floor. The surveyor, MD and MS stepped off the elevator and the surveyor pointed out that the crevices around the elevator were soiled with a blackish-gray debris. The surveyor, MD and MS then walked down to the 200 Unit and walked down the hallway. The surveyor pointed out that the crevices and door-ways were heavily soiled with a blackish-gray debris. The surveyor, MD and MS then took the elevator to the third floor. The surveyor, MD and MS stepped off the	F 252	F252 1. The 200 hall and the hallways at the elevators on the second floor, third floor and fourth floor were cleaned. Due to the 30 year old stone floors and on-going cleaning and waxing, the discolorations did not change. The blackish-gray debris was not dirt, therefore unable to remove. 2. Units that have the stone in the doorways and hallways, where the floor meets the wall, have the potential to be affected. 3. a)The doorways, corners, crevices and edging will continue to be swept, after each buffing, 3 times a week, with on-going daily mopping. b)Director of Housekeeping/Designee will audit the hallways on the 200 unit and the hallways off the elevators on second, third and fourth floors for soiled blackish-grayish debris, weekly for 4 weeks, every other week for 4 weeks and monthly for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations 2. 1. The potting soil from Resident #20's night stand drawer was cleaned immediately ensuring a clean homelike environment. 2. Resident who have plants with potting	

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F 252	Continued From page 6 elevator and the surveyor pointed out that the crevices in the hallway where the floor met the walls were heavily soiled with a blackish-gray debris. The surveyor, MD and MS then took the elevator up to the fourth floor. The surveyor, MD and MS stepped off the elevator and the surveyor pointed out that the crevices in the hallway where the floor met the walls were heavily soiled with a blackish-gray debris. On August 2, 2017 at 12:25 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), Director of Nursing (DON) and Assistant Director of Nursing (ADON). The surveyor informed the Administrative Team (AT) that the floors in the hallway of the 200 Unit and the hall-walls near the 2nd floor elevator, 3rd floor elevator and 4th floor elevator were heavily soiled with a blackish-gray debris. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a clean, comfortable and homelike environment. 2. Facility staff failed to provide a clean homelike environment for Resident #20. The resident's clinical record was reviewed on 8/1/17 at 1:30 PM. Resident #20 was admitted to the facility on 11/25/14. His diagnoses included Asperger's disease, hypertension, diabetes, depression and a history of cerebral vascular infarct (stroke) with resulting right-sided hemiplegia. His latest MDS, dated 5/19/17, coded the resident with moderately impaired cognitive ability. This resident was totally dependent on nursing staff members for all the ADLs (activities of daily	F 252	soil in their room have the potential to be affected. 3. a) Residents who have plants in their rooms will not have them placed on the night stand. b) Staff on 3E have been educated to ensure no plants are placed on the night stand. c) When housekeeping staff perform their daily room cleaning, rooms with plants will be audited to ensure there are no plants on the night stand, every week for 4 weeks, every other week for 4 weeks, and monthly for 4 months. 4. Results of audits will be reported to QA for review, analysis, and recommendations.	

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F 252	Continued From page 7 living). On 8/1/17 at 1:00 PM, the surveyor observed the resident's room. During this observation, the resident's night stand drawer was observed to be full of potting soil, which covered the personal toiletry items contained in the drawer. The drawer also contained a can of shaving creme with the resident's roommate's name on it. On 8/1/17 at 3:40 PM RN I was interviewed about the items in the drawer. She said the shaving cream did not belong in the drawer and thought the dirt had spilled out of his plants on top of the table & into the drawer. RN I stated, "We'll clean it up." The administrator was informed of this finding on 8/2/17 at 8:15 AM. No additional info was provided.	F 252		
F 272 SS=E	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 272		9/16/17

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F 272	Continued From page 8 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. 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 CAA (care area assessment) summary for 4 of 30 Residents, Residents #6, #12, #14, and #5. The findings included:	F 272	F272 1. The CAA (Care area assessment) summary for residents #6, #12, #14, and #5 have been reviewed and activities, social services, and MDS coordinators have been educated that the name and location of the CAA documentation must	

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F 272	Continued From page 9 1. For Resident #6 the facility staff failed to accurately name the date and location of the CAA documentation. Resident #6 was admitted to the facility on 02/05/13. Diagnoses included but not limited to Parkinson's disease, dementia, anxiety, melanoma of eyelid, and coronary artery disease. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 10/22/16 coded the Resident as 0 of 15 in section C, cognitive status. Section V, care area assessment, was reviewed. The facility staff had not identified the date and location of the CAA information used to determine the activities care plan. The only documentation was "see CAA worksheet dated 10/25/17". The CAA worksheet was reviewed and the information could not be located. The surveyor spoke with the MDS coordinator on 08/01/17 at approximately 1030 regarding the missing documentation. MDS coordinator stated that the activities person completed that section of the CAA. Surveyor spoke with the administrator regarding the missing CAA documentation and she stated that all staff completing the CAA summary had been educated on how to do them. The concern of the missing CAA documentation was discussed with the administrative team during a meeting on 08/01/17 at approximately 1600. No further information was provided prior to exit.	F 272	be present on the CAA worksheet 2. Residents with a comprehensive MDS and CAA completion have the potential to be affected. 3. a) The IDT team has been re-educated that a comprehensive assessment of a resident needs, strengths, goals, life history and preferences must be completed, using the (RAI), including documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS), ensuring accurately naming the date and location of the CAA documentation. b) The RN MDS coordinator, signing the CAA summary, will validate all sections of the CAA worksheet have the date and location of the CAA documentation documented. Any discrepancies will be immediately corrected prior to submission of the MDS. c) The MDS Director/designee will complete a random audit of 25% of completed CAA summary worksheets every week for 4 weeks, every other week for 4 weeks and every month for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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2. For Resident #12 the facility staff failed to accurately name the date and location of the CAA documentation.

Resident #12 was admitted to the facility on 04/15/16 and readmitted on 09/10/16. Diagnoses included but not limited to congestive heart failure, hyperlipidemia, dementia, anxiety, depression, coronary artery disease, gastroesophageal reflux disease, and end stage renal disease.

The most recent MDS with an ARD of 09/17/16 coded the Resident as 0 out of 15 in section C, cognitive status. Section V, care area assessment, was also reviewed. The facility staff had not indentified the date and location of the CAA information used to determin the cognitive, communication, psychosocial or activities care plans. The only documentation was "see CAA worksheet dated 09/19/16". The CAA worksheets were reviewed and the information could not be located.

The surveyor spoke with the administrator regarding the missing CAA documentation on 08/01/17 at approximately 1330. The administrator stated that there would be some re-education on completing this section of the MDS.

The concern of the missing CAA documentation was discussed with the administrative team during a meeting on 08/01/17 at approximately 1600. No further information was provided prior to exit.

3. The facility staff failed to ensure a complete Care Area Assessment (CAA) Summary for Resident #14.

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Resident #14 was admitted to the facility on 7/15/15 with diagnoses of diabetes, hypertension, dementia, stroke, insomnia, Vitamin D deficiency, psychosis, and gastro-esophageal reflux disease.

