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LEE HEALTH AND REHAB CENTER	**208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277**

(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 08/29/17 through 08/31/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 101 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents 1 through 18) and 5 closed record reviews (Residents 20 through 24).	F 000		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident’s records,	F 164		10/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/29/2017

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 164	Continued From page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide privacy for 1 of 24 Residents, Resident #7. The findings included: For Resident #7, the facility staff failed to close the window blinds during a skin assessment of the Residents buttocks. The clinical record revealed that Resident #7 had been admitted to the facility 09/16/16. Diagnoses included, but were not limited to, heart failure, age related osteoporosis, dysphagia, hypertension, atrial fibrillation, and generalized anxiety.	F 164	1. Staff members assigned to Resident #7 educated about patient privacy during ADL care. 2. Any resident has the potential to be affected if visual privacy is not provided during ADL care. 3. Nursing staff will be educated regarding ensuring visual privacy to residents during patient care to include window blinds as appropriate. The UM/Designee will audit visual privacy weekly X 4 weeks, then monthly X 2 months to ensure privacy is being offered. 4. Audit results will be reported to the	

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F 164	Continued From page 2 Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/20/17 included a BIMS (brief interview for mental status) summary score of 5 out of a possible 15 points. Section M (skin conditions) was coded to indicate the Resident was at risk for developing pressure areas but did not currently have any pressure areas. On 08/29/17 at approximately 2:40 p.m. the surveyor asked permission to observe the Residents bottom due to concerns expressed by the family. During this assessment LPN (licensed practical nurse) #1 and CNA (certified nursing assistant) #1 turned the Resident toward the window and without closing the blinds uncovered the Residents bottom. The Residents room was on the ground floor and the outside was easily visible standing beside the Residents bed. During an interview with the ADON (assistant director of nursing) on 08/31/17 at approximately 9:45 a.m. the ADON verbalized to the surveyor that the blinds should have been closed. The administrative staff was notified of the issue regarding the Residents privacy in a meeting with the survey team on 08/31/17 at approximately 11:05 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 164	QAPI Committee and any variances addressed.	
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11)	F 167		10/10/17

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F 167	Continued From page 3 (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to post the results of the most recent LSC (life safety code) survey. The findings included. On 08/29/17 during initial tour of the facility the surveyor observed a binder in the front lobby that included the results of the most recent standard survey completed by the office of licensure and	F 167	1. The most recent results of the Life Safety Code were placed in the binder for public viewing. 2. Any resident has the potential to be affected if they do not have accessibility to recent survey results. 3. Administrator will provide education to the administrative team regarding this	

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F 167	Continued From page 4 certification. This binder did not include the results of the most recent LSC survey. On 08/31/17 at approximately 9:00 a.m. the surveyor asked the maintenance director about the survey results. The maintenance director verbalized that he did not know where they were located but the administrator should have them. On 08/31/17 the administrator and DON (director of nursing) were notified that the most recent LSC survey results were not posted. On 08/31/17 at approximately 11:05 a.m. during a meeting with the administrative team of the facility the administrator stated she had put the results of the most recent LSC survey in the binder. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 167	requirement and will monitor weekly X4 weeks, then monthly X2 months to ensure its placement. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F 225		10/10/17

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(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the

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F 225	Continued From page 6 investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review, and clinical record review, the facility staff failed to thoroughly investigate and report an injury of unknown origin to the appropriate state agency for 1 of 24 Residents, Resident #7. The findings included. For Resident #7 the facility staff failed to complete a thorough investigation and report to the OLC (office of licensure and certification) and injury of unknown origin that affected the Residents right lower arm. This area was documented as measuring 84 X 31 X 44 mm (millimeters) after a sonogram was completed and the physician documented the area as measuring 14 x 6 x 4 cm (centimeters). The clinical record revealed that Resident #7 had been admitted to the facility 09/16/16. Diagnoses included, but were not limited to, heart failure, age related osteoporosis, dysphagia, hypertension, atrial fibrillation, and generalized anxiety. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with	F 225	1. Staff members assigned to Resident #7 were educated about resident abuse and reporting protocol. A report was submitted to the OLC on 8/29/17. 2. Any resident has the potential to be affected if abuse is suspected and not reported. 3. DON/Designee will conduct staff education in regards to the resident's right to be free from abuse and the need to immediately report suspected abuse to the DON and Administrator. Social Services will conduct 4 resident interviews weekly X8 weeks in regards to possible abuse. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	

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an ARD (assessment reference date) of 08/20/17 included a BIMS (brief interview for mental status) summary score of 5 out of a possible 15 points. Section E (behaviors) was coded to indicate the Resident had verbal behaviors directed toward others. Section G (functional status) was coded 3/3 for bed mobility and dressing indicating the Resident required extensive assistance of two to complete this task. Transfers, toilet use and personal hygiene had been coded 4/3 to indicate the Resident was totally dependent on one staff person to complete these tasks. The Resident was coded as having no limitations in range of motion in the upper or lower extremities.

The Residents CCP (comprehensive care plan) included the following focus areas-
"...at risk for Impaired social interactions d/t (due to) dementia as evidenced by the following aggressive behavior (s): yelling and cursing at staff, combative and attempting to hit staff, PHQ=11; Staff members enter room with two members at times r/t (related to) resident is accusatory of staff d/t dementia." Interventions included-administer psychoactive medications as ordered, as much as possible maintain consistent routine so the resident knows what to expect, and attempt to distract with activities of interest.
"...requires assist with ADLS (activities of daily living) and Bathing r/t self care deficit...frequently refuses ADL care showers and medications at times...combative with staff at times also...throws...water pitcher and other items in the floor at times. has frequent behaviors r/t yelling out..."
"...is on anticoagulant therapy and at risk for excessive bruising/bleeding r/t Atrial fibrillation...bruises easily." Interventions included-Observe skin for changes, new bruising

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or bleeding. Report changes to the nurse or MD as indicated.
On 08/24/17 the CCP was updated to include "...has altered skin integrity r/t...a large hemotoma to right forearm."

On 08/29/17, during initial tour of the facility, the surveyor entered Resident #7's room at approximately 1:30 p.m. Resident #7 was observed to be resting on bed with daughter at bedside. The bed was observed to be low to the ground and had fall mats in place. The surveyor was able to observe a large hematoma and bruising to the resident's right arm. The daughter verbalized to the surveyor that the resident had hurt her arm and it was being investigated. The daughter stated she did not know how it had happened and the resident was unable to tell her how it had happened. The daughter then stated the Resident was currently on warfarin (blood thinner) and they had changed her bed out and the bed that had been removed had 1/2 siderail's.

Upon exiting the Residents room the surveyor interviewed the unit manager. The unit manager was asked when the injury had occurred and stated last Wednesday (08/23/17). The unit manager stated that it had been investigated by the facility and it was probably done during ADL care as the Resident was resistant to care. When asked if an FRI (facility reported incident) had been completed the unit manager stated she was 100% sure one had not been completed.

