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	495411	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 03/15/2016 through 03/17/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 79 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 1 through 13) and 3 closed record reviews (Residents 14 through 16).	F 000		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview the facility staff failed to ensure a homelike environment in a resident room: Room 212. The wall behind the bed on the window side of the room had paint scraped off in large, vertical lines including wall damage extending into the sheet rock with an area beginning to form an open area. The door side of the room had a horizontal scrape near the bed which had removed the paint. Findings include:	F 252	F 252 1. The walls in room 212 have been repaired. 2. All resident rooms have been inspected for any damage to the walls. There was no other damage identified 3. Staff have been reeducated to report to the Maintenance Director any damage to walls as soon as the damage occurs or when first noticed. This reporting is done by department managers as they complete their morning room rounds and their findings discussed in morning meeting. The Maintenance Director will inspect all resident rooms for damage to walls and report his findings to the Administrator weekly for 12 weeks.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mason Layne — TITLE: Administrator — (X6) DATE: 3-30-16

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

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On 3/16/16 at 10:45 a.m. this surveyor went to interview Resident # 1. During the interview it was noted that a linear area approximately one and a half to two feet long and close to the baseboard was scraped off and paint was missing. The resident was asked how long the wall had been that way, and she stated "Oh, I don't know. I guess I've just gotten used to seeing it there." As this surveyor turned to leave the room after the interview, the wall behind Resident # 1's roommate's bed was observed with large area's of paint scraped off in vertical lines approximately four feet wide and extending down to just above the baseboard. The scraped lines included a larger area approximately three and half inches wide and six to eight inches long where the sheet rock was extensively damaged and beginning to form a hole. The roommate was in her bed reading the paper. This surveyor asked about the damaged area behind the bed. The resident stated "I don't know how long it's been that way; the bed moves and hits up against the wall; even when the wheels are locked it moves, I'm not sure how. They changed my bed once, but that didn't help." The resident went on to say she did not know how long the wall had been damaged, but would guess it had been that way "for a while."

On 3/16/16 at approximately 2:30 p.m. the maintenance director was interviewed about the walls. The maintenance director stated "I've already been back there to fix the wall; the administrator told me about it." This surveyor asked how long the walls had been damaged. The maintenance director stated "Each department head is responsible for room rounds every morning at 9:00 a.m. If there are any

4. The Administrator will report the findings of this monitoring to the Quality Assurance Committee monthly for 3 months for review and recommendations.
5. Completion Date : 4-15-2016

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issues with a room, they are to let me know. The administrator told me to go check and fix the walls in room 212. I've patched and painted it, but it needs another coat of paint after this one dries. I'm not pointing fingers, but I really think what's happening is when the CNA's go in to get that resident up with the lift, they aren't keeping the back of the bed far enough away from the wall. They probably move the bed to the side to get the hoyer lift in and in the process the bed gets pushed against the wall. That's just my assumption; I really don't know how it's happening. I have no idea how long the walls have been in that condition."

The above findings were shared with facility staff during an end of the day meeting 3/16/16 beginning at 4:45 p.m.

No further information was provided prior to the exit conference.

F 271 SS=E 483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE

At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to obtain physician orders for the care of a Foley catheter for one of 16 residents in the survey sample: Resident # 6. Resident # 6's readmission orders dated 02/23/16 did not include orders for the immediate care and services for her Foley catheter. Orders were not

F 252

F 271

F 271

1. The order for the care and services of the Foley catheter for Resident #6 were obtained on 3/16/16 at 6:00pm
2. The orders for all residents with Foley catheters have been reviewed and are complete.
3. Licensed staff have been reeducated to obtain orders for any Foley catheter present on admission.

The Director of Nursing or designee will review the new admission orders vs the hospital discharge orders for all residents admitted/readmitted to

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received until 3/16/16 at 6:00 p.m. for the care and services of the Foley catheter.

Findings include:

Resident # 6 was admitted to the facility 7/30/15 with a readmission date of 2/19/16. Diagnoses for Resident # 1 included, but was not limited to: anxiety and depression, GERD, history of atrial fibrillation, back pain, Stroke, high blood pressure, new colostomy, urinary retention, and arthritis.

The most recent MDS (minimum data set) was a quarterly review dated 2/27/16 and had Resident # 6 assessed with severe impairment in cognition with a total summary score of 09 out of 15. Resident # 6 was also coded on this assessment as having an indwelling (Foley) catheter.

The clinical record was reviewed 3/15/16 at 2:45 p.m. Admission orders from the most recent readmission after hospitalization were dated and signed by the physician 2/23/16. The admission order form included a section for "Catheter Orders: Type, No., Size, Balloon size, Reason." The entire section had no information documented for the catheter. Further review of the admission form revealed there was no information or documentation that the resident had an indwelling catheter. A physician progress note written by the nurse practitioner signed and dated 2/22/16 also did not address the resident's Foley catheter care and services beyond an inclusion in the note for "2. UA(urinary) retention (stable) Follow up with urology." Hospital discharge records reviewed did not include orders for the care and services of the resident's Foley

ensure that Foley orders are complete for any resident admitted with a Foley. The Director of Nursing or designee will maintain a list of residents who have Foley catheters and will document verification at the beginning of each month that the orders are complete. This will be documented for 3 months.

4. The Director of Nursing will report the findings of the verification of orders for all residents who have Foley catheters to the Quality Assurance Committee monthly for 3 months for review and recommendations.
5. Completion Date: 4-15-2016

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F 271	Continued From page 4 catheter. On 3/16/16 at 9:20 a.m. the DON (director of nursing) was interviewed about the physician orders not including care and services for the Foley catheter. She was also asked if nursing staff reviewed the physician orders to ensure completeness. The DON stated "The unit manager (a nurse) usually checks the orders for completeness; there should have absolutely been orders for the catheter." On 3/17/16 at 9:50 a.m. the DON gave this surveyor a copy of a physician's telephone order dated 3/16/16 at 6:00 p.m. for the care and services of the Foley catheter. No further information was provided prior to the exit conference.	F 271		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278	F 278 1. The MDS assessments for Resident #6 has been modified and resubmitted on 3-16-2016. 2. An audit has been done of current residents' most recent MDS assessment to ensure that the data reflects what is documented in the charts for those residents. Any MDS assessment that is inconsistent with the documentation will be modified and resubmitted. 3. The MDS RN has been reeducated as to the guidelines for gathering data for MDS assessments according to the RAI manual. This will include the review of the MDS prior to submission to ensure	

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F 278	Continued From page 5 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for one of 16 residents in the survey sample: Resident # 6's pneumonia vaccination status was incorrectly coded on comparison MDS assessments. Findings include: Resident # 6 was admitted to the facility 7/30/15 with a readmission date of 2/19/16. Diagnoses for Resident # 6 included, but was not limited to: anxiety and depression, GERD, history of atrial fibrillation, back pain, Stroke, high blood pressure, new colostomy, urinary retention, and arthritis. The most recent MDS (minimum data set) was a quarterly review dated 2/27/16 and had Resident # 6 assessed with severe impairment in cognition with a total summary score of 09 out of 15. Resident # 6 was also coded on this assessment as not having had the pneumonia vaccine, and as	F 278	that each section is consistent with the information in the chart. The Director of Nursing or RN designee will complete weekly audits of two resident MDS assessments for 12 weeks. 4. The Director of Nursing will report the findings of the monitoring to the QA committee monthly meeting for review and recommendations for the duration of the monitoring. 5. Completion Date:4-15-2016	

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F 278	Continued From page 6 having been offered the pneumonia vaccine and declining. A comparison MDS dated 8/8/15, which was the admission assessment, documented the resident had received the pneumonia vaccine and was up to date. On 3/16/16 at approximately 10:00 a.m. RN (registered nurse) #5, who was the MDS coordinator, was asked about the discrepancy in the documentation for the pneumonia vaccine. RN # 5 stated she would need to see what happened and get back to me. At 11:00 a.m. RN # 5 came to the conference room and told this surveyor "She [Resident # 6] is documented as having had received the pneumonia vaccine in 2008 according to the doctors office notes....when I did the quarterly assessment I looked at the current hospital discharge records which said she had not had the vaccine and had refused it instead of going back to what I had." The above findings were shared with facility staff during an end of the day meeting 3/16/16 beginning at 4:45 p.m. No further information was provided prior to the exit conference.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	1. The care plan for Resident #6 has been completed to include all aspects of the resident's individual needs. 2. An audit has been completed to identify all residents who have an indwelling catheter. These care plans have been reviewed to ensure that they include all aspects of each resident's needs.	

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needs that are identified in the comprehensive assessment.

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

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed to develop a comprehensive care plan (CCP) to address the care of an indwelling (Foley) catheter for one of 16 residents in the survey sample: Resident # 6.