The annual Minimum Data Set (MDS) with a reference date of 6/16/17 assessed the resident with a cognitive score of "10" of "15". The resident was assessed requiring supervision to extensive assistance fro bed mobility, transfers, toileting, bathing, and hygiene.

The CAA summary was reviewed. The facility staff failed to identify the date and location for the information triggered for care planning for psychosocial well being, dental, and activities. The summary stated to see CAA worksheet and the CAA worksheet stated to see CAA worksheet.

One of the staff MDS coordinators (LPN#3) was interviewed on 8/1/17 at 3:40 p.m. regarding the missing information and she stated she had missed putting the information into the MDS.

The administrator , assistant administrator, director of nursing, and assistant director of nursing were informed of the findings during an end of the day meeting with the survey team on 8/1/17.

4. The facility staff failed to document the dates of when the documentation could be found in Resident #5's clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #5 was admitted to the facility on 3/13/17 with the following diagnosis of, but not limited to high blood pressure, stroke, seizure

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disorder, muscle weakness and above the knee amputee. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/16/17 the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #5 also requires extensive assistance from 1 staff member for dressing, personal hygiene and bathing.

During the clinical record review performed on by the surveyor on 8/1/17, the surveyor noted on the admission MDS with an ARD of 3/20/17 under Section V of the CAA Summary the following documentation was noted: Cognitive Loss/Dementia stated to see "social services assessment", Communication, ADL function and Urinary Incontinence stated to see "CAA WS (Worksheet) dated 3/24/17 ..."Behavioral Symptoms stated to see "social services assessment", Falls, Pressure Ulcer, Psychosocial Drug Use and Pain stated to see "CAA WS dated 3/24/17 ..." and Nutritional Status stated "AA WS dated 3/23/17.

The surveyor reviewed the CAA Worksheets for the areas documented above and the surveyor could not find dates or locations of where this information could be found.

On 8/1/17 at 2:55 pm, MDS #1 was notified of the above documented findings by the surveyor. MDS #1 stated to the surveyor, "I cannot find the documentation needed to support the CAA Section either. It did not include the dates or locations of where to find the supporting documentation."

At approximately 3:30 pm in the conference

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F 272	Continued From page 13 room, the administrative team was notified of the above documented findings by the surveyor. The administrator stated "This is something that we have worked on this past year and we thought we had addressed all of this with the staff." No further information was provided to the surveyor prior to the exit conference on 8/2/17.	F 272		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F 278		9/16/17

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F 278	Continued From page 14 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (Minimum Data Set) for 2 of 30 residents in the survey sample (Resident's #5 and #23). The findings included: 1. The facility staff failed to include the diagnosis of psychosis on the quarterly MDS for Resident #5. Resident #5 was admitted to the facility on 3/13/17 with the following diagnosis of, but not limited to high blood pressure, stroke, seizure disorder, muscle weakness and above the knee amputee. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/16/17 the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #5 also requires extensive assistance from 1 staff member for dressing, personal hygiene and bathing. During the clinical record review performed by the surveyor on 8/1/17, the surveyor noted on the June and July, 2017 MAR (Medication Administration Record) Resident #5 had the following medication ordered by the physician	F 278	F278 1. 1. Resident #5 MDS's was updated to include the diagnosis of psychosis. 2. Residents having a MDS completed, while receiving Seroquel due to an diagnosis of psychosis, have the potential to be affected, if the documentation is not present. Other residents with a diagnosis of psychosis and receiving Seroquel have an accurately coded MDS. 3. a) MDS staff have been re-educated that each MDS assessment must accurately reflect the residents status and include all active diagnosis during the 7 day look back period. b) The MDS Director/designee will complete a random audit of 25% of section I of the MDS for residents with a diagnosis of psychosis and receiving Seroquel every week for 4 weeks, every other week for 4 weeks and every month for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations. 2. 1. Resident # 23 refused his height and	

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F 278	Continued From page 15 which stated "Seroquel 50mg (milligram) Give 1 tablet by mouth at bedtime for psychosis." The surveyor reviewed the quarterly MDS and under Section I, Active Diagnosis, there was no documentation of the diagnosis of psychosis. At 2:55 pm, MDS #1 was notified of the above documented findings. MDS #1 reviewed the quarterly MDS along with the MARs for June and July and stated "That diagnosis should had been added to this quarterly MDS." At approximately 3:30 pm, the administrative team was notified of the above documented findings by the surveyor. On 8/2/17 at approximately 9 am, the director of nursing and administrator provided a copy of the "Diagnosis Report" to the surveyor and the administrator stated "After looking into this after our conference yesterday, we went and added the diagnosis of psychosis to this resident's diagnosis." No further information was provided to the surveyor prior to the exit conference on 8/2/17. 2. The facility staff failed to document Resident #23's height and weight on the admission MDS (Minimum Data Set). Resident #23 was admitted to the facility on 4/21/17 with the following diagnosis of arthritis, anemia, pneumonia, depression, muscle weakness, lack of coordination and dysphagia. On the admission MDS with an ARD (Assessment Reference Date) of 4/28/17 the resident was coded as having short term and long	F 278	weight be obtained and this was documented in the progress notes on 4/22, 4/24, 4/25 and 4/26, therefore resulting in the lack of documentation on the admission MDS. 2. Residents who refuse their admission height and weight to be obtained, have the potential to be affected. 3. a) Staff will continue to document in the clinical record resident refusals to have admission height and weight obtained and continued attempts for compliance. Dietary staff will notify the MDS Director when a dash is put on the MDS for height and weight. c) The MDS Director/designee will complete a random audit of 25% of completed MDS's for dashes on heights and weights, every week for 4 weeks, every other week for 4 weeks and every month for 4 months 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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F 278	Continued From page 16 term memory problems and being moderately impaired in daily decision making skills. Resident #23 also requires extensive assistance of 2 staff members for dressing, personal hygiene and bathing. During the clinical record review on 8/2/17 performed by the surveyor, it was noted on the admission MDS that the resident's height and weight was left blank. The surveyor reviewed the next MDS which was a quarterly review and the height and weight was documented. At approximately 1 pm, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 8/2/17.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that	F 279		9/16/17

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includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) 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 §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care

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F 279	Continued From page 18 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a Comprehensive Care for 1 30 residents in the survey sample. (Resident #5) The findings included: The facility staff failed to develop a care plan that addressed Resident #5's refusal of wound care. Resident #5 was admitted to the facility on 3/13/17 with the following diagnosis of, but not limited to high blood pressure, stroke, seizure disorder, muscle weakness and above the knee amputee. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/16/17 the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #5 also requires extensive assistance from 1 staff member for dressing, personal hygiene and bathing. During the clinical record review performed by the surveyor on 8/1/17, the following documentation was noted by the surveyor in the clinical record of Resident #5: "6/9/17 6:38 pm ...Talked to the resident about her dressing change that needed changed on this shift, she says, "No, it was just changed a short while ago ... 7/7/17 2:11 am Resident refused Silver Sulfadiazine Cream 1%...Rsd (Resident) stated "The other nurse did it earlier and you don't	F 279	F279 1. Resident #5 care plan was updated to include her refusals for wound care. 2. Residents refusing wound care have the potential to be affected if not care planned. No other residents have refused wound care treatments. 3. a) MDS/Licensed nursing staff have been re-educated that refusals of wound care must documented in the clinical record and added to the care plan. b) When refusals of wound care are noted during review of the 24 hour report, the UM/designee will update the care plan as indicated. d) UM/designee will complete a random 25% audit of the 24 hour reports, for refusals of wound care, then ensuring the care plan was updated, every week for 4 weeks, every other week for 4 weeks and every month for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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need to do it ...Rsd stated "No, I refuse, I don't want you to."