A review of the Residents current POS (physician order summary) revealed that Resident #7 was currently receiving the blood thinner medication coumadin 5 mg every evening for the diagnosis of atrial fibrillation, klonopin 0.5 mg every 8 hours for

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generalized anxiety disorder, and seroquel 75 mg at bedtime and 50 mg twice a day for psychosis.

The first entry the surveyor was able to find in the clinical record that referenced the injury to the Residents right arm was documented on 08/23/17 at 21:29 (9:29 p.m.) "This nurse alerted into room per CNA's (certified nursing assistants) into room to provide care to resident. This nurse into room, noted bruise with some minor swelling noted to Right forearm. Resident maintain normal ROM (range of motion) to hand and fingers. Resident when asked what happened to right arm, is unaware of any bruising to affected site. This nurse applied cool compress Contacted PCP (Dr. _____) at this time. MD state he was at facility earlier today, And he visited with this resident and he is aware of swelling and bruising to right forearm. No new orders noted at this time..." The RP (responsible party) was notified.

On 08/29/17 at approximately 2:10 p.m. the surveyor interviewed the administrator regarding the Residents injury to the right arm. The administrator verbalized to the surveyor that they facility had not completed an FRI, that the Resident could be combative, and that the injury was unwitnessed.

The Resident was seen at the local ER (emergency room) on 08/24/17 an X-ray was completed of the right arm the findings were as follows-"No evidence of acute fractures or dislocations is seen. Large soft tissue swelling is noted over the dorsal, radial aspect of the forearm suggestive of bruising or hematoma."

On 08/26/17 the physician documented the size of the hematoma as being 14 x 6 x 4 cm.

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Nonvascular sonogram was completed on 08/27/17 impression-complex fluid collection in area of palpable mass/ecchymosis, measuring 84 X 31 X 44 mm. Findings may be consistent with hematoma given superficial appearance of skin site and history.

When asked for the facility investigation the facility provided the surveyor with a copy of a form titled "INVESTIGATION OF BRUISE, SKIN TEARS, SCRATCHES, etc...To determine Etiology or Origin of Injury." This form was dated 08/24/17 and had been completed by the ADON (assistant director of nursing). The ADON had checked the following boxes-Resident interviewable (BIMS score was documented as 5), prolonged use of aspirin, bruises easily, and self inflicted. There were no individual statements from staff that accompanied this investigation and all of the individual statements provided to the surveyor were either not dated, dated 08/29, or 08/30 after the surveyors had entered the building.

One statement obtained on 08/30/17 resulted in a CNA being suspended due to failure to report.

During the course of the survey the surveyor interviewed CNA's and nurses regarding Resident #7 and her ability to use her arms. None of the staff interviewed stated they had ever seen the Resident hurt or abuse herself. When asked about siderail's the consensus of the staff was that the Resident was not able to use her siderail's and one staff (CNA#1) stated she had never seen the Resident hit her siderail's. CNA #2 verbalized to the surveyor that there was no way the Resident could hit someone or anything. LPN

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#3 did provide a written statement on 08/29/17 at 1820 (6:20 p.m.) to the facility that stated "...Resident frequently yells out + swings arms when staff is not present in room..."

The Residents physician was interviewed on 08/30/17 at approximately 12:45 p.m. and accompanied the surveyor to the Residents room. The physician stated the area had started off as a small bruise but it had gotten worse during the night. The Resident was sent out to the hospital had an X-ray and came back to the facility with an ace bandage in place. The physician stated the ace bandage caused swelling in the Residents hands so it was removed. The physician stated the Resident had an appointment with a surgeon and they would see what they recommended. (Per the nurse and family this appointment was scheduled for 08/31/17).

The ADON was interviewed on 08/30/17 at approximately 4:15 p.m. and verbalized to the surveyor that he had done an investigation and reviewed the Residents progress notes and care plan. The ADON stated the Resident had a history of being combative with staff during ADLS.

The DON (director of nursing) was interviewed on 08/30/17 at 4:25 p.m. and stated she was out of the building at the time of the occurrence but she had been notified. The DON stated to begin with the bruising was only in the middle of the forearm and the Resident had 1/2 rails on their bed. The DON stated the siderail's lined up perfectly with the area and the Resident had behaviors of frailing her arms. The DON stated they didn't feel as if it was abusive in nature.

During a second interview with the ADON on

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F 225	Continued From page 12 08/31/17 at approximately 8:10 a.m. the ADON verbalized to the surveyor that he had not obtained any individual written statements from the staff concerning the Residents injury and confirmed that the written statements that had been obtained from staff had been obtained after the surveyors entered the building for the current survey. The facility provided the survey team with a copy of their facility policy titled "Facility Internal Investigations of Abuse, Neglect, and Misappropriation of Resident Personal Property." "...Within 24 hours of learning of an incident the facility must report it to the OLC...Facilities must conduct an internal investigation and document their findings for all alleged incidences at the facility within 5 days of the incident. A thorough internal investigation should include, but is not limited to: Collecting physical and documentary evidence; Interviewing victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist; and Documenting each step taken during the internal investigation." The administrative staff was made aware of the concerns regarding the lack of an FRI and the investigation of the Residents injury due to the size and appearance of the injury and the injury being unwitnessed during a meeting with the survey team on 08/31/17 at approximately 11:05 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 225		
F 241	DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		10/10/17

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F 241 SS=D	Continued From page 13 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 and staff interview, the facility staff failed to promote and enhance the dignity for 1 of 27 residents (Resident #12). The findings included: The surveyor reviewed Resident #12's clinical record on 8/29/17 and 8/31/17. Resident #12 was admitted to the facility on 1/5/12 with diagnoses that included but were not limited to: dysphagia, anxiety, dementia, seizure disorder, gastrostomy, and atrial fibrillation. Resident #12's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/17 assessed the cognitive status indicating she had both long and short term memory problems. She was assessed and coded in section G to require total assistance with all activities of daily living. On 8/30/17 at 8:05am, the surveyor was outside Resident #12's room and noticed a strong urine smell. Upon entrance to her room the smell became even stronger. LPN #1 was in the hall at her medication cart and the surveyor asked if she could come into the room and check Resident #12 for wetness. LPN #1 entered the room, put on gloves and proceeded to check the resident. She checked the brief and stated, "She is wet." The surveyor then asked the LPN to turn the resident and check under the pad to see if the	F 241	1. Resident #12 was immediately cleaned and provided new bedding. Staff members assigned to Resident #12 were educated about proper ADL care and linen changes. 2. Any resident has the potential to be affected if ADL care is not provided. 3. Education will be provided to nursing regarding proper ADL care and linen changes. 5 random resident observations will be done weekly X 4 weeks, then monthly X 2 months to ensure residents/linens are clean. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	