Findings include:

Resident # 6 was admitted to the facility 7/30/15 with a readmission date of 2/19/16. Diagnoses for Resident # 1 included, but was not limited to: anxiety and depression, GERD, history of atrial fibrillation, back pain, Stroke, high blood pressure, new colostomy, urinary retention, and arthritis.

The most recent MDS (minimum data set) was a quarterly review dated 2/27/16 and had Resident # 6 assessed with severe impairment in cognition with a total summary score of 09 out of 15.

The clinical record was reviewed 3/15/16 at 2:45 p.m. During review of the care plan for Resident

3. The MDS RN has been educated concerning the RAI guidelines concerning the requirement that the comprehensive care plan be completed by day 21 post admission for all newly admitted/readmitted residents. The MDS RN or designee will attend the morning clinical meeting and will update the care plan at that time for any resident with a change of condition.
The MDS RN will update the care plan quarterly after the completion of the quarterly assessment for each resident.
The Director of Nursing or RN designee will review 2 care plans that were updated for the quarterly MDS to ensure that the care plan is consistent with the quarterly MDS and chart information monthly for 3 months.
4. The Director of Nursing will report the findings of the monitoring to the QA committee monthly meeting for review and recommendation for the duration of the monitoring process.
5. Completion Date: 4-15-2016

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6 it was noted there was no care plan for care of the indwelling catheter.

On 3/16/16 at 10:00 a.m. RN (registered nurse) # 5, who was the MDS coordinator, was asked for assistance in locating the care plan. RN # 5 stated she would look to see if there was a care plan on paper, or one in progress, and get back to me.

On 3/16/16 at 11:00 a.m. RN # 5 informed this surveyor "I did not do a care plan for the catheter."

On 3/17/16 this surveyor found a care plan for Resident # 6's Foley catheter dated 3/16/16 in a stack of information that had been requested earlier.

The above findings were shared with facility staff during an end of the day meeting 3/16/16 beginning at 4:45 p.m.

No further information was provided prior to the exit conference.

F 280 SS=E 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

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

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending

F 280

1. The care plans for Residents #3, #4, and #9 have been corrected and accurately reflect the condition of the residents.
2. Care plans for current residents have been reviewed to ensure that each care plan accurately reflects the resident's condition.

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physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to review and revise a comprehensive care plan for four of 16 residents in the survey sample, Residents #4, #3, #9 and #5.

1. Facility staff failed revise the CCP for Resident #4 regarding care of a stage 4 pressure ulcer and an indwelling catheter.

2a. The facility failed to revise Resident # 3's plan of care to reflect a healed pressure sore.

2b. The facility staff failed to revise Resident # 3's care plan to include her self-imposed weight loss program.

Findings included:

1. Facility staff failed revise the CCP for Resident #4 regarding care of a Stage 4 pressure ulcer and an indwelling catheter.

1. Resident #4 was admitted to the facility on 07/28/2015 with diagnoses including, but not

3. The Licensed Nurses have been reeducated concerning the RAI manual stated expectations concerning the updating of the care plan when a resident has a change in condition.
The MDS RN or designee will attend the morning clinical meeting and will update the care plan at that time for any resident with a change of condition.
The Director of Nursing or designee will review the update of each care plan during the morning clinical meeting by having the MDS RN or designee read back the update to the team during the discussion and before moving on to the next issue.
4. The Director of Nursing will report the continuation of this practice to the Quality Assurance Committee monthly for three months.
5. Completion Date: 4-15-2016

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limited to: Dementia, Anxiety with Depression, Osteoporosis, Chronic Back Pain, Urinary Tract Infection, Hypertension and Anemia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/06/2015. Resident #4 was assessed as severely impaired in cognitive skills with a total cognitive score of three out of 15.

Resident #4's clinical record was reviewed on 03/15/2016 at approximately 2:40 p.m. and 03/16/2016 at approximately 7:45 a.m. During the record review it was discovered Resident #4 had a Stage 4 pressure ulcer on her right ischium that was discovered on 12/01/2015 and an indwelling catheter (Foley) that was originally placed on 01/08/2016 and replaced on 01/16/2016. The CCP for this resident did not include revised interventions for either focus area.

The CCP included the following for skin breakdown. "Focus: Actual skin breakdown to buttocks...At risk for further skin breakdown related to: decreased mobility, weakness, incontinent of bladder, hx. (history) skin breakdown and infection...Date initiated: 02/03/2016. Goal: will have no further preventable skin breakdown thru next review, skin will improve AEB (wound vac): decreased size and depth by next review, will have no preventable s/s (signs/symptoms) of infection thru next review. Interventions/Tasks: ...keep clean and dry...monitor for s/s of infection, monitor for skin breakdown...pressure reducing surface to bed, pressure reducing surface to chair, wound vac as ordered." All goals and interventions had an initiation date of 02/03/2016.

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The clinical record included documentation Resident #4's pressure ulcer was discovered on 12/01/15. The physician was notified and dressing change orders were obtained. Resident #4 was seen by the wound management physician on 01/13/16 and new wound care orders were started. A wound vac was ordered and placed on 01/20/2016. The wound vac was d/c'd (discontinued) on 03/09/2016 and daily dressing change orders were restarted. None of the above mentioned treatments were included in the CCP, except the wound vac, which was placed on 01/20/2016, but not noted on the CCP until 02/03/2016.

Resident #4 had a Foley catheter placed on 01/08/16, discontinued on 01/14/16 and replaced on 01/16/16. The CCP included the following: "Focus: Impaired Elimination Status - Potential for UTI/Constipation?Diarrhea r/t (related to) incontinence, advanced dementia, requires assist of staff w/ADLs (with activities of daily living). 1/18/2016 Foley cath. Goal: ...Will be free of complications r/t Foley cath use through next review. Date Initiated: 01/18/2016." There were no interventions/tasks included for the care of the Foley catheter.

The DON (director of nursing) was interviewed on 03/06/2016 at approximately 4:45 p.m. during a meeting with the survey team. She was asked who is supposed to update CCP's. The DON stated, "MDS, they attend morning meetings during the week and are supposed to update the CCP's accordingly." The Administrator was informed of the above during this meeting.

No further information was received by the survey team prior to the exit conference on 03/17/2016.

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2a. The facility failed to revise Resident # 3's plan of care to reflect a healed pressure sore.

Resident # 3 in the survey sample, a 64 year-old female, was admitted to the facility on 12/23/14, and readmitted on 9/7/15 with diagnoses that included generalized muscle weakness, Vitamin B deficiency, Vitamin D deficiency, major depressive disorder, anxiety disorder, bipolar disorder, osteoarthritis, constipation, sepsis, urinary tract infection, and Cerebral Palsy. According to a Medicare 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/14/15, and the most Quarterly MDS with an ARD of 1/25/16, the resident was assessed under Section (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Under Section M (Skin Conditions), at Item M0210 - Unhealed Pressure Ulcer(s), the resident was assessed on both the Medicare 5-Day MDS and the Quarterly MDS as not having any unhealed pressure ulcers.

Review of Resident # 3's care plan revealed the following problem, dated 4/7/15, "Resident is at nutritional risk related to: elevated BMI (Body Mass Index) at risk for weight related complications such as increased mobility and mortality with deceased functionality, mobility and quality of life. Rsd. (Resident) at risk for further skin break down due to current stage II buttocks ulcer, has increased nutritional needs."

The failure to update the resident's care plan to

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reflect a healed pressure ulcer was discussed during a meeting at 4:00 p.m. on 3/16/16 with the survey team and the administrative staff, including the Administrator and Director of Nursing (DON).

2b. The facility staff failed to revise Resident # 3's care plan to include her self-imposed weight loss program.

Review of Resident # 3's care plan revealed the following problem, dated 4/7/15, "Resident is at nutritional risk related to: elevated BMI (Body Mass Index) at risk for weight related complications such as increased mobility and mortality with deceased functionality, mobility and quality of life. Rsd. (Resident) at risk for further skin break down due to current stage II buttocks ulcer, has increased nutritional needs."

The goals for the problem were, "Will be free of significant weight changes q (every) month 5% +/- per nursing/grand rounds/weight reports; Will be free of s/s (signs and symptoms) dehydration, fluid overload, electrolyte imbalance through next review; Resident will acknowledge potential consequences of choosing to decline nutrition interventions through next review; Meet nutritional needs despite varied intake; Diet/Supplements to support skin integrity; and, Diet/Supplements to support normal lab values." All of the goals were dated 4/7/15.

The interventions for the stated problem were, "Encourage adequate fluid intake; Encourage resident to dine in dining room as appropriate; Monitor dietary intake; Monitor for s/s dehydration, i.e. poor skin turgor, cracked lips, thirst, fever, abnormal labs, concentrated urine;

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Monitor med (medication) changes for potential food/drug interaction; Monitor need for increased nutritional intervention r/t (related to) diagnosis, medications and listed problems; Monitor weight per protocol; Provide diet per order; and, Respect resident dietary choices." All of the interventions were dated 4/7/15.