7/20/17 9:34 pm Rsd refused treatment to left buttock stating that the treatment was done after her bath this morning and that she didn't want to have it done again today.

7/14/17 9:18 pm Resident refused treatment of silvadene crème and dressing to buttocks. She stated that the old dressing was "sticking good" and she wanted it left alone ..."

The surveyor reviewed the care plan for Resident #5. There was no documentation in the resident's care plan concerning the resident's refusal of care.

On 8/1/17 at 2:55 pm the MDS (Minimum Data Set) nurse #1 was notified of the above documented findings. The MDS nurse #1 stated, "The resident's refusal of care has not been care planned." The surveyor asked MDS nurse #1 if this should had been care planned if the resident was refusing wound care and the MDS nurse #1 stated "Yes, it should be."

At 3:30 pm on 8/1/17, the administrative team was notified of the above documented findings by the surveyor.

On 8/2/17 at approximately 9 am, the director of nursing and administrator provided a copy of the care plan for Resident #5. The director of nursing stated "We included the refusal of care to the resident's care plan after we were made aware of it yesterday."

No further information was provided to the surveyor prior to the exit conference on 8/2/17.

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F 280	Continued From page 20	F 280		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 280		9/16/17

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(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary

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F 280	Continued From page 22 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, facility staff failed to review and revise 1 of 30 resident's CCP (comprehensive care plan) with fall prevention interventions and comfort measures as they were assessed. Findings: The facility staff failed to update Resident #20's fall prevention interventions and comfort measures as they were assessed. The resident's clinical record review was reviewed on 8/1/17 at 1:30 PM. Resident #20 was admitted to the facility on 11/25/14. His diagnoses included Asperger's disease, hypertension, diabetes, depression and a history of cerebral vascular infarct (stroke) with resulting right-sided hemiplegia (paralysis). His latest MDS, dated 5/19/17, coded the resident with moderately impaired cognitive ability. This resident was totally dependent on nursing staff members for all the ADLs (activities of daily living). The resident was coded as unable to reposition himself in his bed or chair and unable to ambulate, even with assistance. The latest CCP, updated on 5/12/17, included the problem, "At risk for falls/safety related to: History of recent falls, CVA with right sided hemiplegia...." The interventions included "Therapy eval for transfer. 2/3/17)	F 280	F280 1. Resident #20's care plan was revised to include fall prevention interventions and comfort measures by adding the FBL (full body lift) and pillow underneath the right hand, while OOB, to the care plan. 2. Residents who are a FBL and have comfort measures in place to have a pillow under the right hand, while OOB, have the potential to be affected. 3. a) Nursing staff have been re-educated that the Kardex (pocket care plan) interventions must also be on the care plan. b) At the care plan meetings the MDS coordinator will compare the care plan to the Kardex (pocket care plan) for accuracy. c) The MDS coordinator/designee will complete random audits of 25% of the Kardex (pocket care plans) to compare to the care plans to ensure the information is contained on both care plan tools, weekly for 4 weeks, every other week for 4 weeks and every month for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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F 280	Continued From page 23 The CCP also included the problem of "pressure ulcer/skin integrity" and documented the potential for impairment due to physical limitations....right sided paralysis. The interventions included a splint to right hand as tolerated. On 8/1/17 at 1:12 PM the CNA Kardex (ADL care plan) was reviewed. It documented Resident #20 was a FBL (full body lift). He was to be seated in a Geri-chair with side wedges in chair, gel boots on while in chair, & a splint to right hand and hand on pillow while out of bed. During this review, the resident was observed to be transferred by two CNAs from his geri-chair and back to his bed via hoyer lift (full body lift). Prior to that he was observed in his chair, with wedges and a right hand splint--but no pillow underneath his right arm. On 8/2/17 at 10:43 AM, the ADON was interviewed about the Kardex items that had not been careplanned--specifically, the hoyer/full body lift implemented after a fall on 2/3/17 and the pillow under the resident's right arm. Both these items were on the ADL Kardex, but had been overlooked during care-planning. The ADON stated, "Those updates were not made to the CCP--only to the KARDEX. Yes they should match." These observations were reported to the administrator on 8/2/17 at 8:10 AM. No additional information was provided.	F 280		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l)	F 309		9/16/17

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F 309	Continued From page 24 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed	F 309	F309 1. Resident #6 did receive his physician	

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F 309	Continued From page 25 to provide treatment for the highest practicable level of well-being for 1 of 30 Residents, Resident #6 The findings included: For Resident #6 the facility staff failed to administer the physician ordered medication Xanax. Resident #6 was admitted to the facility on 02/05/13. Diagnoses included but not limited to Parkinson's disease, dementia, anxiety, melanoma of eyelid, and coronary artery disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/21/17 coded the Resident as 0 of 15 in section C, cognitive status. This is a quarterly MDS. Resident #6's clinical record was reviewed on 08/01/17. It contained a signed physician's order summary for the month of July 2017 which read in part "Xanax tablet 0.25mg give 1 tablet by at bedtime for anxiety, jerking". Resident #6's MAR (medication administration record) for the month of July was reviewed and contained an entry which read in part "Xanax 0.25mg give 1 tablet by mouth at bedtime for anxiety, jerking". This entry had been marked with "9" on 07/24/17 and 07/26/17. Chart code on the MAR indicated that "9" was "other/see progress notes". Progress note for 07/24/17 read in part "New orders noted, may hold until arrives from pharmacy". Progress note for 07/26/17 read in part "Xanax tablet 0.25mg give 1 tablet by mouth one time a day for anxiety, jerking see PRN (as needed) documentation". The surveyor could not locate any prn documentation or prn order for Xanax on	F 309	ordered Xanax .25mg at bedtime on 7/24/17, after obtaining it from the Omnicell. On 7/26/17, the medication was "en route" from the pharmacy. The MD was made aware and approved that the medication could not be given as it was en route from the pharmacy. 2. Residents who do not receive Xanax have the potential to be affected if the nurse does not properly document. 3. a) Licensed nursing staff were re-educated on the Remedi routine medication orders, after hours pharmacy service, and ordering and procuring "stat" medications policy and procedure. b) Licensed nursing staff were re-educated to notify the MD and UM/supervisor when medications are not available and to document in the clinical record. The UM/supervisor will ensure the process was followed to obtain the medications per policy. c) The UM/designee will complete a random 25% audit, based on the 24 hour report, to identify medications not available and if the policy and procedures were followed, every week for 4 weeks, every other week for 4 weeks, and every other month for 4 months. 4. Results of the audits will be reported to QA for review, analysis and recommendations.	