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F 241	Continued From page 14 sheet was soiled. The surveyor could see that the sheet was wet and noted the light brown ring of old urine. LPN #1 informed the surveyor that she would get the CNA to come and change the resident. She then removed her gloves put them in the trash and went out the door to find the CNA. At 8:15am, the surveyor returned to Resident #12's room to find two CNA's and a RN preparing to change the resident. The resident's entire bed was changed due to the soiling. The CNA also cleaned the wet area on the mattress. The surveyor asked the CNA's when they made rounds for Resident #12 last. CNA #2 stated, "We changed her roommate at 7:00am, not Resident #12 because we thought it was her roommate who smelled of urine. The surveyor asked the CNA if when rounds were made routinely, would the urine normally leak through the pad. CNA #2 said, "Not normally." On 8/30/17 at approximately 4:55pm, during a meeting with the administration team, the surveyor informed them of Resident #12's soiled condition. Prior to exit on 8/31/17, no further information was provided to the surveyor related to Resident #12's soiled condition.	F 241		
F 252 SS=D	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	F 252		10/10/17

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F 252	Continued From page 15 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 or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide housekeeping services necessary to maintain a clean, comfortable, and homelike environment in 1 of 24 resident's rooms. The findings include: The surveyor reviewed Resident #12's clinical record on 8/29/17 and 8/31/17. Resident #12 was admitted to the facility on 1/5/12 with diagnoses that included but were not limited to: dysphagia, anxiety, dementia, seizure disorder, gastrostomy, and atrial fibrillation. Resident #12's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/17 assessed the cognitive status indicating she had both long and short term memory problems. She was assessed and coded in section G to require total assistance with all activities of daily living.	F 252	1. Resident #12 was immediately cleaned and provided new bedding. Resident #12□s privacy curtain was immediately replaced. 2.Any resident has the potential to be affected if ADL care is not provided and/or privacy curtains are not clean. 3. Education will be provided in regards to providing a clean, comfortable and homelike environmentm to include providing ADL care as appropriate. 5 random resident observations will be done weekly X4 weeks, then monthly X2 months to ensure the above is achieved. 5 random privacy curtain observations will be made weekly X4 weeks, then monthly	

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F 252	Continued From page 16 On 8/30/17 at 8:05 am, the surveyor was outside Resident #12's room and noticed a strong urine smell. Upon entrance to her room the smell became even stronger. While in Resident #12's room, the privacy curtain was observed to have a black stain and a brown smear was also noted. RN #2, who was in the room, was asked by the surveyor if it was bowel movement (BM) on the curtain. He looked and said, "This black isn't, but the brown looks like BM." On 8/30/17 at approximately 4:55pm, during a meeting with the administration team, the surveyor informed them of Resident #12's soiled privacy curtain. Prior to exit on 8/31/17, no further information was provided to the surveyor related to resident #12's soiled privacy curtain.	F 252	X2 months to ensure cleanliness. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	
F 285 SS=E	PASRR REQUIREMENTS FOR MI & MR CFR(s): 483.20(e)(k)(1)-(4) (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a	F 285		10/10/17

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F 285	Continued From page 17 significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 285		

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(2) Exceptions. For purposes of this section-

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

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

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

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

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

(3) Definition. For purposes of this section-

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

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

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F 285	Continued From page 19 described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete a level 1 PASRR (pre-admission screening and resident review) for 11 of 24 Residents, Residents #2, #7, #11, #13, #1, #4, #5, #8, #3, #9, and #12. The findings included. 1. For Resident #2, the facility staff failed to complete a level 1 PASRR. A PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. The record review revealed that Resident #2 had been admitted to the facility 11/20/13. Diagnoses included, but were not limited to, cerebral infarction, dementia, anxiety, depressive disorder, hypertension, and blindness. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/03/17 included a BIMS (brief interview for mental status) summary score of 2 out of a possible 15 points. Section I (active diagnoses) included non-Alzheimer dementia, anxiety disorder, depression, and hallucinations. Section N	F 285	1. Staff members responsible for ensuring PASARR's are obtained were educated in regards to this requirement. A review of current residents has been completed. 2. Any resident has the potential to be affected if a PASARR is not obtained as required. 3. Staff education will be provided to the admissions team by the Administrator in regards to the requirement to ensure PASSR's are in place as required. An audit will be completed on new admissions to the center weekly X4 weeks, then monthly X2 months to ensure PASARR's are in the clinical record. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	

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(medications) was coded to indicate the Resident had received 7 days of antianxiety and antidepressant medications.

The clinical record did not include a PASRR.

The DON (director of nursing) was asked about the missing PASRR on 08/29/17 and stated that the Resident had been admitted from another facility.

On 08/29/2017 the SW (social worker) verbalized to the surveyor that the Resident did not have a PASRR.

On 08/30/17 at approximately 4:55 p.m. during a meeting with the survey team the administrator verbalized to the surveyor team that this Resident did not have a PASRR.

The administrative staff was notified of the missing PASRR on 08/31/17 at approximately 11:05 a.m.

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

2. For Resident #7, the facility staff failed to complete a level 1 PASRR.

A PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

The clinical record revealed that Resident #7 had been admitted to the facility 09/16/16. Diagnoses included, but were not limited to, heart failure, age related osteoporosis, dysphagia,

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hypertension, atrial fibrillation, and generalized anxiety.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/20/17 included a BIMS (brief interview for mental status) summary score of 5 out of a possible 15 points. Section I (active diagnoses) included Non-Alzheimer's dementia, anxiety disorder, and psychotic disorder. Section N (medications) was coded to indicate the Resident had received 7 days of an antipsychotic medication and 7 days of an antianxiety medication.

The clinical record did not include a PASRR.

On 08/30/17 at approximately 4:55 p.m. during a meeting with the survey team the administrator verbalized to the surveyor team that this Resident did not have a PASRR.

The administrative staff was notified of the missing PASRR on 08/31/17 at approximately 11:05 a.m.

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

3. For Resident #11, the facility staff failed to complete a level 1 PASRR.

A PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

The clinical record revealed that Resident #11 had been admitted to the facility 05/23/13.

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Diagnoses included, but were not limited to, generalized anxiety disorder, hypertension, essential tremor, hypothyroidism, cardiac murmur, and osteoporosis.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/13/17 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section I (active diagnoses) included anxiety and depression. Section N (medications) was coded to indicate the Resident had received 7 days of an antidepressant medication.

The clinical record did not include a PASRR.

On 08/30/17 at approximately 4:55 p.m. during a meeting with the survey team the administrator verbalized to the surveyor team that this Resident did not have a PASRR.

The administrative staff was notified of the missing PASRR on 08/31/17 at approximately 11:05 a.m.

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

4. For Resident #13, the facility staff failed to complete a level 1 PASRR.

A PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

The clinical record revealed that Resident #13

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F 285	Continued From page 23 had been admitted to the facility 03/09/13. Diagnoses included, but were not limited to, dementia, depression, dysphagia, anxiety Alzheimer's, and arthritis. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/27/17 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points. Section I (active diagnoses) included Alzheimer's, dementia, anxiety and depression. Section N (medications) was coded to indicate the Resident had received 7 days of an antianxiety and antidepressant medication. The clinical record did not include a PASRR. The administrative staff was notified of the missing PASRR on 08/31/17 at approximately 11:05 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 5. For Resident #1 the facility staff failed to obtain a level I PASRR (preadmission screening and Resident review) within 30 days of admission. Resident #1 was admitted to the facility on 12/21/10 and readmitted on 06/08/17. Diagnoses included but not limited to anemia, hypertension, urinary tract infection, hyperlipidemia, thyroid disorder, Alzheimer's disease and dementia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 08/03/17 coded the Resident as having as having	F 285		

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problems with both long and short term memory problems, and severely impaired cognitive skills for daily decision making in section C, cognitive status. This is a quarterly MDS.