Review of the Nutritional Progress Notes in Resident # 3's clinical record revealed the following entries:

10/9/15 - "CBW (Current Body Weight) 173 (pounds) 18 (pound loss) in 30 days with 9.4% loss...has been declining since admission. Rsd. reports she is losing weight on purpose her goal rate (sic) is 155 (pounds) per report...."

12/8/15 - "CBW 165 (pounds) 6 (pound loss) in 30 days. 3.5% loss. Rsd. noted to have significant wt (weight) loss x 90 and 180 days. Wt. loss has been done intentionally per rsd. who want to lose...."

Review of the resident's weight records revealed her weight on 9/1/15 was 191 pounds, and on 3/7/16 it was 163.2 pounds, for a weight loss of 28.8 pounds, or 14.5%

The failure to update the resident's care plan to reflect her self-imposed weight loss program was discussed during a meeting at 4:00 p.m. on 3/16/16 with the survey team and the administrative staff, including the Administrator and Director of Nursing (DON).

3. The facility staff failed to revise the care plan of Resident # 9 to reflect her hospitalization and treatment for suicidal and homicidal ideations.

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Resident # 9 in the survey sample, a 68 year-old female, was admitted to the facility on 2/13/13, and readmitted on 7/7/15 with diagnoses that included hypertension, diabetes mellitus, chronic obstructive pulmonary disease, depression, hypothyroidism, hypokalemia, atrial fibrillation, gastroesophageal reflux disease, angina, abdominal hernia, seizure disorder, anxiety disorder, psychotic disorder, and schizophrenia. According to a Medicare 5-Day MDS with an ARD of 7/14/15, and the most Quarterly MDS with an ARD of 3/4/16, the resident was assessed under Section (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Review of the Social Service Progress Notes revealed the following entries:

6/30/15 - "Resident came to SW (Social Worker) on this date with thoughts of paranoia and self harm. When SW asked resident if she had thoughts of harming herself or others, she said that she had thoughts of harming herself. I then asked her if she had a plan she said that she wanted to choke herself, then proceeded to say, 'You know that's why they won't let you wear shoestrings in the hospital, right?' Asked resident if she would like to go to the ED (Emergency Department) for an eval (evaluation); resident agreed...."

7/1/15 - "Resident sent out to the hospital on 6/30 and was admitted."

Resident # 9's care plan included the following problem, dated 2/25/13, "At risk for altered mood/behavior r/t depression, schizophrenia, hx (history) of auditory hallucinations/delusions."

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The failure to update the resident's care plan to reflect her hospitalization and treatment for suicidal and homicidal ideations was discussed during a meeting at 4:00 p.m. on 3/16/16 with the survey team and the administrative staff, including the Administrator and DON.

4. The facility staff failed to review and revise the care plan addressing Resident # 5's risk for falls.

Findings include:

Resident # 5 was admitted to the facility 4/13/15 with a readmission date of 7/12/15. Diagnoses for Resident # 5 included, but were not limited to: right above knee amputation, left above elbow amputation, chronic respiratory failure, COPD, peripheral artery disease, high blood pressure, cardiomyopathies, GERD, gout, and depression.

The most recent MDS (minimum set) was a quarterly assessment dated 1/19/16. Resident # 5 was coded as having moderate impairment in cognition with a total summary score of 11 out of 15.

The clinical record was reviewed 3/15/16 at 4:30 p.m. It was noted in the nursing notes that Resident # 5 had a fall on 2/29/16 from his motorized wheel chair while outside the facility on the front porch area. Resident # 5 sustained some abrasions to the forehead, knee, and elbow but did not need any further medical attention beyond first aid applied by the facility. Resident # 5 was documented as telling staff he had fallen asleep in his wheel chair and fell. The care plan

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F 280	Continued From page 17 for falls was then reviewed for an update of the fall, and no documentation for the incident was able to be located on the current falls care plan. On 3/16/16 at 10:00 a.m. RN (registered nurse) # 5, who was the MDS coordinator, was asked about the update for the care plan addressing the recent fall for Resident # 5. RN # 5 stated she would see what she could find out and get back to me. At 11:10 a.m. RN # 5 told this surveyor "No, the care plan wasn't updated after the fall 2/29/16; I did that today." The above findings were shared with facility staff during an end of the day meeting 3/16/16 beginning at 4:45 p.m. No further information was provided prior to the exit conference.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility staff failed to follow physician orders for two of 16 residents in the survey sample: Resident # 6 and Resident # 12.	F 309	1. The urology appointment for Resident #6 has been made for April 13th. The physician was notified of the missed weights for Residents #6 and #12 and new orders were received. The weights have been taken as ordered. 2. Current residents' orders for the last 30 days have been reviewed to ensure that no other orders for weights have been missed. Any issues have been addressed by notifying the physician and receiving new orders. 3. The Licensed staff has been reeducated to follow physician orders as written. The	

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F 309	Continued From page 18 1 A. Resident # 6 did not have an appointment scheduled per order. 1 B. Resident # 6 did not have weights done per physician order. 2. Resident # 12 did not have weights done per physician order. Findings include: 1 A. Facility staff did not schedule a urology appointment for Resident # 6. Resident # 6 was admitted to the facility 7/30/15 with a readmission date of 2/19/16. Diagnoses for Resident # 1 included, but was not limited to: anxiety and depression, GERD, history of atrial fibrillation, back pain, Stroke, high blood pressure, new colostomy, urinary retention, and arthritis. The most recent MDS (minimum data set) was a quarterly review dated 2/27/16 and had Resident # 6 assessed with severe impairment in cognition with a total summary score of 09 out of 15. The clinical record was reviewed 3/15/16 at 2:45 p.m. Admission orders from the most recent readmission after hospitalization were dated and signed by the physician 2/23/16. The admission form included orders for "Weight on admission. Weight following 2 days after admission- 7-3. Weekly weights for 3 weeks - 7-3." Further review of the record failed to reveal the weights. The current MAR (medication administration record) and TAR (treatment administration record) was reviewed and no weights were found to be documented.	F 309	Licensed staff have been reeducated to document the weights received for each resident in Point Click Care and documenting completion of obtaining the weight in the paper MAR. A list of ordered weights will be maintained by the Director of Nursing. This list will be brought to the morning clinical meeting by the Director of Nursing or designee and will be checked against the weights that have been obtained to ensure the orders are followed. 4. The Director of Nursing will report the status of the weights being obtained according to the physician orders to the Quality Assurance Committee monthly for 3 months for review and recommendations. 5. Completion Date: 4-15-2016	

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On 3/16/16 at 9:05 a.m. RN (registered nurse) # 4 was asked for assistance in locating the weights. RN # 4 stated she did not know where the weights would have been recorded, and would look in several places to see if she could find anything. A few moments later RN # 4 brought this surveyor a plain sheet of paper with three dates of weights written on it. The dates were 2/23/16, 2/24/16, and 2/26/16. This surveyor asked where the information had been obtained, and RN # 4 stated she had gotten them from the computer. RN # 4 was then asked where the admission weight for 2/19/16 was, and she stated "That's all I could find; you'll need to talk to the DON (director of nursing). She may have more information."

On 3/16/16 at 9:20 a.m. the DON was asked about the documentation for Resident # 6's weights. The DON stated the three dates given to me by RN # 4 was all she could locate as well, but stated she would look further to see what she could find. The DON also stated that Resident # 6 refuses frequently to be weighed. The DON was asked where the refusals were documented and she stated "They aren't." A short time later, the DON gave this surveyor a copy of the MAR for February 2016 which included the admission orders. Beside the order for "Weight on admission" the 19th of February had been bracketed in by staff, but was blank. Beside the order for "Weights for 2 days after admission" staff had bracketed in the 20th through the 25th of February; the only weight documented was for the 23rd of February. Beside the order for "Weekly weights for 3 weeks" staff had bracketed the 26th of February, and had written "carry over" beside the bracket. A weight was documented in

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the bracket. The DON acknowledged the weights were not done per physician order, and no further documentation could be located for the weekly weights. The DON stated "Those weren't done."

No further information was provided prior to the exit conference.

1 B. Facility staff failed to schedule a urology appointment for Resident # 6.

The clinical record was reviewed 3/15/16 at 2:45 p.m. Admission orders and hospital discharge orders were also reviewed. The hospital discharge orders dated 2/19/16 included under "nursing" documented "Follow up with urology in 1-2 weeks. Make appointment: Nursing to schedule appointment." The hospital discharge orders were dated with initials at the top, and the order for the appointment was highlighted in yellow. The physician progress note for resident # 6's readmission to the facility documented ".....Follow up with urology." The consult section of the clinical record was then reviewed, as well as nursing progress notes, but no information was located regarding an appointment for the resident.