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F 309	Continued From page 26 Resident #6's clinical record. The surveyor requested and was provided a list of medications in the stat box. This list contained the medication Xanax 0.25mg. Surveyor spoke with LPN #1 on 08/01/17 at approximately 1535. Surveyor asked LPN #1 what the procedure was when they did not have a medication available. LPN #1 stated they would get it out of the Omnicell (stat box), and if it was not available in Omnicell, they would call MD/pharmacy to get order to have it delivered from back up pharmacy. The concern of not administering the Resident's medication was discussed with the administrative team during a meeting on 08/01/17 at approximatley1600. No further information was provided prior to exit.	F 309		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview and clinical record review, it was determined the facility staff failed to provide documented comfort measures to 1 of 30 residents (Resident #20). Findings:	F 312	F312 1.Resident #20 was provided comfort measures when the pillow was provided under the residents right hand, while out of bed. 2. Residents with comfort measures to have a pillow under their right hand, while	9/16/17

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F 312	Continued From page 27 The facility staff failed to provide Resident #20's comfort measures as they were assessed. The resident's clinical record review was reviewed on 8/1/17 at 1:30 PM. Resident #20 was admitted to the facility on 11/25/14. His diagnoses included Asperger's disease, hypertension, diabetes, depression and a history of cerebral vascular infarct (stroke) with resulting right-sided hemiplegia (paralysis). His latest MDS, dated 5/19/17, coded the resident with moderately impaired cognitive ability. This resident was totally dependent on nursing staff members for all the ADLs (activities of daily living). The resident was coded as unable to reposition himself in his bed or chair and unable to ambulate, even with assistance. The latest CCP, updated on 5/12/17, included the problem, "At risk for falls/safety related to: History of recent falls, CVA with right sided hemiplegia...." The interventions included "Therapy eval for transfer. 2/3/17) The CCP also included the problem of "pressure ulcer/skin integrity" and documented the potential for impairment due to physical limitations....right sided paralysis. The interventions included a splint to right hand as tolerated. On 8/1/17 at 1:00 PM the resident was observed in his room with a family member. The family member pointed out the resident's geri-chair was elevated too high for safety and he did not have a pillow under his arm for comfort. The family member said the CNAs knew they were supposed to put his arm on a pillow for comfort--but they always claimed they could not	F 312	out of bed, have the potential to be affected. No other residents have comfort measure orders for a pillow under the right hand, while OOB. 3. a) MDS/Nursing staff were re-educated to ensure all comfort measure interventions, on the Kardex (pocket care plan) and care plan, are in place. b) UM/designed will complete a random audit of 25% of Kardex (pocket care plan) and care plans to ensure comfort measure interventions are in place weekly for 4 weeks, every other week for 4 weeks and monthly for 4 months. 4.Results of the audits will be reported to QA for review, analysis, and recommendations.	

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F 312	Continued From page 28 find an extra pillow. On 8/1/17 at 1:12 PM the CNA ARDEN (ADL care plan) was reviewed. It documented Resident #20 was a FBL (full body lift). He was to be seated in a Geri-chair with side wedges in chair, gel boots on while in chair, & a splint to right hand and hand on pillow while out of bed. During this review, the resident was observed to be transferred by two CNAs from his geri-chair and back to his bed via hoyer lift (full body lift). Prior to that he was observed in his chair, with wedges and a right hand splint--but no pillow underneath his right arm. On 8/2/17 at 10:43 AM, the ADON was interviewed about the Kardex items that had not been careplanned--specifically, the hoyer/full body lift implemented after a fall on 2/3/17 and the pillow under the resident's right arm. Both these items were on the ADL Kardex, but had been overlooked during care-planning. The ADON stated, "Those updates were not made to the CCP--only to the KARDEX. Yes they should match." The ADON said the pillow had been recognized by the nursing staff as a comfort issue and had been added to the KARDEX, but left off the CCP. These observations were reported to the administrator on 8/2/17 at 8:10 AM. No additional information was provided.	F 312		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3)	F 323		9/16/17

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F 323	Continued From page 29 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview and clinical record review it was determined the facility staff failed to ensure an environment free of accident hazards for 1 of 30 residents (Resident #20--was seated in a broken geri-chair) and for 2 of 9 units in the facility. Findings: 1. The facility staff failed to ensure Resident #20's environment was free of accident hazards. The resident was seated in a broken geri-chair that	F 323	1. Resident #20's geri-chair was repaired on 7/17 and again on 7/19 per work orders #5209763 and #5198983. Resident #20 was purchased a new geri-chair after several attempts to repair the secured/hooked device stabilizing the chair were unsuccessful. 2. Residents seated in a geri-chair have the potential to be affected. Other residents sitting in geri-chairs were assessed to ensure there chair was properly secured/hooked for stabilization	

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F 323	Continued From page 30 could not be secured/hooked for stable positioning. The resident's clinical record review was reviewed on 8/1/17 at 1:30 PM. Resident #20 was admitted to the facility on 11/25/14. His diagnoses included Asperger's disease, hypertension, diabetes, depression and a history of cerebral vascular infarct (stroke) with resulting right-sided hemiplegia (paralysis). His latest MDS, dated 5/19/17, coded the resident with moderately impaired cognitive ability. This resident was totally dependent on nursing staff members for all the ADLs (activities of daily living). The resident was coded as unable to reposition himself in his bed or chair and unable to ambulate, even with assistance. The latest CCP, updated on 5/12/17, included the problem, "At risk for falls/safety related to: History of recent falls, CVA with right sided hemiplegia...." The interventions included "Therapy eval for transfer. 2/3/17) The CCP also included the problem of "pressure ulcer/skin integrity" and documented the potential for impairment due to physical limitations....right sided paralysis. The interventions included a splint to right hand as tolerated. On 8/1/17 at 1:00 PM Resident #20 was observed in his room. A family member was present and she told the surveyor the resident's chair was broken and the CNAs had been positioning him too high in his chair. She feared he would tumble out of his geri-chair. The surveyor observed the geri-chair was not hooked into the back rung of the device, and could fall flat back with the resident in the chair.	F 323	and safety. 3. a) Nursing staff were re-educated on properly securing/hooking the back device of the chair to ensure stabilization of the chair, reporting any broken geri-chairs to maintenance and UM/supervisor, and removing the geri-chair from the nursing unit. b) Restorative aides will audit geri-chairs every week for 4 weeks, every other week for 4 weeks and every month for 4 months to ensure the chairs lock for safety and stable positioning. 4. Results of the audits will be reported to QA for review, analysis, and recommendations 2. 1. The metal door frame on the shower room on the 200 hall was replaced. The metal threshold around the elevator on the first floor was immediately repaired and secured to the wall. 2. A hallway that has an exposed sharp edge has the potential to affect the environment from being free of accident hazards. No further sharp edges were noted 3 a) Staff were re-educated to report any sharp edges or accident hazards to maintenance and/or the UM/supervisors for repair. Documentation to occur in the maintenance care portal. b) Maintenance/housekeeping will monitor hallways and resident areas for sharp edges during preventive maintenance rounds every week for 4 weeks, every	