Resident #1's clinical record was reviewed on 08/29/17. The surveyor could not locate the PASRR form in the clinical record.

The surveyor spoke with the DON (director of nursing) on 08/29/17 at approximately 1655 regarding the missing PASRR. The DON informed the surveyor on 08/31/17 at approximately 0830 that the PASRR could not be located.

The concern of the missing PASRR was discussed with the administrative team during a meeting on 08/31/17 at approximately 1100.

No further information was provided prior to exit.

6. For Resident #4 the facility staff failed to obtain a level I PASRR within 30 days of admission

Resident #4 was admitted to the facility on 01/13/17 and readmitted on 03/25/17. Diagnoses included but not limited to hypertension, hyperlipidemia, dementia, dysphagia, atrial fibrillation, coronary artery disease, and anxiety.

The most recent MDS with an ARD of 08/01/17 coded the Resident as 03 out of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #4's clinical record was reviewed on 08/29/17. The surveyor could not locate the PASRR form in the clinical record.

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F 285	Continued From page 25 The surveyor spoke with the DON (director of nursing) on 08/29/17 at approximately 1655 regarding the missing PASRR. The DON informed the surveyor on 08/31/17 at approximately 0830 that the PASRR could not be located. The concern of the missing PASRR was discussed with the administrative team during a meeting on 08/31/17 at approximately 1100. No further information was provided prior to exit. 7. For Resident #5 the facility staff failed to obtain a lever I PASRR within 30 days of admission. Resident #5 was admitted to the facility on 11/04/14 and readmitted on 10/06/15. Diagnoses included but not limited to congestive heart failure, chronic kidney disease, diabetes mellitus type II, dementia, atrial fibrillation, dysphagia, anxiety, gastroesophageal reflux disease, hyperlipidemia, hypertension, and coronary artery disease. The most recent MDS with an ARD of 06/13/17 coded the Resident as 3 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #5's clinical record was reviewed on 08/29/17. The surveyor could not locate the PASRR form in the clinical record. The surveyor spoke with the DON (director of nursing) on 08/29/17 at approximately 1655 regarding the missing PASRR. The DON informed the surveyor on 08/31/17 at approximately 0830 that the PASRR could not be located.	F 285		

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The concern of the missing PASRR was discussed with the administrative team during a meeting on 08/31/17 at approximately 1100.

No further information was provided prior to exit.

8. For Resident #8 the facility staff failed to obtain a level I PASRR within 30 days of admission.

Resident #8 was admitted to the facility on 04/09/17. Diagnoses included but not limited to dysphagia, hemiplegia, chronic kidney disease, hypertension, depression, congestive heart failure, atrial fibrillation, hyperlipidemia, benign prostatic hyperplasia, hypothyroidism, anxiety and diabetes mellitus type II.

The most recent MDS with and ARD of 08/23/17 coded the Resident as 10 out of 15 in section C, cognitive patterns. This is a significant change MDS.

Resident #8's clinical record was reviewed on 08/29/17. The surveyor could not locate the PASRR form in the clinical record.

The surveyor spoke with the DON (director of nursing) on 08/29/17 at approximately 1655 regarding the missing PASRR. The DON informed the surveyor on 08/31/17 at approximately 0830 that the PASRR could not be located.

The concern of the missing PASRR was discussed with the administrative team during a meeting on 08/31/17 at approximately 1100.

No further information was provided prior to exit.

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9. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #3.

The Code of Virginia reads "§ 32.1-330. Preadmission screening required. All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require a preadmission screening of all individuals who, at the time of application for admission to a certified nursing facility as defined in § 32.1-123 http://law.lis.virginia.gov/vacode/32.1-123/>, are eligible for medical assistance or will become eligible within six months following admission. For community-based screening, the screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center (WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals. The Department shall contract with other public or private entities to conduct required community-based and institutional screenings in addition to or in lieu of the screening teams described in this section in jurisdictions in which the screening team has been unable to complete screenings of individuals within 30 days of such individuals' application."

The PASRR process requires that all applicants

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to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID).

The surveyor reviewed Resident #3's clinical record on 8/29/17 and 8/31/17. Resident #3 was admitted to the facility 9/29/16 with diagnoses that included but were not limited to: dysphagia, anxiety, hypertension, chronic kidney disease, depression, hypothyroidism, urinary retention, and insomnia.
Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/17 assessed the cognitive status as 6 out of 15 in Section C Summary Score.
During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #3.

The surveyor interviewed the director of nurses on 8/30/17 at 5:05p.m. for assistance to locate the pre-admission screening form. On 8/31/17, the surveyor was informed by the director of nurses that Resident #3 did not have a PASRR.

The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the above finding on 8/31/17.

No further information was provided prior to the exit conference on 8/31/17.

10. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #12.

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

The surveyor reviewed Resident #12's clinical record on 8/29/17 and 8/31/17. Resident #12 was admitted to the facility on 1/5/12 with diagnoses that included but were not limited to: dysphagia, anxiety, dementia, seizure disorder, gastrostomy, and atrial fibrillation.
Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/17 assessed the cognitive status indicating she had both long and short term memory problems.
During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #12.

The surveyor interviewed the director of nurses on 8/30/17 at 5:05p.m. for assistance to locate the pre-admission screening form. On 8/31/17, the surveyor was informed by the director of nurses that Resident #12 did not have a PASRR.

The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the above finding on 8/31/17.
No further information was provided prior to the exit conference on 8/31/17.

11. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #9.

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F 285	Continued From page 30 The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID). The surveyor reviewed Resident #9's clinical record on 8/29/17 and 8/31/17. Resident #9 was admitted to the facility on 9/29/16 with diagnoses that included but were not limited to: dysphagia, anemia, hypertension, atrial fibrillation, urinary retention, and arthritis. Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/31/17 assessed the cognitive status as 2 out of 15 in Section C Summary Score. During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #9. The surveyor interviewed the director of nurses on 8/30/17 at 5:05p.m. for assistance to locate the pre-admission screening form. On 8/31/17, the surveyor was informed by the director of nurses that Resident #9 did not have a PASRR. The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the above finding on 8/31/17. No further information was provided prior to the exit conference on 8/31/17.	F 285		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life	F 309		10/10/17

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F 309	Continued From page 31 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 observation, staff interview, facility document review, resident interview, and clinical record review, the facility staff failed to maintain the highest practical well-being for 6 of 24	F 309	1. Staff members assigned to resident #6, #2, #3, and #11 were educated regarding non-pharmacological interventions, obtaining weights and	

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residents in the survey sample (Resident's #3, #6, #2, #7, and #11).