During an interview with the DON 3/16/16 beginning at 9:20 a.m. she was asked about the hospital order, and the initials on the top of the pages. The DON stated those were the facility physicians initials indicating having reviewed and accepting the hospital discharge orders. The DON was then asked about the appointment, and if she knew whether it had been made. The DON stated she wasn't sure she was even aware of the order, but would check with staff to see if the appointment had been scheduled.

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On 3/17/16 at 9:50 a.m. during a meeting with facility staff, the DON informed this surveyor that an appointment had not been made for the resident, so she had called and scheduled an appointment 3/16/16. The DON stated "The first available appointment was in April."

No further information was provided prior to the exit conference.

2. The facility staff failed to obtain weights for Resident # 12 per physician order.

Resident # 12 was admitted to the facility 12/30/15 and re-admitted 3/8/16. Diagnoses for Resident # 12 included, but were not limited to: muscle weakness, hypothyroidism, high blood pressure, hyperlipidemia, diabetes, heart disease, and Alzheimer's disease with psychosis.

The resident had been discharged from the facility in February 2016, and the admission MDS (minimum data set) was not available as this was a new admission. The resident was documented to be severely impaired in cognition by staff.

The clinical record was reviewed 3/17/16 at 8:00 a.m. The admission orders dated and signed by the physician documented "Weight on admission. Weight following 2 days after admission. Weekly weights for 3 weeks." The current MAR (medication administration record) was then reviewed for the weights. Weights were documented for 3/8/16 and 3/10/16. There was no weight documented for 3/09/16.

The above findings were shared with facility staff

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during a morning meeting 3/17/16 at 9:50 a.m.

F 312 SS=E 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, facility staff failed to provide ADL (activities daily living) care r/t (related to) showers for four of 16 residents in the survey sample, Resident #10, #13, #6 and #12.

1. Resident staff failed to ensure Resident #10 received showers per her preference.

2. Resident #13 was not provided showers per preference.

3. The facility staff failed to provide two showers per week as scheduled for Resident # 6.

4. Resident # 12 did not receive two showers per week as scheduled by the facility.

Findings included:

1. Facility staff failed to ensure Resident #10 received at least two showers per week per her preference.

F 309

F 312

1. Residents #6, #10, #12, and #13 have received showers at least twice a week according to their preference since the end of the survey visit.
2. All residents are scheduled for a shower twice a week according to their preference.
3. Nursing staff has been reeducated that all residents will receive a shower at least twice a week according to their preference. The Charge Nurse is responsible to ensure that the showers are completed and documented on the resident ADL flow sheet before the end of the assigned CNA's shift. Any resident refusal must be documented by the charge nurse in the resident's medical record after at least 2 attempts to convince the resident to shower. The Director of Nursing or designee will review the ADL monitoring of all residents for the documentation of the showers given daily x 5 days, then three days a week x 3 weeks, and then weekly x 8 weeks.
4. The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for review and recommendations.
5. Completion Date: 4-15-2016

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1. Resident #10 was originally admitted to the facility on 05/18/2014 and readmitted on 09/29/2014 with diagnoses including, but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Depression, Anxiety, Sleep Apnea, Anemia, Chronic Kidney Disease, Chronic Pain, Congestive Heart Failure and Morbid Obesity.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/21/2016. Resident #10 was assessed as cognitively intact with a total cognitive score of 15 out of 15. For hygiene and bathing Resident #10 was a 3/2, meaning Resident #10 needed extensive assistance of one person.

During a resident interview conducted on 03/16/2016 at approximately 11:25 a.m., Resident #10 stated, "Sometimes I don't get my showers because there isn't enough staff. I just do the best I can." The resident stated, "My shower days are Tuesday and Friday." When asked if she is offered a shower another day Resident #10 stated, "No, they are too busy."

Subsequent review of Resident #10's "CNA (certified nursing assistant) - ADL (activities daily living) TRACKING FORM on 03/16/2016 at approximately 2:00 p.m. revealed the following: For the month of January 2016 Resident #10 received a tub bath on the 8th, 16th and 26th. The rest of the days she received a partial bath, bed bath or no bath. There was no documentation of resident refusal of a bath for the month of January. The month of February

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2016 Resident #10 received a tub bath on the 2nd, 9th and a shower on the 19th. All other days she received a partial bath, bed bath or no bath. No resident bath refusals were documented for the month of February. The month of March 2016 Resident #10 had received a shower on the 1st and tub baths on the 8th and 15th. All other days she received a partial bath or no bath. Again, no resident refusal of baths was documented.

On 03/17/2016 at approximately 9:30 a.m., during a meeting with the survey team, the Administrator and DON (director of nursing) were made aware of the above information. Administration gave no response as to why residents were not receiving their baths.

No further information was received by the survey team prior to the exit conference on 03/17/2016.
2. Resident #13 was not provided showers per preference.

Resident #13 was originally admitted to the facility on 6/12/13 and readmitted on 10/15/13 with, but not limited to, the following diagnoses: major depressive disorder, hypothyroidism, anemia and vascular dementia without behavioral disturbances. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/16 was an annual assessment. The resident was assessed as being a fourteen (14) for cognitive skills, no cognitive impairments. For hygiene and bathing Resident #13 was a 3/2 and for dressing Resident #13 was a 3/2 meaning Resident #13 needed extensive assistance of one person.

On 3/15/16 at approximately 3:32 p.m., during an

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interview with the resident's family member, a concern was addressed regarding the resident not receiving her showers twice a week. The family stated that the staff was unable to perform this task due to shortage of staff, which caused the showers to be omitted.

On 3/16/16 at approximately 4:30 p.m., during the Abuse Protocol interview, a Certified Nursing Assistant, CNA #5, stated that staff was "unable to perform care and duties" due to a shortage in staff. When interviewed regarding residents receiving showers twice a week, CNA #5 stated, "We can't do it all, there's just not enough time. We have two or three CNA's, twenty-two people and six to seven showers a night. We can't get them done."

On 3/17/16 at approximately 8:40 a.m., CNA #5 was interviewed regarding the location of Resident #13's shower log. CNA #5 stated, "The logs are in the shower book and on the ADL (activities of daily living) Tracking Form, she [Resident named] gets her showers on Tuesday and Thursday. Resident #13's shower log sheets and ADL Tracking Form was reviewed to include the following:

February 2016 showers were documented for the following days 2/2, 2/5, 2/12 , 2/23, and 2/26.

March 2016 showers were documented for the following days 3/1, 3/4, and 3/12.

The documentation evidenced that the resident was not receiving showers twice a week.

On 3/17/16 at approximately 9:31 a.m. the administrative staff were made aware of the

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above findings.

No further documentation was provided during the course of the survey regarding the resident not receiving showers twice a week.

3. The facility staff failed to provide two showers per week as scheduled for Resident # 6.

Resident # 6 was admitted to the facility 7/30/15 with a readmission date of 2/19/16. Diagnoses for Resident # 1 included, but was not limited to: anxiety and depression, GERD, history of atrial fibrillation, back pain, Stroke, high blood pressure, new colostomy, urinary retention, and arthritis.

The most recent MDS (minimum data set) was a quarterly review dated 2/27/16 and had Resident # 6 assessed with severe impairment in cognition with a total summary score of 09 out of 15.

The clinical record was reviewed 3/15/16 at 2:45 p.m. During review of ADL (activities of daily living) tracking forms it was noted a section for bathing as related to the level of assistance needed, and a section for the type of bath the resident received with the following legend: P=Partial, SH=shower, BB=bed bath, and T=tub. The January 2016 ADL tracking form was reviewed, and revealed Resident # 6 received a partial bath all days in January 2016 except 1/11/16, 1/28/16, and 1/29/16. On 1/18/16 it was noted to be coded for a shower. The resident went out to the hospital 2/6/16, and returned 2/19/16 to the facility. The ADL tracking form for February 2016 revealed 2/20/16 through 2/29/16

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the resident received a partial bath. The March 2016 ADL tracking form revealed from March 1st through March 13th the resident had received partial baths with the exception of a bed bath 2/10/16. The shower book, which had the shower schedule by room on the front of the book was reviewed. Resident # 6 was to receive a shower on Mondays and Thursdays. Located in the shower book were forms used to document the type of bath given, and also had areas to document skin concerns, nail care, if the resident refused, and whether the nurse was notified of a refusal. The most recent shower form located for Resident # 6 was dated 2/25/16, and had written across the form "Hospital" when the resident had actually been re-admitted 2/19/16.

On 3/17/16 at 10:30 a.m. the DON (director of nursing) was asked about the documentation for Resident # 6, and that according to the shower schedule she was not receiving the 2 showers per week. The DON stated "Well, she refuses a lot." The DON was asked where that would be documented, as there were no current shower forms that documented refusals. The DON indicated it would be documented on the ADL tracking form as an "R." The DON then reviewed the ADL tracking forms for January, February, and March and stated "Well, I thought there was a space for an 'R' if the resident refused; there isn't. And it's not documented that she refuses anywhere else." The DON was asked for a copy of the facility policy for bathing. The policy was received a few minutes later and reviewed.(1).