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F 323	Continued From page 31 On 8/1/17 at 1:12 PM the CNA KARDEX (ADL care plan) was reviewed. It documented Resident #20 was a FBL (full body lift). He was to be seated in a Geri-chair with side wedges in chair, gel boots on while in chair, & a splint to right hand and hand on pillow while out of bed. The specific positioning of the chair was not noted. During this review, the resident was observed to be transferred by two CNAs from his geri-chair and back to his bed via hoyer lift (full body lift). RN I was in attendance for this maneuver at the request of the surveyor. RN I was asked to check the hooking mechanism at the rear of the chair--as neither CNA had been able to secure it properly. She said the hooks were not seated properly and that "could be an issue." Unable to fix/secure the chair--RN I chose to stay with the two CNAs transferring the resident until he was safely into his bed and out of the broken chair. RN I said the physical therapy department had ordered a new chair for Resident #20 on 7/31/17 after his was broken. She said the maintenance department had fixed the chair in the interim. She stated, "We thought it was fixed, I had not seen this as an accident hazard--I had not seen it at all." These observations were reported to the administrator on 8/2/17 at 8:10 AM. No additional information was provided. 2. The facility staff failed to ensure an environment free of accident hazards on 2 of 9 units in the facility.	F 323	other week for 4 weeks, and every month for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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On August 1, 2017 at 2:45 p.m. the surveyor made an initial tour of the facility. The surveyor observed that the shower room located on the Unit that housed the #200 rooms had a metal door frame. The surveyor observed that the metal door frame facing out into the hallway hall-way was rusted and moved when the surveyor pushed the area with her foot. The surveyor observed that the rusted area was on the right hand side of the metal door frame, located near the floor, had an approximately 6 inch area of rust and that the rusted area had rough and jagged edges.

On August 2, 2017 at 11:15 a.m. the surveyor made a tour of the facility with the Maintenance Director (MD) and Maintenance Supervisor (MS). The surveyor, MD and MS walked to the elevator on the first floor. The surveyor observed that the metal threshold around the elevated had been pulled apart from the wall exposing sharp edges. The metal threshold exposed approximately 8-10 inches of a sharp edge. The surveyor pointed out the area to the MD and MS. The MS stated that a wheelchair had probably hit the area and caused the metal to lift away from the elevator shaft. The surveyor informed the MD and MS that she felt that the exposed sharp edge could be a safety concern as residents could hit their foot/ankle/leg on the area. The MS kicked the metal threshold with his foot in an attempt to put the metal back into place.
The surveyor, MD and MS continued with the tour of the facility. The surveyor, MD and MS went to the 200 hallway and the surveyor pointed out the shower room where the metal door frame was rusted and had rough and ragged edges. The surveyor notified the MD and MS that she felt the

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F 323	Continued From page 33 area was a safety concern as a resident could hit their foot/ankle/leg on the jagged and sharp area. On August 2, 2017 at 12:25 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), DON and Assistant Director of Nursing (ADON). The surveyor informed the Administrative Team (AT) that the metal threshold around the elevator on the first floor had lifted and exposed a sharp edge. The surveyor also notified the AT that the shower room metal door frame was rusted and exposed sharp and jagged edges. The surveyor notified the AT that she felt these issues were a concern of safety for the residents. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure an environment free of accident hazards.	F 323		
F 328 SS=D	TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care.	F 328		9/16/17

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The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.

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F 328	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store nebulizer equipment in a clean and sanitary manner for 1 of 30 Residents in the sample survey, Resident #22. The Findings Included: Resident #22 was an 84 year old male who was admitted on 7/31/17. Admitting diagnoses included, but were not limited to: fractured humerus, Parkinson's, tremors, hypertension, end stage renal disease and dialysis. Due to Resident #22's recent admission no Minimum Data Set (MDS) assessments were available. On August 2, 2017 at 7:25 a.m. the surveyor observed Resident #22 sitting in a chair at the side of his bed. The surveyor observed the room and noted that Resident #22's nebulizer mask was lying on the bed side table and in contact with the bedside table. The surveyor noticed a clear plastic bag lying on the bedside table and beside the nebulizer mask. On August 2, 2017 at 7:40 a.m. the surveyor reviewed Resident #22's clinical record. Review of the clinical record produced physician orders. Orders included, but were not limited to: "Albuterol Sulfate Nebulizer Solution (2.5MG/3ML) 0.083% 1 vial inhale orally two times a day for pna (pneumonia) for 30 days." (sic) On August 2, 2017 at 9:30 a.m. the surveyor	F 328	F328 1. The nebulizer equipment, for Resident #22, was properly stored in a clean and sanitary environment when placed in the plastic bag at the bedside. 2. Residents who receive nebulizer treatments have the potential to be affected if the nebulizer is not stored properly. Other residents nebulizers had been stored in the plastic bag at the bedside. 3. a)Licensed nursing staff have been re-educated that nebulizer equipment must be stored in a clean and sanitary environment. b) Licensed staff have been re-educated on the Respiratory Care: Nebulizer Machine and Oxygen Policy and Procedures. c)UM/designee will complete oxygen audits on nursing units weekly for 4 weeks, every other week for 4 weeks, and monthly for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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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 328	Continued From page 36 notified the Director of Nursing (DON) that Resident #22's nebulizer mask was not stored in a clean and sanitary manner. The surveyor notified the DON that the nebulizer mask was lying on the bedside table and was not covered. The surveyor asked for the facility policy and procedure for storing nebulizer equipment. On August 2, 2017 at 10:15 a.m. the DON hand delivered a policy and procedure titled, "Respiratory Care: Nebulizer Machines, Care of." The policy and procedure read in part ...Objective: To provide inhalation medications to residents with respiratory problems. ... Cleaning of Nebulizer Equipment: 1. Rinse well and air dry after each use 2. Air dry 3. Place in plastic bag ..." (sic) On August 2, 2017 at 12:25 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), DON and Assistant Director of Nursing (ADON). The surveyor informed the Administrative Team (AT) that Resident #22's nebulizer was not stored in a clean and sanitary manner. The surveyor notified the AT that the nebulizer mask was lying on the bedside table and was not stored in a plastic bag. No additional information was provided prior to exiting the facility as to why the facility staff failed to store Resident #22's nebulizer mask in a clean and sanitary manner.	F 328		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General.	F 329		9/16/17

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F 329	Continued From page 37 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record	F 329	F329	