The findings included:

1. For Resident #6, the facility staff failed to follow physician's orders in obtaining weekly weights.

The surveyor reviewed Resident #6's clinical record on 8/29/17 and 8/31/17. Resident #6 was admitted to the facility on 10/5/16, with diagnoses that included, but were not limited to: anemia, high blood pressure, urinary tract infection, depression, and stroke.

Resident #6's current minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/17 assessed the resident with a cognitive summary score of 99. Section G coded the resident to require assistance with activities of daily living.

Further review of Resident #6's medical record revealed he had had a weight loss. On 6/19/17, an order was written for Resident #6 to have weekly weights, every day shift, every Monday for edema.

Resident #6's medication administration record (MAR) and weight record evidenced that on Monday 7/17/17, Monday, 7/24/17, Monday 8/7/17, and Monday 8/14/17, his weight was not obtained.

On 8/30/17 at 9:40 am, RN #2 was asked to assist in locating the weight documentation. After searching for the information RN #2 stated, "It looks like we missed them."

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following bowel protocol.

2. Any resident has the potential to be affected that has orders for weights, PRN pain medications, and those whose bowel protocol has not been followed.

3. Nursing staff will be educated regarding weight protocols, offering non-pharmacological interventions prior to PRN pain meds, and adherence to bowel protocols. Residents requiring "as needed" pain medications will be reviewed to ensure non-pharmacological interventions have been attempted, bowel alerts will be reviewed to ensure meds administered, and weekly weights reviewed each morning (M-F) in clinical meeting weekly x 4 weeks then monthly x 2 months.

4. Audit results will be reported to the QAPI Committee and any variances addressed.

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The administrator and director of nursing were informed of the above finding on 8/31/17.
No further information was provided prior to the exit conference on 8/31/17.

2.The facility staff failed to provide non-pharmacological interventions for pain for Resident #3 prior to the administration of Lortab a pain medication.

The surveyor reviewed Resident #3's clinical record on 8/29/17 and 8/31/17. Resident #3 was admitted to the facility on 9/29/16, with diagnoses that included, but were not limited to: dysphagia, anxiety, hypertension, chronic kidney disease, depression, hypothyroidism, urinary retention, and insomnia.
Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/17 assessed the cognitive status as 6 out of 15 in Section C summary score. In section J, she was coded to have pain.
The current comprehensive care plan initiated 10/9/15 and revised on 3/31/17 included a focus area that read "Resident #6 is at risk for pain related to osteoporosis with history of compression fracture, osteoarthritis, and decreased mobility." The non-pharmacological intervention in the care plan read: Offer non-pharmacological interventions as needed such as turn and repositioning, low light and quiet environment with a date of 6/10/2016.

Review of the Resident 's current physician 's summary of orders dated 8/1/17-8/30/17, revealed Resident #3 had an order for Lortab7.5-325 mg, one tablet every 6 hours as needed for pain (PRN).

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Resident #3's PRN medication documentation sheet revealed she received pain medication for complaint of pain. There was no documentation in the nurse's progress notes to indicate if non-pharmacological interventions had been tried prior to the administration of the medication.

The Resident's PRN medication documentation sheet revealed she received pain medication on 7/2717 at 09:53 and 7/17/17 at 20:27, for complaint of (C/O) pain "not saying where." The documentation of the results indicated the medication was effective. There was no documentation in the nurse's progress notes to indicate if non-pharmacological interventions had been tried prior to the administration of the medication.

The Resident's PRN medication documentation sheet revealed she received pain medication on 8/3/17 at 22:33, 8/4/17 at 8:01, 8/6/17 at 05:30, 8/11/17 at 20:13, 8/18/17 at 22:06, 8/20/17 at 23:10, 8/25/17 at 10:42, and 8/30/17 at 06:46, for complaint of (C/O) pain "not saying where." The documentation of the results indicated the medication was effective. There was no documentation in the nurse's progress notes to indicate if non-pharmacological interventions had been tried prior to the administration of the medication.

There was no documented non-pharmacological intervention prior to the administration of the pain medication for any of the above dates and times when Resident #3 complained of pain.

The failure of the facility to provide non-pharmacological interventions for resident complaints of pain was discussed with the

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F 309	Continued From page 35 administrative staff on 8/30/17. No further information was provided prior to the exit conference on 8/31/17. 3. For Resident #2, the facility staff failed to follow their bowel protocol and failed to provide non-pharmacological interventions prior to administering a pain medication. The record review revealed that Resident #2 had been admitted to the facility 11/20/13. Diagnoses included, but were not limited to, cerebral infarction, dementia, anxiety, depressive disorder, hypertension, and blindness. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/03/17 included a BIMS (brief interview for mental status) summary score of 2 out of a possible 15 points. Section H (bowel and bladder) was coded (3/3) to indicate the Resident was always incontinent in both of these areas. The Residents CCP (comprehensive care plan) included the following focus areas- "...at risk for constipation..." Interventions included observe/document/report to MD PRN (as needed) s/sx (signs/symptoms) of complications related to constipation. "...at risk for unresolved pain..." Interventions included assess need for pain relief often and respond to any complaint of pain and offer non-pharmacological interventions to pain as needed such as: providing low light, providing a quiet environment and repositioning. Resident #2's clinical record included a physician progress note dated 06/28/17 indicating the Resident had been impacted on that date. The	F 309		

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clinical record included documentation to indicate the Resident had a BM on 06/15, 06/16, 06/18, 06/20, 06/21, 06/24, and 06/25/17 prior to be checked by the physician on 06/28/17. However, a review of the BM (bowel movement) sheets for June indicated that the Resident had a BM on 06/06/17 but did not have another BM until 06/12/17 and for the month of August the Resident had a BM on 08/10/17 but did not have another BM until 08/16/17.

The Resident was currently receiving glycolax powder 17 grams every 12 hours for constipation and had a prn order dated 06/28/17 for a dulcolax suppository 10 mg every 24 hours as need for constipation. There was no documentation to indicate that the suppository had been administered per the prn order in August.

A review of the Residents eMAR's (electronic medication administration records) for August 2017 indicated that the facility staff had administered acetaminophen (no strength listed) 3 tabs on 08/16, 08/17, and 08/24 for a pain scale of "3." The medication had been documented as being effective. A review of the Residents clinical record revealed no non-pharmacological interventions prior to administering the pain medication.

During an interview with LPN (licensed practical nurse) #2 on 08/31/17 at 10:10 a.m. LPN #2 verbalized to the surveyor that if a prn medication is given for pain you should offer to reposition the Resident, offer a muscle rub if applicable to them, and document what you had done.

The administrative staff was notified of the above concerns regarding Resident #2 during a meeting

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with the survey team on 08/31/17 at 11:05 a.m.

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

4. For Resident #7, the facility staff failed to provide non-pharmacological interventions prior to administering pain medications.

The clinical record revealed that Resident #7 had been admitted to the facility 09/16/16. Diagnoses included, but were not limited to, heart failure, age related osteoporosis, dysphagia, hypertension, atrial fibrillation, and generalized anxiety.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/20/17 included a BIMS (brief interview for mental status) summary score of 5 out of a possible 15 points.

The surveyor had requested the Residents comprehensive care plan but only part of it was provided by the facility.