No further information was provided prior to the exit conference.

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4. Resident # 12 did not receive two showers per week as scheduled by the facility.

Resident # 12 was admitted to the facility 12/30/15 and re-admitted 3/8/16. Diagnoses for Resident # 12 included, but were not limited to: muscle weakness, hypothyroidism, high blood pressure, hyperlipidemia, diabetes, heart disease, and Alzheimer's disease with psychosis.

The resident had been discharged from the facility in February 2016, and the admission MDS (minimum data set) was not available as this was a new admission. The resident was documented to be severely impaired in cognition by staff.

The clinical record was reviewed 3/17/16 at 8:00 a.m. During review of ADL (activities of daily living)tracking forms it was noted a section for bathing as related to the level of assistance needed, and a section for the type of bath the resident received with the following legend: P=Partial, SH=shower, BB=bed bath, and T=tub. The March 2016 ADL tracking form was reviewed, and revealed Resident # 12 had only received a partial bath from 3/9/16 through 3/16/16.

On 3/17/16 at 9:00 a.m. CNA (certified nursing assistant) # 7 was asked for assistance in locating shower information for Resident # 12. CNA # 7 stated "There should be a shower sheet for her in the shower book, as well as the schedule of when she's to get a shower." CNA # 7 then located the shower book, which had Resident # 12 as scheduled for a shower on Tuesdays and Fridays. CNA # 7 looked under the tab of the resident's room number for the shower sheet, but there were no sheets filed for the

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resident. CNA # 7 then stated "Let me look in the front of the book; they may not have gotten filed yet." CNA # 7 retrieved a shower sheet from the front of the shower book and stated "That's the only sheet I can find for her; there should be one for each day." The shower sheet was dated 3/15/16, and was marked as the resident receiving a bed bath. CNA # 7 was then asked when the resident should have gotten a shower. CNA # 7 replied the resident should have gotten a shower 3/11/16 and 3/15/16. CNA # 7 further stated "It doesn't document that she refuses a shower, so I'm not sure why she didn't get one unless we just didn't have time."

The above findings were shared with facility staff during a morning meeting 3/17/16 beginning at 9:50 a.m. The DON was asked for a policy on bathing. The policy was received and reviewed.

(1). The policy, titled "Resident Bath-Shower Schedule Policy" documented "Policy: A bath-shower schedule will be developed and maintained to assist with providing residents the necessary services to maintain good personal hygiene." Under "Procedure" documentation included: "1. Each resident will be scheduled to receive a bath-shower at a minimum of two times per week.....2. The Director of Nursing Services(DON) or designee will develop and maintain a master Resident Bath-Shower Schedule for all units. 3. The Resident Bath-Shower Schedule will be placed in the front of the nurse aid Activities of Daily Living (ADL) Flow Record Book. 4. At the beginning of each shift, the Charge Nurse will make a copy of the Resident Bath-Shower Schedule and review the schedule for that day and shift with the nurse aids. 5. When the bath-shower is completed, the

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nurse aid will place their initials in the designated space provided on the Charge Nurse's copy of the Resident Bath-Shower Schedule and the ADL Flow Sheet. 6. If the bath-shower is not given or the resident refuses, the nurse aid will immediately report this to the Charge Nurse. If the resident continues to refuse, the nurse aid will document the refusal or reason not given in the designated space provided on the ADL Flow Sheet. 7. The Charge Nurse will speak with the resident who refuses. If the resident continues to refuse the Charge Nurse will inform the DON and document the resident's refusal in the Nurses Notes and on the 24 Hour Report. 8. The Charge Nurse of each successive shift will attempt to get the resident who has refused to bathe or shower. Interventions will be implemented until the resident has bathed or showered. The attempts and interventions will be documented in the Nurses Notes and on the 24 Hour Report. 9. At the end of each shift, the Charge Nurse will forward a copy of the Resident Bath-Shower Schedule to the DON or designee. The names of the scheduled residents who did not receive a bath or shower will be highlighted. 10. During Risk Rounds, the Interdisciplinary Team will review and update the Resident Bath-Shower Schedule to verify that the names of newly admitted or transferred residents have been included and the names of discharged residents have been removed. 11. Any revision to the Resident Bath-Shower Schedule must be approved by the DON or designee."

No further information was provided prior to the exit conference.

F 328 SS=D 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS — F 328

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The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, facility staff failed to ensure oxygen was administered per physician order for one of 16 residents in the survey sample, Resident #10.

During an interview of Resident #10, resident was found with her nasal cannula in place, but was not connected to the oxygen concentrator.

Findings included:

Resident #10 was originally admitted to the facility on 05/18/2014 and readmitted on 09/29/2014 with diagnoses including, but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Depression, Anxiety, Sleep Apnea, Anemia, Chronic Kidney Disease, Chronic Pain, Congestive Heart Failure and Morbid Obesity.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/21/2016. Resident #10 was

1. Resident #10 was reconnected to her concentrator with a new humidification bottle as soon as the nurse was notified.
2. Current residents with orders to receive oxygen have been assessed to ensure that they have the oxygen setting per order and that the humidification bottle has water in it.
3. Nursing staff were reeducated to notify the charge nurse if an oxygen humidification bottle is close to going dry or if the resident who usually has oxygen is connected to the concentrator.
Licensed staff has been reeducated to verify the setting and delivery system of oxygen of each of their residents with orders for oxygen thru the shift. Management team room rounds participants will check that o2 is on and connected and will notify nurse if any questions.
The Director of Nursing or designee will make random rounds to verify that residents with oxygen orders are receiving oxygen according to their order. These rounds will occur all three shifts x 3 days, then once a day x 5 days, and then weekly x11 weeks.
4. The Director of Nursing will report the findings of the monitoring to the Quality Assurance Committee monthly x 3 months for review and recommendations.
5. Completion Date: 4-15-2016

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assessed as cognitively intact with a total cognitive score of 15 out of 15.

A resident interview was conducted with Resident #10 on 03/16/2016 at approximately 11:25 a.m. Resident #10 was sitting upright in her recliner with a nasal cannula in place. The oxygen concentrator was sitting by the nightstand. The humidifier bottle was empty and the concentrator was operating at 3L/min. (liters per minute). The resident appeared to be short of breath. Resident #10 was asked if she felt SOB (short of breath) and she stated, "yes." Upon further inspection of the concentrator it was discovered that the oxygen tubing wasn't connected to the concentrator, therefore Resident #10 wasn't receiving any supplemental oxygen.

This surveyor approached RN #1 (registered nurse) at approximately 11:45 a.m. and asked her to accompany me to Resident #10's room. RN #1 and this surveyor entered Resident #10's room together. RN #1 was shown the concentrator without the oxygen tubing attached and the empty humidifier bottle. RN #1 found the end of the oxygen tubing and attached it to the concentrator. This surveyor asked how much oxygen this resident was supposed to receive. Resident #10 stated, "four liters." RN #1 changed the concentrator from 3L to 4L. An O2 sat (oxygen saturation) was performed by RN #1 per this surveyor's request. Resident #10's O2 sat was 95% (percent).

RN #1 was asked how often humidifier bottles are changed and who is responsible for changing the bottles. RN #1 stated, "The tubing and bottles are changed weekly. It is on the MAR (medication administration sheet). Wait, let me

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say the tubing is changed every week. I will have to see about the bottle." RN #1 then stated to Resident #10, "You may have been off of your oxygen since your neb (nebulizer) treatment this morning." RN #1 and this surveyor left the room.

Outside of the room at approximately 11:50 a.m., RN #1 was interviewed regarding what time Resident #10 had received her neb treatment. RN #1 stated, "About quarter to nine." RN #1 and this surveyor agreed it takes approximately 20 minutes for a neb treatment to be completed. RN #1 was asked if Resident #10's oxygen had been disconnected since approximately 9:05 a.m. RN #1 stated, "I'm not sure. How do we know if it didn't just come loose from the tank?"

RN #1 was then questioned regarding who is supposed to check the oxygen tanks and humidifier bottles. RN #1 stated, "Night shift. They work 12 hour shifts." She was asked if night shift had changed the humidifier bottle for Resident #10. RN #1 stated, "I don't know. I don't know how long it takes for a bottle to empty." RN #1 was asked if she was going to change the bottle and she stated, "Yes, right now."

During a meeting with the survey team on 03/16/2016 at approximately 4:45 p.m. the Administrator and DON (director of nursing) were informed of the above interaction. The DON was asked for a copy of the facility oxygen administration policy.

On 03/17/2016 at approximately 9:30 a.m., while meeting with the survey team, the DON was again asked for the facility oxygen policy. The DON stated, "We do not have an oxygen policy.