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F 329	Continued From page 38 review the facility staff failed to administer medications per physician ordered parameters for 1 of 30 Residents The findings included: For Resident #12 the facility staff failed to follow physician ordered parameters for the administration of the medication clonidine. Clonidine is an antihypertensive agent used to control high blood pressure. Resident #12 was admitted to the facility on 04/15/16 and readmitted on 09/10/16. Diagnoses included but not limited to congestive heart failure, hyperlipidemia, dementia, anxiety, depression, coronary artery disease, gastroesophageal reflux disease, and end stage renal disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/16/17 coded the Resident as 5 out of 15 in section C, cognitive status. This is a quarterly MDS. Resident #12's clinical record was reviewed on 08/01/17. It contained a signed physician's order summary for the month of July which read in part "clonidine hcl tablet 0.1mg give 1 tablet by mouth every 6 hours as needed for systolic BP (blood pressure) 180 and above or diastolic BP 98 and above". Resident #12's MAR (medication administration record) for the month of July was reviewed and contained an entry which read in part "clonidine hcl tablet 0.1mg give 1 tablet by mouth every 6 hours as needed for systolic BP 180 and above or diastolic BP 98 and above". On 07/23/17, Resident's BP at 12am was 186/89 and there was no documentation that clonidine had	F 329	1. Resident #12's physician ordered parameters for the administration of the medication Clonidine was discontinued. 2. Residents with orders for Clonidine, with parameters, have the potential to be affected. No other residents have parameters while receiving Clonidine. 3. a) Licensed nursing staff were re-educated on following physician orders regarding parameters. b) New orders are reviewed upon admission and during monthly change over. Orders for parameters will be discussed with nursing staff and MD to evaluate effectiveness of medication and continued use. c) UM/designee will complete an audit of prn Clonidine orders for documentation of parameters, every 4 weeks for 4 weeks, every other week for 4 weeks and every month for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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F 329	Continued From page 39 been administered. On 07/28/17 at 6am, Resident's BP was 190/102 and there was no documentation that clonidine had been administered. Resident's MAR for June 2017 was reviewed and contained an entry which read in part "systolic BP 180 and above or diastolic BR 98 and above give PRN clonidine every 6 hours for hypertension". On 06/10/17 at 12am Resident's BP had not been documented as having been taken, at 6am Resident's BP was 178/102 and prn clonidine had not been documented as having been administered. On 06/11/17, Resident's BP had not been documented for 12am or 6am. On 06/14/17 at 6pm Resident's BP was 168/98 and prn clonidine had not been documented as having been administered. Surveyor spoke with the administrator regarding Resident #12's clonidine on 08/02/17 at approximately 0830. Administrator stated they had been trying to get all orders of this nature changed, and stated that she would be discussing this with the medical director. The concern of not administering the medication per ordered parameters was discussed with administrative team during a meeting on 08/01/17 at approximately 1600. No further information was provided prior to exit.	F 329		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local	F 371		9/16/17

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F 371	Continued From page 40 authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to ensure clean and sanitary food storage for residents in two of two kitchens. Findings: Facility staff failed to ensure clean and sanitary food storage for facility residents. The initial tour was conducted on 7/31/17 between 6:00 PM and 7:00 PM for the facility's two kitchens (Main Kitchen & Rehabilitation Kitchen). The following were observed in the Main Kitchen: 1. Sliced tomatoes in a plastic container dated	F 371	F371 1. All items not dated, labeled, and covered or sealed were discarded. The sprinkler nozzle over the four burner gas cook stove was cleaned 2. When the kitchen is not clean and food properly stored, residents living in the facility have the potential to be affected. 3. a) Staff were re-educated on the Food & Supply Storage policy and procedure. b) Staff were re-educate on cleaning schedules. c) Kitchen manager/designee will inspect the kitchen for cleanliness and accurate	

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F 371	Continued From page 41 with a discard date 7/27/17 2. Pickle slices dated with a discard date 7/27/17. The clinical nutrition manager (DM I) discarded the items. The following were observed in the Rehabilitation Kitchen: 1. The sprinkler nozzles over the four burner gas cook stove were observed with smut taggles/dust hanging over the cooking surface. 2. The first refrigerator cooler contained 2 plastic cups of watermelon, stored without dates and one tray of sliced lemons dated to dispose on 7/29/17; one open pint of milk, with no open or discard date & a large squeeze type bag of whipped topping, opened with a baggie slipped over the cut end. No labels/dates. 3. The freezer contained opened bags of french fries, chicken patties and sweet potato fries which had not been covered and resealed properly and did not have dates. 4. The walk-in refrigerator contained a white grocery bag with grapes that was stored there by KS I (kitchen staff member #1.) He told the surveyor he didn't know staff could not store their home brought food in the resident's refrigerator. The administrator was informed of the surveyor's findings on 8/1/17 at 2:24 PM. She brought the facility policy for refrigerated food storage for the surveyor to review. The Food & Supply Storage policy, revised on 1/17, included the following: ".....Cover, label and date unused portions and open packages.....Products are good through the close of business on the date noted on the label....."	F 371	dating and labeling weekly for 4 weeks, every other week for 4 weeks and monthly for 4 months. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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F 371	Continued From page 42 No additional information was provided prior to the survey team exit.	F 371		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to ensure that physician ordered medications were available for3 of 30 Residents in the sample survey, Resident #4, Resident #22 and Resident #6. The Findings Included: 1. For Resident #4 the facility staff failed to ensure that physician ordered Hydrochloroquine Sulfate and Estradiol were available for administration on 7/12/17. Resident #4 was a 67 year old female who was admitted on 7/11/17. Admitting diagnoses included, but were not limited to: cutaneous	F 425	F425 1. Resident # 4, #22, and #6 did not receive their medications due to not being available. MD was notified and no negative outcomes were noted 2. Residents who do not have their medications available have the potential to be affected. 3. a) Nursing staff were re-educated on the Remedi routine medication orders, after hours pharmacy service, and ordering and procuring "stat" medications policy and procedure. b) Licensed nursing staff were educated to notify the MD and UM/supervisor when medications are not available and to	9/16/17

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F 425	Continued From page 43 abscess of the right foot, diabetes mellitus, rheumatoid arthritis, hypertension, anemia, depression, hypothyroidism, fibromyalgia and anxiety. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date of 7/25/17. The facility staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On August 1, 2017 at 2 p.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record produced signed physician orders dated 7/2/17. Signed physician orders included, but were not limited to: "Estradiol Tablet 2 MG Give 1 tablet by mouth one time a day for Estrogen. Hydrochloroquine Sulfate Tablet 200 MG give 2 tablet by mouth two times a day for rheumatoid arthritis." (sic) Continued review for the clinical record produced the July 2017 Medication Administration Records (MAR's). Review of the July 2017 MAR's documented that on 7/12/17 that the Hydrochloroquine was not available for administration at 9 a.m. and 5 p.m. and the Estradiol was not available for administration on 7/12/17 at 9 a.m. The MAR's documented to see "other/See Progress Notes." (sic) Further reviewed of the clinical record produced the nursing progress notes. The nursing progress notes documented that the Hydrochloroquine and Estradiol were not given as the facility was	F 425	document in the clinical record. The UM/supervisor will ensure the process was followed to obtain the medications per policy. c) The UM/designee will complete a random 25% audit, based on the 24 hour report, to identify medications not available and if the policy and procedures were followed, every week for 4 weeks, every other week for 4 weeks, and every other month for 4 months. 4. Results of the audits will be reported to QA for review, analysis and recommendations.	