A review of the Residents eMAR's (electronic medication administration records) for August 2017 indicated that the facility staff had administered acetaminophen 650 mg on 08/25/17 for a pain scale of "3." The facility nursing staff had documented that the medication was effective. The Resident had also been administered the pain medication lortab 5/325 mg 17 times in August 2017. A review of the Residents clinical record revealed that on 08/10 the facility nursing staff had documented that they had repositioned the Resident with no relief. No

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other non-pharmacological interventions prior to administering the pain medications were shared with the surveyor during the course of the survey.

During an interview with LPN (licensed practical nurse) #3 on 08/31/17 at 10:15 a.m. LPN #3 verbalized to the surveyor that you should definitely reposition the Residents and try to get her to focus on something else. When asked to show the surveyor where this would be documented LPN #3 was able to bring up a screen on the computer but was unable to maneuver through the steps.

The administrative staff was notified of the concerns regarding non-pharmacological interventions and Resident #7 during a meeting with the survey team on 08/31/17 at 11:05 a.m.

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

5. For Resident #11, the facility staff failed to follow their bowel protocol and failed to provide non-pharmacological interventions prior to administering a pain medication.

The clinical record revealed that Resident #11 had been admitted to the facility 05/23/13. Diagnoses included, but were not limited to, generalized anxiety disorder, hypertension, essential tremor, hypothyroidism, cardiac murmur, and osteoporosis.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/13/17 included a BIMS (brief interview for

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mental status) summary score of 15 out of a possible 15 points. Section H (bowel and bladder) was coded to indicate the Resident was frequently incontinent of bowel.

The Residents CCP (comprehensive care plan) included the following focus areas-
"...at risk for constipation r/t (related to) decreased mobility and pain medication side effects" and included the intervention encourage resident to sit on toilet to evacuate bowels if possible, follow facility bowel protocol for bowel management, observe medications for side effects of constipation, and observe/document/report to MD PRN (as needed) s/sx (signs/symptoms) of complications related to constipation.
"...at risk for pain r/t ataxia, tremors, osteoporosis and neuropathy" and included the intervention offer non-pharmacological pain interventions as needed such as: turning/repositioning, low light, quiet environment etc.

A review of Resident #11's BM (bowel movements) sheets for August 2017 revealed that Resident #11 had a BM on 08/12 and did not have another BM until 08/17 and had a BM on 08/20 but did not have another BM until 08/26.

A review of the Residents eMAR's (electronic medication administration records) revealed that the Resident was receiving polyethylene glycol 17 grams one time a day for constipation.

A review of the Residents current POS (physician order summary) indicated that the Resident had an order for "Bowel Routine as per policy."

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F 309	Continued From page 40 A review of the Residents eMAR's (electronic medication administration records) revealed that the facility nursing staff had administered acetaminophen 650 mg on 08/12 for a pain scale of "5" and hydrocodone-acetaminophen 5/325 mg 46 times in August 2017. During an interview with LPN (licensed practical nurse) #2 on 08/31/17 at 10:10 a.m. LPN #2 verbalized to the surveyor that if a prn medication is given for pain you should offer to reposition the Resident, offer a muscle rub if applicable to them, and document what you had done. On 08/31/17 at approximately 10:25 a.m. Resident #11 was asked by the surveyor if the facility staff offered to reposition her or anything else prior to administering her prn pain medication. Resident #11 replied they did not but that the staff was good to her. The administrative staff was notified of the above regarding Resident #11 in a meeting with the survey team on 08/31/17 at 11:05 a.m. During this meeting the administrative staff verbalized that they did not have any standing orders. No further information regarding these issues was provided to the survey team prior to the exit conference.	F 309		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		10/10/17

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F 323	Continued From page 41 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure a hazard free environment on 1 of 3 units (stallard). The findings included. The surveyor observed (2) unsecured containers of sani-cloth germicidal disposable wipes and (1) container of dermaseptin skin protectant in the shower room on the stallard hall. On 08/29/17 at approximately 4:45 p.m. the surveyor entered the shower room on the stallard hall (400 hall) this door was unlocked. When entering the shower room the surveyor was able	F 323	1. Cabinet was locked and sani-cloths were removed. 2. Any resident has the potential to be affected if allowed access to chemicals. 3. Nursing staff will be educated regarding ensuring that cabinets are locked and chemicals are not within resident access. Shower room areas to be checked weekly x 4 weeks then monthly x 2 months to ensure cabinets are locked and chemicals are secured. 4. Audit results will be reported to the QAPI Committee and any variances	

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F 323	Continued From page 42 to observe 2 containers of sani-cloth germicidal disposable wipes 160 count each sitting on top of the cabinet. This cabinet was a short cabinet and would have been easily accessible by the Residents of the facility. This cabinet was also observed to be unlocked inside the cabinet the surveyor observed 1 container of dermaseptin skin protectant. Upon exiting the bathroom the surveyor was able to observe Residents in the vicinity of this shower room. The unit manager was asked to accompany the surveyor into the bathroom and notified of the unsecured items. The MSDS (material safety data sheets) were requested at that time. The facility provided the surveyor with copies of the MSDS for both products. Sani-cloth germicidal wipes-disinfectant-Health Hazard-Serious eye damage/eye irritation. Dermaseptin-skin ointment-For external use only-Irritating if placed in eyes or if ingested. The administrative staff was notified of the unsecured items during a meeting with the survey team on 08/31/17 at approximately 11:05 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 323	addressed.	
F 371 SS=F	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		10/10/17

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F 371	Continued From page 43 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 and staff interview, the facility staff failed to prepare and serve food under sanitary conditions. The findings include: The initial tour of the kitchen was conducted on 8/29/17 at 12:43pm. Upon entrance of the kitchen, the surveyor noticed the milk coolers lid was open. The surveyor asked for hair nets and waited by the cooler looking for the thermometer; one was not noted inside the cooler, but the one on the outside was 40 degrees. The milk inside the cooler was cold to touch, but sweating. On 8/30/17, at10:30 am, the surveyor entered to the kitchen, the hood over the stove was noted to be dusty and the dietary manager was informed	F 371	1. Milk cooler lid was closed, hood was cleaned and cleaning schedule updated. Hairnets were replaced to properly restrain hair. Possibly contaminated food and out of temperature range milk was discarded, and thermometer was placed inside milk cooler. Staff education related to findings was initiated. 2. Any resident has the potential to be affected when food is not stored at proper temperatures, when there is possible cross-contamination, or there is a delay in timely meal service.	