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F 328	Continued From page 34 We have looked everywhere and can't find one." The DON was asked how often a humidifier bottle should be changed. She stated, "I would expect they would be changed when identified as dry." No further information was received by the survey team prior to the exit conference on 03/17/2016.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, clinical record review, staff interview, and resident interview, the facility staff failed to ensure a medication error rate of less than 5%. Facility staff failed to ensure two medications were administered with a meal. The failure to correctly administer the two medications to Resident # 11 resulted in an error rate of 5.2%, resulting in two errors out of 38 attempts. The findings were: Resident # 11 in the survey sample, a 72 year-old female, was admitted to the facility on 11/6/14, and readmitted on 3/5/16 with diagnoses that included generalized muscle weakness, chronic diastolic heart failure, anemia, diabetes mellitus, dementia, hyperthyroidism, hypertension, arteriosclerotic heart disease, peripheral vascular disease, hypoglycemia, status post amputation, and end stage renal disease with hemodialysis.	F 332	1. The physician for Resident #11 was notified of med error. Physician had no new orders. 2. Current residents will be asked if they have eaten prior to being given any medications required to be given with food. The medication will be held while food is obtained if the resident does not have food at that time. 3. Licensed staff have been reeducated concerning appropriate medication administration procedure. The Director of Nursing or designee will randomly observe medication administration performed by a charge nurse 3x a week for 4 weeks. Each observation will be with a different charge nurse. 4. The Director of Nursing will report the findings of these observations to the Quality Assurance Committee monthly for the duration of the monitoring for review and recommendations. 5. Completion Date: 4-15-2016	

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According to a Medicare 5-Day Minimum Data Set, with an Assessment Reference Date of 2/28/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

At 8:10 a.m. on 3/16/16, a medication pass and pour observation was begun on the facility's 200 wing of the Long Term Care Unit. The observation was started with RN # 1 (Registered Nurse), who was assisted by RN # 2. While RN # 1 replenished supplies on the medication cart, RN # 2 took over the medication pass.

Resident # 11, who resided on the 200 wing, and who was dressed in street clothes and seated in a wheelchair, was brought to the medication cart for the administration of her medications. Resident # 11 received eight medications and one injection. After administration of her medications, Resident # 11 was returned to the Nurses Station to await transportation to a doctor's appointment. Both RN's indicated they were aware the resident was leaving the facility for the appointment.

During medication reconciliation, the following medications were found to have been incorrectly administered:

Renvela 800 mg (milligrams), three tablets (2400 mg) by mouth with meals.

Humulin 70/30 insulin 6 u (units) SQ (subcutaneously) with breakfast.

Renvela (sevelamer carbonate) is used for the control of serum phosphate in patients with

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chronic kidney disease on dialysis. According to the General Dosing Information, "Renvela should be given three times a day with meals." (Refs. http://www.drugs.com/renvela-drug.htm, and Rxlist.com/renvela-drug.htm.)

Humulin is an antidiabetic, pancreatic hormone used in the treatment of diabetes. (Ref. Mosby's Nursing Drug Reference, 23rd Edition, 2010, page 590.)

According to the Medication Administration Record, the resident's blood sugar level at 6:30 a.m. on 3/16/16 was 122.

At approximately 8:30 a.m. on 3/16/16, the meal cart with breakfast trays arrived on the 200 unit. At 8:45 a.m., CNA # 3 (Certified Nursing Assistant), who was serving breakfast trays from the cart, was asked if there was breakfast tray for Resident # 11 in the meal cart. CNA # 3 looked in the tray cart and removed a meal tray bearing a meal ticket with Resident # 11's name. CNA # 3 took the tray to the resident's room, but returned the tray to the cart when she saw the resident was not in her room.

At 9:20 a.m. on 3/16/16, the Unit Secretary for the Long Term Care Unit was asked about the resident's doctor appointment. According to the Unit Secretary, the resident had a follow-up appointment with her surgeon. Asked when the resident left the building, the Unit Secretary said, "She left the building at 9:00 a.m."

CNA # 1, who was assigned to care for Resident # 11 on 3/16/16, was interviewed at 9:30 a.m. Asked if the resident had eaten breakfast, CNA # 1 said, "She should have." When informed

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F 332	Continued From page 37 Resident # 11's breakfast tray was still on the cart and that she had left the building, CNA # 1 said, "Her daughter was here with a bag of things. I think she had a bag from Hardee's. Maybe she had a sandwich for her." At 2:45 p.m. on 3/16/16, Resident # 11 was interviewed. Asked if she had eaten breakfast, Resident # 11 said, "No, I didn't eat anything." Asked if her daughter had a sandwich for her when she picked her up to take her to the doctor, Resident # 11 said, "No." Resident # 11 went on to say that when her daughter brought her back to the facility around 1:00 p.m., they shared sandwiches for lunch.	F 332		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334	1. The responsible parties for Residents #1, #2, #5, #6, #7, and #10 have been notified that the resident received the flu vaccine without written consent. No ill effects have been noted. 2. The responsible parties for other current residents that received the flu vaccine without written consent have been notified of the vaccine having been given. There has been no ill effect to any of these residents noted from this vaccine being given.	

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F 334	Continued From page 38 the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative	F 334	3. Licensed staff have been reeducated concerning the requirement that no flu vaccine may be given without written, informed consent. Flu season is over for this year and no more flu vaccines will be given until the next flu season begins. 4. The Director of Nursing will report the education of the licensed staff to the Quality Assurance Committee for review and recommendation. 5. Completion Date: 4-15-2016	

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F 334	Continued From page 39 refuses the second immunization.	F 334		

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, facility staff failed to ensure consent was obtained prior to administration of influenza vaccinations for six of 16 residents in the survey sample, Resident #7, #10, #2, #5, #6 and #1.

1. Facility staff administered an influenza vaccine to Resident #7 without proper consent.

2. Facility staff administered an influenza vaccine to Resident #10 without proper consent.

3. Resident #2 was not provided consent and education prior to the administration of the influenza (flu) vaccination.

Findings included:

1. Resident #7 was admitted to the facility on 08/24/2015 with diagnoses including, but not limited to: Hypertension, Diabetes Mellitus, Dysphagia, Osteoarthritis, Hemiplegia, Cerebrovascular Accident, Anemia and Chronic Kidney Failure.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/04/2016. Resident #7 was assessed as cognitively intact with a total cognitive score of 14 out of 15.

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F 334	Continued From page 40	F 334		

During the clinical record review of Resident #7's record on 03/16/2016 at approximately 9:00 a.m. It was noted Resident #7 received an influenza vaccine on 10/30/2015. No consent could be located in the clinical record. The Medical Records director was asked to see if she could locate a consent in the resident's thinned, clinical record.

During a meeting with the survey team on 03/16/2016 at approximately 4:45 p.m. the Administrator and DON (director of nursing) were informed of the above findings.

On 03/17/2016 at approximately 9:30 a.m. the DON entered the conference room with a consent in hand. Review of the consent revealed the following: "Vaccine Consent... I give permission for Resident to have the INFLUENZA VACCINE annually if ordered by the physician: ___ YES ___ NO." A check was present in the NO box..." The consent was signed by the resident.

The DON was interviewed regarding the reason Resident #10 received an influenza vaccine without proper consent. The DON stated, "I agree she received the flu vaccine without consent. I can't answer as to why."

2. Facility staff administered an influenza vaccine to Resident #10 without proper consent.

2. Resident #10 was originally admitted to the facility on 05/18/2014 and readmitted on 09/29/2014 with diagnoses including, but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Depression, Anxiety, Sleep Apnea, Anemia, Chronic Kidney

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F 334	Continued From page 41	F 334		

Disease, Chronic Pain, Congestive Heart Failure and Morbid Obesity.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/21/2016. Resident #10 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

During the clinical record review of Resident #10's record on 03/16/2016 at approximately 9:30 a.m. It was noted Resident #10 received an influenza vaccine on 10/31/2015. No consent could be located in the clinical record. The Medical Records director was asked to see if she could locate a consent in the resident's thinned, clinical record.

During a meeting with the survey team on 03/16/2016 at approximately 4:45 p.m. the Administrator and DON (director of nursing) were informed of the above findings.

On 03/17/2016 at approximately 9:30 a.m. the DON entered the conference room with a consent in hand. Review of the consent revealed the following: "Vaccine Consent...To my knowledge, Resident has had the INFLUENZA VACCINE: __YES (Date_____) ___NO ___DO NOT KNOW. The "YES" was marked with a check and the date was 1/14. "I give permission for Resident to have the INFLUENZA VACCINE annually if ordered by the physician: ___ YES ___ NO." Neither YES or NO was marked... The consent was signed by the resident.