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"awaiting from pharmacy." (sic)

On 8/1/17 at 2:35 p.m. the surveyor notified the Unit Manager (UM, who was a Registered Nurse (RN), that Resident #4 did not have physician ordered medications available for administration on 7/12/17. The surveyor reviewed the clinical record with the UM. The surveyor specifically pointed out the physician orders for Hydrochloroquine and Estradiol. The surveyor then reviewed the July 2017 MAR's with the UM. The surveyor pointed out that the medications were not given and to see the nursing progress notes. The surveyor then reviewed the nursing progress notes with the UM. The surveyor pointed out that the nursing staff documented that they were waiting for the medication to be delivered by the pharmacy. The surveyor asked the UM if the facility had a backup pharmacy and she named a local pharmacy. The surveyor requested a copy of the facility policy and procedure for obtaining medication.

On August 1, 2017 at 4:15 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), Director of Nursing (DON) and Assistant Director of Nursing (ADON). The surveyor notified the Administrative Team (AT) that Resident #4 did not have physician ordered medications available for administration on 7/12/17.

On August 2, 2017 at 9:40 a.m. the DON hand delivered the facility policy and procedure titled, "Ordering and Procuring "Stat" Medication." The policy and procedure read in part ...

"Procedure: ... 2. If the medication is not available from the above sources, call the

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pharmacy to request a "STAT" delivery of the medication order submitted. ...2.b. The pharmacist will determine if the medication will be dispensed from (name of facility vendor pharmacy withheld) directly or sent from a local back-up pharmacy."

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that physician ordered medications were available for administration to Resident #4.

2. For Resident #22 the facility staff failed to ensure that physician ordered medication, Albuterol Sulfate Nebulizer and Symbicort, were available for administration on 7/31/17.

Resident #22 was an 84 year old male who was admitted on 7/31/17. Admitting diagnoses included, but were not limited to: fractured humerus, Parkinson's, tremors, hypertension, end stage renal disease and dialysis.

Due to Resident #22's recent admission no Minimum Data Set (MDS) assessments were available.

On August 2, 2017 at 7:40 a.m. the surveyor reviewed Resident #22's clinical record. Review of the clinical record produced physician orders. Orders included, but were not limited to: "Albuterol Sulfate Nebulizer Solution (2.5MG/3ML) 0.083% 1 vial inhale orally two times a day for pna (pneumonia) for 30 days. Symbicort Aerosol 16004.5 MCG/ACT (Budesonide-Formoterol) 2 puff inhale orally two times a day for COPD (chronic obstructive pulmonary disease)." (sic)

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Continued review for the clinical record produced the July 2017 Medication Administration Records (MAR's). Review of the July 2017 MAR's documented that on 7/31/17 that the Albuterol and the Symbicort were not available for administration at 5 p.m. The MAR's documented to see "other/See Progress Notes." (sic)

Further reviewed of the clinical record produced the nursing progress notes. The nursing progress notes documented that the Albuterol and Symbicort were not given as the facility was "not available on hand. Waiting from pharmacy." (sic)

On 8/2/17 at 7:40 a.m. the surveyor notified the Unit Manager (UM, who was a Registered Nurse (RN), that Resident #2 did not have physician ordered medications available for administration on 7/31/17. The surveyor reviewed the clinical record with the UM. The surveyor specifically pointed out the physician orders for Albuterol and Symbicort. The surveyor then reviewed the July 2017 MAR's with the UM. The surveyor pointed out that the medications were not given and to see the nursing progress notes. The surveyor then reviewed the nursing progress notes with the UM. The surveyor pointed out that the nursing staff documented that they were waiting for the medication to be delivered by the pharmacy.

On August 2, 2017 at 9:40 a.m. the DON hand delivered the facility policy and procedure titled, "Ordering and Procuring "Stat" Medication." The policy and procedure read in part ...

"Procedure: ... 2. If the medication is not available from the above sources, call the pharmacy to request a "STAT" delivery of the medication order submitted. ...2.b. The

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pharmacist will determine if the medication will be dispensed from (name of facility vendor pharmacy withheld) directly or sent from a local back-up pharmacy."

On August 2, 2017 at 12:25 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), Director of Nursing (DON) and Assistant Director of Nursing (ADON). The surveyor notified the Administrative Team (AT) that Resident #22 did not have physician ordered medications available for administration on 7/31/17.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that physician ordered medications were available for administration to Resident #22.
3. For Resident #6 the facility staff failed to ensure the physician ordered medication Neupro was available for administration. According to "Nursing Drug Handbook 2017", Neupro is a transdermal skin patch used to treat symptoms of Parkinson's disease.

Resident #6 was admitted to the facility on 02/05/13. Diagnoses included but not limited to Parkinson's disease, dementia, anxiety, melanoma of eyelid, and coronary artery disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/21/17 coded the Resident as 0 of 15 in section C, cognitive status. This is a quarterly MDS.

Resident #6's clinical record was reviewed on 08/01/17. It contained a signed physician's order summary for the month of July which read in part "Neupro patch 24 hour 6mg/24HR apply 1 patch

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transdermal (on the skin) one time a day related to Parkinson's disease and remove per schedule". Resident #6's MAR (medication administration record) for the month of July was reviewed. It contained an entry which read in part "Neupro patch 24 hour 6mg/24HR apply 1 patch transdermal (on the skin) one time a day related to Parkinson's disease and remove per schedule". This entry had been coded with "5" on 07/05/17. The chart codes on the MAR indicated that "5" is "hold/See Progress Notes". Progress note for 07/05/17 was reviewed and read in part "Neupro patch 24 Hour 6mg/24HR apply 1 patch transdermal on time a day related to Parkinson's disease and remove per schedule Per Dr .... (name omitted) hold x 1 day until medication arrives from pharmacy".

Surveyor requested and was provided with a list of medications located in the stat box. Neupro was not listed as being available in the stat box. Surveyor requested and was provided with a policy entitled "After Hours Pharmacy Service" which read in part "Emergency pharmaceutical service is available 24-hours per day, 365 days a year. Emergency needs for medication are met by using the on-site supplies that the pharmacy provides (emergency box, interim box, starter kit, controlled substance interim box and medDispense system) or by special order from the pharmacy".