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F 371	Continued From page 44 of the issue. She said she would have it cleaned. Two female staff members were observed to be preparing food for the day. Both had on hair nets, but their hair was not restrained by the net. One had hair coming out from under the net on both sides of her head. At 12:25pm, the surveyor returned the kitchen to check the tray line. The temperatures on the tray line were maintained at 140 degrees and greater. However, the cook leaned the food thermometer against the egg salad sandwiches and allowed the plastic to touch the coleslaw. The milk was tested and it was found to be 49 degrees; it was not kept on ice when removed from the cooler. A carton of milk that was removed from the cooler; it tested was 39 degrees. The dietary manager was informed of the above issues and she had the dietary aide remove the milk that was sitting out and get out more from the cooler as it was needed. The dietary manager was asked by the surveyor if the milk should have been on ice. She said, "Yes." A test tray was requested by the surveyor and taken to the last unit served. It arrived on the unit at 1:00pm. The staff started serving the trays at 1:21pm. At 1:35pm, the test tray temperatures were checked and the food tasted. The food was palatable, the warm-food was warm, and the cool-food was cool. On 8/30/17 at approximately 5:05pm, a meeting was held with the administrator, director of nurses, and other administrative individuals. The issues found in the kitchen and with the test tray was discussed. They were asked by the surveyor if the CNA's were the only staff who were to serve the meal trays. The administrator said, "It everyone's job." Prior to exit on 8/30/17, no further information was provided to the survey team.	F 371	3. Administrator/designee to provide education related to food storage, sanitary preparation of food, equipment cleaning, and timely meal service. Observations will be completed twice weekly X4 weeks, then weekly X8 weeks to ensure food is stored and served at proper temperatures, food is prepared appropriately to avoid cross-contamination, kitchen equipment is in sanitary condition, and meal service is timely. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	

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F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) 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-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws,	F 431		10/10/17

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F 431	Continued From page 46 the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure medications were stored appropriately on 1 of 3 units (dementia unit). The findings included. The surveyor observed 1 tablet of levothyroxine 25 mg and 2 tablets of 25 mg quetiapine on top of the medication cart. Levothyroxine is a thyroid medication. Quetiapine is an antipsychotic medication and is also known as seroquel. On 08/31/17 at approximately 6:10 a.m. the surveyor entered the dementia unit. Upon entering the unit the surveyor was able to observe LPN (licensed practical nurse) #4 walking toward the medication cart. The surveyor and LPN #4 both approached the medication cart. Upon reaching this cart the surveyor was able to observe 1 tablet of levothyroxine 25 mg and 2	F 431	1. Staff members assigned to medication carts were educated about proper medication storage and med pass procedure. 2. Any resident has the potential to be affected if medications are left accessible. 3. Nursing staff will be educated regarding ensuring that medications are not left unattended and accessible to residents. Med pass audits to be completed weekly x 4 weeks, then monthly x 2 months. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	

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F 431	Continued From page 47 tablets of 25 mg quetiapine on top of the medication cart. These medications were sealed in blister packets. The surveyor asked LPN #4 if she had left this medication on top of the cart to which LPN #4 stated she had but that she didn't usually leave medication on top of her cart. The surveyor was able to observe one Resident in the vicinity of this medication cart. The administrative staff was notified of the unsecured medications during a meeting with the survey team on 08/31/17 at approximately 11:05 a.m. No further information regarding the unsecured medications was provided to the survey team prior to the exit conference.	F 431		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		10/10/17

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F 441	Continued From page 48 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 49 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review the facility staff failed to follow established infection control guidelines for 2 of 3 units, while completing a medication pass and pour and for 1 of 24 Residents, Residents #11. The findings included: 1. For the long-term care unit (200 hall) and the memory care unit the facility staff failed to follow established infection control policy by sitting on Residents bed while assisting in feeding. On 08/30/17 at approximately 0820, surveyor observed CNA (certified nursing assistant) #1 in the long term care unit seated on unsampled Resident's bed while assisting Resident with eating breakfast. Resident was seated in wheelchair at side of bed and CNA was seated on side of Resident's bed. On 08/30/17 at approximately 0920, surveyor observed CNA's in the memory care unit seated on unsampled Residents beds while assisting with eating breakfast. Residents were in the beds at the time. On 08/31/17 at approximately 0805 surveyor	F 441	1.Staff education initiated pertaining to infection control guidelines. 2. Any resident has the potential to be affected if staff sit on beds while feeding, administer medication improperly, and practice poor hand hygiene. 3. Nursing staff will be educated on correct medication administration procedure and infection control guidelines. Five random obserbations to be performed when staff are feeding residents weekly X4 weeks, then monthly X2 months. Five random observations to be performed during patient care to ensure correct hand hygiene is performed weekly X4 weeks, then monthly X2 months. Five random observations to be performed during medication administration to ensure no contamination weekly X4 weeks, then monthly X2 months. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	

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observed CNA #2 seated on unsampled Resident's bed while assisting with eating breakfast. Resident was sitting up in bed at time.

On 08/31/17 at approximately 0815, surveyor observed CNA #3 seated on unsampled Resident's bed while assisting with eating breakfast. Resident was seated in wheelchair at side of bed.

On 08/31/17 at approximately 0850 surveyor spoke with CNA #3 regarding sitting on Resident's bed. Surveyor asked CNA if it was common practice to sit on Resident's bed while feeding and CNA #3 stated "sometimes because she is in a wheelchair".

On 08/31/17 at approximately 0855 surveyor spoke with CNA #2 regarding sitting on Resident's bed. Surveyor asked CNA #2 if it was common practice to sit on Resident's bed while feeding and CNA #2 stated "normally when I feed her that's where I sit".

On 08/31/17 at approximately 0925 surveyor spoke with the administrator and DON (director of nursing) regarding CNA's sitting on Residents beds. Administrator stated that it depended on the Resident, and they felt like the Resident would eat better if CNA was seated on bed.

On 08/31/17 at approximately 1000, surveyor spoke with the infection control nurse regarding CNA's sitting on Residents beds. Surveyor asked infection control nurse if he regarded this as an infection control issue and he stated that he did not see this as a problem.

The concern of CNA's sitting on Resident's beds

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F 441	Continued From page 51 was discussed during a meeting with the administrative staff on 08/31/17 at approximately No further information was provided prior to exit. 2. Facility staff failed to observe established infection control procedures during a medication pass and pour. The surveyor observed LPN (licensed practical nurse) #1 during a medication pass and pour on 08/30/17 at approximately 0815. LPN #1 exited a Resident's room and returned to the medication cart, began preparing another Resident's medication and did not perform and hand hygiene. LPN #1 prepared the medication, entered the Resident's room, administered the medication, returned to the cart and again, began preparing medication, without performing any hand hygiene. The surveyor observed LPN #2 during a medication pass and pour on 08/30/17 at approximately 0825. After performing hand hygiene, LPN #2 prepared medications, announced herself and entered Resident's room. LPN #2 poured the medications into Resident's open hand. Resident dropped on of the medications onto bed covers, where LPN picked the medication up with her bare hand and placed it back into the pill cup, then administered it to the Resident. The surveyor observed LPN #3 during a medication pass and pour on 08/31/17 at approximately 0635. While preparing medications, LPN #3 dropped a tablet onto the top of the medication cart, picked it up with her bare hand and placed it in the cup with the other	F 441		

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prepared medications. LPN #3 then proceeded to administer all medications in the cup to the Resident.

On 08/30/17, surveyor requested and was provided with a policy entitled "General Guidelines for Medication Administration" which read in part "Procedure: 2. Cleanse hands as appropriate. 6. Tablets and Capsules b. Never touch any of the medications with fingers".