The DON was interviewed regarding the reason Resident #10 received an influenza vaccine without proper consent. The DON stated, "I

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F 334	Continued From page 42 agree she received the flu vaccine without consent. I can't answer as to why." No further information was received by the survey team prior to the exit conference on 03/17/2016.	F 334		

3. Resident #2 was not provided consent and education prior to the administration of the Influenza (flu) vaccination.

Resident #2 was admitted to the facility on 2/13/13 with, but not limited to the following diagnoses: hypertension, hemiplegia, hemiparesis and hyperparathyroidism. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/16 was incomplete during the survey process; a MDS with an ARD of 12/16/15 was used for comparison. The resident was assessed as being a fourteen (14) no cognitive impairments.

On 3/16/16 at approximately 9:45 a.m., Resident #2's Immunization Record was reviewed in the clinical record. The immunization record contained documentation that the resident refused the Flu vaccine during the 2013 and 2014 Flu season. The clinical record did not have any documentation for 2015.

On 3/16/16 at approximately 11:00 a.m., the director of nursing (DON) was interviewed regarding the location of the immunization information for 2015. The DON stated that the resident "had received" the immunization for the

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current Flu season. The DON presented a 2015-2016 Flu Vaccine log to this Surveyor. The Flu Vaccine log was reviewed and it was documented that Resident #2 received the Flu vaccine for 2015-16. The DON was interviewed and asked if the resident signed a consent form indicating that she wanted the Flu vaccine, since she had refused it for the previous years. The DON stated, "We go in the room and give them [Residents] the form to read and that's their consent (sic)." The DON was interviewed and asked if the facility documented anything in the clinical record regarding consent for the Flu vaccine. The DON stated, "No." When interviewed and asked if the resident should have given consent and education prior to the administration of the Flu vaccine,since she had previously declined for 2013-14, the DON stated, "Yes, there should have been a form for consent and education provided."

On 3/17/16 at approximately 9:40 a.m. during the meeting with the administrative staff, the DON stated, in reference to the education and consent for the Flu vaccine prior to the administration, "I am not going to dispute, we did not have clear documentation regarding obtaining consents. I don't feel I have what you all are looking for. You are looking for 2014-15 consent forms and I do not have them."

No further information was provided during the course of the survey regarding education and consents prior to the administration of the Flu vaccines.

5. The facility staff failed to obtain consent prior to the administration of the influenza vaccine for

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Resident # 1.

Resident # 1 was admitted to the facility 6/2/13 with diagnoses including, but were not limited to:difficulty walking, hyponatremia, high blood pressure, depression, vitamin D deficiency, glaucoma, and essential tremor.

The most recent MDS (minimum data set) was a quarterly review dated 2/16/16. Resident # 1 was scored as cognitively intact with a total summary score of 14 out of 15. This MDS also documented the resident had received the influenza vaccine 11/4/15.

The clinical record was reviewed 3/15/16 at 3:30 p.m. A thorough review of the record, including the thinned portion of the record, failed to reveal a consent for the receipt of the vaccine. The November 2015 MAR (medication administration record) documented the resident was administered the vaccine 11/4/15.

On 3/17/16 at 9:50 a.m. the DON (director of nursing) was asked about the informed consent/education regarding Resident # 1's influenza vaccine. The DON stated "There is no clear consent signed for receipt of the flu vaccine."

No further information was presented prior to the exit conference.

6. The facility staff failed to obtain consent prior to administration of the influenza vaccine for Resident # 5.

Resident # 5 was admitted to the facility 4/13/15 with a readmission date of 7/2/15. Diagnoses for

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Resident # 5 included, but was not limited to: right above the knee amputation, left above the elbow amputation, chronic respiratory failure, COPD, cardiomyopathies, peripheral vascular disease, high blood pressure, gout, and depression.

The most recent MDS (minimum set) was a quarterly assessment dated 1/19/16. Resident # 5 was coded as having moderate impairment in cognition with a total summary score of 11 out of 15. This MDS also documented Resident # 5 received the influenza vaccine 11/3/15.

The clinical record was reviewed 3/15/16 at 4:30 p.m. A thorough review of the record, including the thinned portion of the record, failed to reveal a consent for the receipt of the vaccine. The November 2015 MAR (medication administration record) documented the resident was administered the vaccine 11/3/15.

On 3/17/16 at 9:50 a.m. the DON (director of nursing) was asked about the informed consent/education regarding Resident # 5's influenza vaccine. The DON stated "There is no clear consent signed for receipt of the flu vaccine."

No further information was presented prior to the exit conference.

7. The facility staff failed to document refusal of the influenza vaccine for Resident # 6.

Resident # 6 was admitted to the facility 7/30/15 with a readmission date of 2/19/16. Diagnoses for Resident # 1 included, but was not limited to: anxiety and depression, GERD, history of atrial

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F 334	Continued From page 46 fibrillation, back pain, Stroke, high blood pressure, new colostomy, urinary retention, and arthritis. The most recent MDS (minimum data set) was a quarterly review dated 2/27/16 and had Resident # 6 assessed with severe impairment in cognition with a total summary score of 09 out of 15. Resident # 1 was also coded on this assessment as having been offered the influenza vaccine and refusing. The clinical record was reviewed 3/15/16 at 2:45 p.m. A thorough review of the record, including the thinned portion of the record, failed to reveal any documentation, including a signed consent documenting refusal of the vaccine. On 3/17/16 at 9:50 a.m. the DON (director of nursing) was asked about the informed consent documenting the refusal of Resident # 6's influenza vaccine. The DON stated "There is no clear documentation or signature for the refusal of the flu vaccine." No further information was presented prior to the exit conference.	F 334		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient	F 353	1. Residents #6, #10, #12, and #13 have all received showers. 2. All residents are scheduled for a shower twice a week according to their preference.	

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F 353	Continued From page 47 numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, facility staff failed to ensure sufficient staff was available to provide ADL (activities daily living) care related to showers for four of 16 residents in the survey sample, Resident #10, #13, #6 and #12. 1. Resident #10 did not receive showers twice weekly due to not enough staff available to perform bathing services. 2. Resident #13 was not provided showers two times a week due to not enough staff available to perform the task. 3. The facility failed to ensure sufficient staff was available to provide ADL care related to showers for Resident # 6. 4. The facility failed to ensure sufficient staff were available to provide ADL care related to	F 353	3. Nursing staff has been reeducated that all residents will receive a shower at least twice a week according to their preference. The Charge Nurse is responsible to ensure that the showers are completed and documented on the resident ADL flow sheet before the end of the assigned CNA's shift. Any resident refusal must be documented by the charge nurse in the resident's medical record after at least 2 attempts to convince the resident to shower. The Charge nurse is responsible to identify if there is insufficient staffing to have all showers given and report immediately to the Director of Nursing. Additional staff will be called in to complete any showers that were not deemed able to be completed with the current level of staff. The Director of Nursing or designee will review the ADL monitoring of all residents for the documentation of the showers given daily x 5 days, then three days a week x 3 weeks, and then weekly x 8 weeks. 4. The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for review and recommendations. 5. Completion Date: 4-15-2016	

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showers for Resident # 12.

Findings included:

1. Resident #10 was originally admitted to the facility on 05/18/2014 and readmitted on 09/29/2014 with diagnoses including, but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Depression, Anxiety, Sleep Apnea, Anemia, Chronic Kidney Disease, Chronic Pain, Congestive Heart Failure and Morbid Obesity.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/21/2016. Resident #10 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

During a resident interview on 03/16/2016 at approximately 11:25 a.m. Resident #10 stated, "Sometimes I don't get my showers because there isn't enough staff. I just do the best I can." The resident stated, "My shower days are Tuesday and Friday." When asked if she is offered a shower another day Resident #10 stated, "No, they are too busy."

Subsequent review of Resident #10's "CNA (certified nursing assistant) - ADL (activities daily living) TRACKING FORM on 03/16/2016 at approximately 2:00 p.m. revealed the following: For the month of January 2016 Resident #10 received a tub bath on the 8th, 16th and 26th. The rest of the days she received a partial bath, bed bath or no bath. There was no documentation of resident refusal of a bath for the month of January. The month of February 2016 Resident #10 received a tub bath on the

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2nd, 9th and a shower on the 19th. All other days she received a partial bath, bed bath or no bath. No resident bath refusals were documented for the month of February. The month of March 2016 Resident #10 had received a shower on the 1st and tub baths on the 8th and 15th. All other days she received a partial bath or no bath. Again, no resident refusal of baths was documented.

During the abuse protocol interview with CNA's (certified nursing assistants) on the 7-3 shift at approximately 2:45 p.m. on 03/16/2016 several CNA's were asked about giving resident baths, showers. The CNA's were interviewed individually, but all concurred when they are working with only three CNA's to a unit and have 18 to 22 residents apiece it is impossible to get all the showers assigned for their shift completed. When asked if they would let the next shift know if showers weren't done on the day light shift it was stated, "Yes, but they are as busy as we are and have just as many to give." The CNA's interviewed were identified as CNA #1, #2, #3 and #4.