Surveyor spoke with LPN #1 on 08/01/17 at approximately 1535. Surveyor asked LPN #1 what the procedure was when they did not have a medication available. LPN #1 stated they would get it out of the Omnicell (stat box), and if it was not available in Omnicell, they would call MD/pharmacy to get order to have it delivered

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F 425	Continued From page 49 from back up pharmacy. Surveyor asked how long it usually took to have medication delivered from the pharmacy and LPN #1 stated "around a couple of hours". There was no documentation to indicate that after hours pharmacy had been notified to obtain the medication for Resident #6. The concern of the medication not being available for administration was discussed with the administrative team on 08/01/17 at approximatley 1600. No further information was provided prior to exit.	F 425		
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered laboratory test for 1 of 30 residents in the survey sample. (Resident #13) The findings included: The facility staff failed to obtain a physician ordered Liver Function Test for Resident #13. Resident #13 was admitted to the facility on 1/27/06 with the following diagnoses of, but not limited to high blood pressure, Alzheimer's disease, seizure disorder, malnutrition, anxiety	F 502	F502 1. Resident #13 did not have a Liver Function Test(LFT) competed per physician order. No negative outcomes noted. 2. Residents who do not have their labs drawn due to having a change in their routine lab orders have the potential to be affected. 3 a) Unit secretaries were re-educated on ordering labs when routine lab orders are changed. b) Unit secretaries will complete a random	9/16/17

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F 502	Continued From page 50 disorder, manic depression and osteoporosis. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/21/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 2 out of a possible score of 15. Resident #13 also requires extensive assistance of 1 staff member for personal hygiene and bathing. During the clinical record review by surveyor on 8/1/17, the surveyor noted a physician's order dated for 5/26/17 which stated "Pheno (Phenobarbital), Primidone, Folate, CBC and LFT q (every) 6 months May/Nov." The surveyor found the above documented lab results which were obtained in the month of May, 2017 but the LFT test result was not found in the clinical record for the month of May, 2017. At approximately 3:30 pm, the administrative team was notified of the above documented findings by the surveyor. On 8/2/17, the director of nursing returned to the surveyor and stated "We had looked over all the labs for the resident's months ago and tried to decrease the number of sticks the residents had to have for blood work. The last LFT was drawn in February, 2017 but the order never got changed to reflect getting the labs in May when the other ones were scheduled." No further information was provided to the surveyor prior to the exit conference on 8/2/17.	F 502	audit of 25% of routine lab orders every week for 4 weeks, every other week for 4 weeks, and every month for 4 months to ensure the lab was drawn per MD order. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		9/16/17

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F 514	Continued From page 51 CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a complete and	F 514	F514 1. Resident #18's progress notes for 5/15/17, 6/6/17, and 7/4/17 were placed in	

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accurate clinical record for 2 of 30 Residents in the sample survey, Resident #8 and Resident #12.

The Findings Included:

1. For Resident #8 the facility staff failed to ensure that physician progress notes were contained in the clinical record.

Resident #8 was a 63 year old female who was admitted on 1/25/10. Admitting diagnoses included, but were not limited to: unspecified intellectual disability, falls, psychosis, seizures, depression, glaucoma, hypothyroidism and hypertension.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/19/17. The facility staff coded that Resident #8 had a Cognitive Summary Score of 4. The facility staff also coded that Resident #8 required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On August 2, 2017 at 9:40 a.m. the surveyor reviewed Resident #8's clinical record. Review of the clinical record produced recapitulations of the physician orders that were signed by the physician on 5/2/17, 6/2/17 and 7/4/17.

Continued review of the clinical record produced physician progress notes dated 4/5/17. No additional physician progress notes could be located in the clinical record since 4/5/17.

On August 2, 2017 at 10:40 a.m. the surveyor notified the Quality Assurance Nurse (QAN), who

the clinical record.
2. Residents who do not have a copy of the progress note in the chart have the potential to be affected.
3)
a)Physicians were re-educated that the facilty must receive copies of all progress notes upon completion.
b) Medical records coordinator was re-educated to utilize the physician visits report in PCC for tracking of physician visits. Any discrepancies must be reported to the Administrator for follow up.
c)The Medical Records coordinator will audit the physician visits report weekly for 4 weeks, every other week for 4 weeks, and monthly for 4 months to ensure physician progress notes have been completed and filed. A random audit of 25% of the completed physician progress notes will be verified that they are in the clinical record each month.
4. Results of the audit will be reported to QA for review, analysis, and recommendations.

2.
1. The pharmacy regime review, for January 2017, was completed and not in clinical record due to no recommendations were made. The pharmacist was educated in January 2017 that all pharmacy regime reviews must be in the clincal record regardless if recommendations are made or not.
2. Residents have the potential to be affected if no pharmacy regime review is in the clinical record
3.

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F 514	Continued From page 53 was a Registered Nurse (RN), that Resident #8's clinical record did not have a physician progress note since 4/5/17. The surveyor pointed out that the physician signed the recapitulation of orders on 5/2/17, 6/2/17 and 7/2/17. The surveyor informed the QAN that progress notes should have been made by the physician during those visits. On August 2, 2017 at 11 a.m. the QAN approached the surveyor and informed the surveyor that Resident #8's physician had been out of the office for a few weeks and was behind on getting the notes completed. The QAN stated that she had contacted the office and they had stated that the physician was busy and would not be able to get the notes completed by the end of the day. On August 2, 2017 at 12:25 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), Director of Nursing (DON) and Assistant Director of Nursing (ADON). The surveyor informed the Administrative Team (AT) that Resident #8 did not have current physician progress notes in her clinical record. The surveyor notified the AT that the most current physician progress note located in the clinical record was 4/5/17. On August 2, 2017 at 1 p.m. the Adm hand delivered two documents to the surveyor. The surveyor reviewed the documents and noted that the documents were physician progress notes dated 5/15/17 and 6/6/17. The surveyor notified the Adm that the physician progress notes should have been contained in the clinical record. No additional information was provided to the	F 514	a) The new pharmacy consultant was re-educated that documentation must be present in the clinical record every month to verify a review was completed. b) The medical records coordinator will complete a random audit of 25% of pharmacy regime reviews, monthly for 6 months, to ensure the documentation is present in the clinical record. 4. Results of the audits will be reported to QA for review, analysis, and recommendations.	

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survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #8. The facility staff failed to ensure that physician progress notes were contained in the clinical record.

2. For Resident 12 the facility staff failed to ensure the monthly pharmacy review was included in the clinical record.

Resident #12 was admitted to the facility on 04/15/16 and readmitted on 09/10/16. Diagnoses included but not limited to congestive heart failure, hyperlipidemia, dementia, anxiety, depression, coronary artery disease, gastroesophageal reflux disease, and end stage renal disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/17/16 coded the Resident as 0 out of 15 in section C, cognitive status. This is a quarterly MDS.

Resident #12's clinical record was reviewed on 08/01/17. Surveyor could not locate the pharmacy regimen review for the month of January 2017. The administrator and DON (director of nursing) were informed of the missing pharmacy review on 08/01/17 at approximately 1530. DON stated that they had a different pharmacist doing reviews during that time frame and she did not know that she needed to make a note in the clinical record if there had not been any changes/recommendation.

DON provided surveyor with a copy of a list of Residents that had been reviewed by pharmacist in January with no changes/recommendation on

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F 514	Continued From page 55 08/02/17 at approximately 0800. Resident #12 was included on this list. The concern of the missing pharmacy review was discussed with the administrative team during a meeting on 08/02/17 at approximately 1215. No further information was provided prior to exit.	F 514		