The concern of not using proper hand hygiene and touch the medications with bare hands was discussed with the administrative team during a meeting on 08/31/17 at approximately 1100.

No further information was provided prior to exit.
3. For Resident #7, the facility staff failed to perform hand hygiene after the removal of gloves, prior to leaving the Residents room, and during patient care.

The clinical record revealed that Resident #7 had been admitted to the facility 09/16/16. Diagnoses included, but were not limited to, heart failure, age related osteoporosis, dysphagia, hypertension, atrial fibrillation, and generalized anxiety.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/20/17 included a BIMS (brief interview for mental status) summary score of 5 out of a possible 15 points.

On 08/29/17 at approximately 2:40 p.m. the surveyor asked permission to observe the Residents bottom due to concerns expressed by the family. LPN (licensed practical nurse) #1 and

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F 441	Continued From page 53 CNA (certified nursing assistant) #1 entered the Residents room with the surveyor and both of these staff applied gloves, after positioning the Resident on their side and untaping the Residents brief, CNA #1 stated she needed to leave the room to obtain hygiene supplies (wipes), CNA #1 removed her gloves and without performing any hand hygiene, placed her bare hand on the doorknob, opened the door and exited the room. When entering the room CNA #1 reapplied gloves and continued to provide care to Resident #7. After cleaning the Resident's bottom with the wipes provided by CNA #1 LPN #1 applied dermaseptin to the Residents bottom without changing her gloves and/or performing any hand hygiene. After applying the dermaseptin LPN #1 did change her gloves but did not complete any hand hygiene before repositioning the Resident. CNA #1 was observed by the surveyor to place the used brief in the trash can change her gloves but did not complete any hand hygiene. CNA #1 then used the controls to the bed to raise the head of the Residents bed. Prior to leaving the room LPN #1 did remove her gloves and use hand sanitizer. CNA #1 gathered up the trash, removed her gloves, and washed her hands. On 08/31/17 at approximately 9:45 a.m. the surveyor interviewed the designated infection control nurse/ADON (assistant director of nursing). When asked about completing hand hygiene the ADON stated anytime staff removes their gloves they should perform hand hygiene. When asked if the staff should have completed hand hygiene/glove change after cleaning the Residents bottom and applying dermaseptin the ADON verbalized to the surveyor that the nursing	F 441		

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staff should have changed their gloves and performed hand hygiene after cleaning the Residents bottom and before applying the dermaseptin.

The facility policy/procedure titled "GENERAL INFECTION CONTROL POLICIES" read in part "Proper hand washing between each resident contact is always necessary (refer to detailed policy on hand washing)."

The facility policy/procedure titled "HAND WASHING" read in part "...TIMES WHEN HAND WASHING IS VERY IMPORTANT...Before and after resident contact...After handling resident's articles or equipment used in his care..."

The administrative staff was notified of the concerns regarding hand hygiene/infection control and Resident #7 during a meeting with the survey team on 08/31/17 at approximately 11:05 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.
4. For Resident #12 the facility staff failed to follow infection control practices for hand washing.
The surveyor reviewed Resident #12's clinical record on 8/29/17 and 8/31/17. Resident #12 was admitted to the facility on 1/5/12 with diagnoses that included but were not limited to: dysphagia, anxiety, dementia, seizure disorder, gastrostomy, and atrial fibrillation.
Resident #12's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/17 assessed the cognitive status indicating she had both long and

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F 441	Continued From page 55 short term memory problems. She was assessed and coded in section G to require total assistance with all activities of daily living. On 8/30/17 at 8:05 am, the surveyor was outside Resident #12's room and noticed a strong urine smell. Upon entrance to her room the smell became even stronger. LPN #1 was in the hall at her medication cart and the surveyor asked if she could come into the room and check Resident #12 for wetness. LPN #1 entered the room, put on gloves and proceeded to check the resident. She checked the brief and stated, "She is wet." The surveyor then asked the LPN to turn the resident and check under the pad to see if the sheet was soiled. The surveyor could see that the sheet was wet and noted the light brown ring of old urine. LPN #1 informed the surveyor that she would get the CNA to come and change the resident. She then removed her gloves, put them in the trash, and went out the door to find the CNA. LPN #1 did not wash her hands before leaving the resident's room. On 8/30/17 at approximately 4:55pm, during a meeting with the administration team, the surveyor informed them of LPN #1's failure to follow infection control practices in hand washing. Prior to exit on 8/31/17, no further information was provided to the surveyor related to resident #12's soiled condition.	F 441		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE 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	F 514		10/10/17

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F 514	Continued From page 56 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 and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 24 Residents, Residents #2 and #11. The findings included. 1. For Resident #2, the facility staff failed to identify in the clinical record the strength of the	F 514	1. Resident #2's order for Tylenol is complete to include dosage information. Staff education initiated in regards to complete and accurate medical records. 2. Any resident has the potential to be affected if medical record documentation is incomplete.	

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F 514	Continued From page 57 Residents acetaminophen to be administered. The record review revealed that Resident #2 had been admitted to the facility 11/20/13. Diagnoses included, but were not limited to, cerebral infarction, dementia, anxiety, depressive disorder, hypertension, and blindness. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/03/17 included a BIMS (brief interview for mental status) summary score of 2 out of a possible 15 points. A review of the Residents current POS (physician order sheet) and eMARs (electronic medication administration records) revealed that the facility failed to identify the strength of the acetaminophen the Resident was to receive. The order on both of these documents read "Acetaminophen Tablet Give 3 tablet orally every 12 hours as needed for pain/elevated temp." The order date was documented as 04/08/16. The Resident had received this medication 3 times in August for a pain level of "3." The facility nursing staff documented that if had been effective. 2. For Resident #11, the facility failed to document for the administration of the medication levothyroxine and for the application of the Residents TED hose. The clinical record revealed that Resident #11 had been admitted to the facility 05/23/13. Diagnoses included, but were not limited to, generalized anxiety disorder, hypertension, essential tremor, hypothyroidism, cardiac	F 514	3. DON/Designee to provide education to staff regarding complete and accurate medical records. Five random audits to be completed to ensure complete and accurate medical records weekly X4 weeks, then monthly X2 months. 4. Audit results will be reported to the QAPI Committee and any variances addressed.	

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F 514	Continued From page 58 murmur, and osteoporosis. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/13/17 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. A review of the Residents eMARs (electronic medication administration records) indicated that the facility nursing staff had not documented that they had administered the Residents levothyroxine on 08/06, 08/07, 08/17, and 08/25 at 6:30 a.m. They also had not documented they had applied the Residents physician ordered TED hose at 6:00 a.m. on 08/01, 08/03, 08/06, 08/07, 08/08, 08/11, 08,12, 08/16, 08/17, 08/22, 08/25, and 08/26. The nursing staff had documented for the removal of the hose at bedtime. The administrative staff were notified of the missing documentation during a meeting with the survey team on 08/31/17 at approximately 11:05 a.m. No further information regarding the missing documentation was provided to the survey team prior to the exit conference.	F 514		