The Administrator and DON (director of nursing) were informed of the above information during a meeting with survey team on 03/17/2016 at approximately 9:30 a.m.

No further information was received by the survey team prior to the exit conference on 03/17/2016.

2. Resident #13 was not provided showers two times a week due to not enough staff available to perform the task.

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Resident #13 was originally admitted to the facility on 6/12/13 and readmitted on 10/15/13 with, but not limited to, the following diagnoses: major depressive disorder, hypothyroidism, anemia and vascular dementia without behavioral disturbances. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/16 was an annual assessment. The resident was assessed as being a fourteen (14) for cognitive skills, no cognitive impairments.

On 3/15/16 at approximately 3:32 p.m., during an interview with the resident's family member, a concern was addressed regarding the resident not receiving her showers twice a week. The family stated that the staff was unable to perform this task due to shortage of staff, which caused the showers to be omitted.

On 3/16/16 at approximately 4:30 p.m., during the Abuse Protocol interview, a Certified Nursing Assistant, CNA #5, stated that staff was "unable to perform care and duties" due to a shortage in staff. When interviewed regarding residents receiving showers twice a week, CNA #5 stated, "We can't do it all, there's just not enough time. We have two or three CNA's, twenty-two people and six to seven showers a night. We can't get them done."

On 3/17/16 at approximately 8:40 a.m., CNA #5 was interviewed regarding the location of Resident #13's shower log. CNA #5 stated, "The logs are in the shower book and on the ADL (activities of daily living) Tracking Form, she [Resident named] gets her showers on Tuesday and Thursday. Resident #13's shower log sheets and ADL Tracking Form was reviewed to include

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the following:

February 2016 showers were documented for the following days 2/2, 2/5, 2/12 , 2/23, and 2/26.

March 2016 showers were documented for the following days 3/1, 3/4, and 3/12.

The documentation evidenced that the resident was not receiving showers twice a week.

On 3/17/16 at approximately 9:31 a.m. the administrative staff were made aware of the above findings.

No further documentation was provided during the course of the survey regarding the resident not receiving showers twice a week.

3. The facility failed to ensure sufficient staff was available to provide ADL care related to showers for Resident # 6.

Resident # 6 was admitted to the facility 7/30/15 with a readmission date of 2/19/16. Diagnoses for Resident # 1 included, but was not limited to: anxiety and depression, GERD, history of atrial fibrillation, back pain, Stroke, high blood pressure, new colostomy, urinary retention, and arthritis.

The most recent MDS (minimum data set) was a quarterly review dated 2/27/16 and had Resident # 6 assessed with severe impairment in cognition with a total summary score of 09 out of 15.

The clinical record was reviewed 3/15/16 at 2:45 p.m. During review of ADL (activities of daily

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living)tracking forms it was noted a section for bathing as related to the level of assistance needed, and a section for the type of bath the resident received with the following legend: P=Partial, SH=shower, BB=bed bath, and T=tub. The January 2016 ADL tracking form was reviewed, and revealed Resident # 6 received a partial bath all days in January 2016 except 1/11/16, 1/28/16, and 1/29/16. On 1/18/16 it was noted to be coded for a shower. The resident went out to the hospital 2/6/16, and returned 2/19/16 to the facility. The ADL tracking form for February 2016 revealed 2/20/16 through 2/29/16 the resident received a partial bath. The March 2016 ADL tracking form revealed from March 1st through March 13th the resident had received partial baths with the exception of a bed bath 2/10/16. The shower book, which had the shower schedule by room on the front of the book was reviewed. Resident # 6 was to receive a shower on Mondays and Thursdays. Located in the shower book were forms used to document the type of bath given, and also had areas to document skin concerns, nail care, if the resident refused, and whether the nurse was notified of a refusal. The most recent shower form located for Resident # 6 was dated 2/25/16, and had written across the form "Hospital" when the resident had actually been re-admitted 2/19/16.

On 3/17/16 at 10:30 a.m. the DON (director of nursing) was asked about the documentation for Resident # 6, and that according to the shower schedule she was not receiving the 2 showers per week. The DON stated "Well, she refuses a lot." The DON was asked where that would be documented, as there were no current shower forms that documented refusals. The DON indicated it would be documented on the ADL

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tracking form as an "R." The DON then reviewed the ADL tracking forms for January, February, and March and stated "Well, I thought there was a space for an 'R' if the resident refused; there isn't. And it's not documented that she refuses anywhere else."

No further information was provided prior to the exit conference.

4. The facility failed to ensure sufficient staff were available to provide ADL care related to showers for Resident # 12.

Resident # 12 was admitted to the facility 12/30/15 and re-admitted 3/8/16. Diagnoses for Resident # 12 included, but were not limited to: muscle weakness, hypothyroidism, high blood pressure, hyperlipidemia, diabetes, heart disease, and Alzheimer's disease with psychosis.

The resident had been discharged from the facility in February 2016, and the admission MDS (minimum data set) was not available as this was a new admission. The resident was documented to be severely impaired in cognition by staff.

The clinical record was reviewed 3/17/16 at 8:00 a.m. During review of ADL (activities of daily living)tracking forms it was noted a section for bathing as related to the level of assistance needed, and a section for the type of bath the resident received with the following legend: P=Partial, SH=shower, BB=bed bath, and T=tub. The March 2016 ADL tracking form was reviewed, and revealed Resident # 12 had only received a partial bath from 3/9/16 through 3/16/16.

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F 353	Continued From page 54 On 3/17/16 at 9:00 a.m. CNA (certified nursing assistant) # 7 was asked for assistance in locating shower information for Resident # 12. CNA # 7 stated "There should be a shower sheet for her in the shower book, as well as the schedule of when she's to get a shower." CNA # 7 then located the shower book, which had Resident # 12 as scheduled for a shower on Tuesdays and Fridays. CNA # 7 looked under the tab of the resident's room number for the shower sheet, but there were no sheets filed for the resident. CNA # 7 then stated "Let me look in the front of the book; they may not have gotten filed yet." CNA # 7 retrieved a shower sheet from the front of the shower book and stated "That's the only sheet I can find for her; there should be one for each day." The shower sheet was dated 3/15/16, and was marked as the resident receiving a bed bath. CNA # 7 was then asked when the resident should have gotten a shower. CNA # 7 replied the resident should have gotten a shower 3/11/16 and 3/15/16. CNA # 7 further stated "It doesn't document that she refuses a shower, so I'm not sure why she didn't get one unless we just didn't have time." No further information was provided prior to the exit conference.	F 353		
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the	F 368	1. Resident #11 returned to the facility with no apparent ill effect. 2. All residents who have scheduled transportation prior to or just at breakfast delivery times have been identified and arrangements made to ensure they are offered their food in a time frame that will allow them to eat before they leave.	

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following day, except as provided below.

The facility must offer snacks at bedtime daily.

When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interview, and resident interview, the staff failed, for one of 16 residents in the survey sample (Resident # 11), to ensure that no more than 16 hours lapsed between the evening meal and breakfast. Resident # 11 was not served breakfast on 3/16/16.

The findings were:

Resident # 11 in the survey sample, a 72 year-old female, was admitted to the facility on 11/6/14, and readmitted on 3/5/16 with diagnoses that included generalized muscle weakness, chronic diastolic heart failure, anemia, diabetes mellitus, dementia, hyperthyroidism, hypertension, arteriosclerotic heart disease, peripheral vascular disease, hypoglycemia, status post amputation, and end stage renal disease with hemodialysis. According to a Medicare 5-Day Minimum Data Set, with an Assessment Reference Date of 2/28/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

3. After making an appointment, the transportation coordinator will notify the nursing and dietary departments during the next morning meeting if a resident is scheduled to leave the facility prior to or just at breakfast delivery time. The dietary manager will order the tray to be sent out early on the day designated. Nursing staff will ensure the delivery of the tray to the resident the morning of the scheduled transportation. The Director of Nursing or designee will place that information on the 24hour sheet for the nurses to alert the staff to ensure that breakfast is served appropriately. The Director of Nursing or designee will audit 100% of residents who are transported from the facility prior to breakfast daily x 7days, 3 days a week x 3 weeks, and then weekly x 4 weeks.
4. The Director of Nursing will report the findings of the monitoring to the QA Committee monthly for the duration of the audit for review recommendations.
5. Completion Date: 4-15-2015

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At 8:10 a.m. on 3/16/16, a medication pass and pour observation was begun on the facility's 200 wing of the Long Term Care Unit. The observation was started with RN # 1 (Registered Nurse), who was assisted by RN # 2. While RN # 1 replenished supplies on the medication cart, RN # 2 took over the medication pass.

Resident # 11, who resided on the 200 wing, and who was dressed in street clothes and seated in a wheelchair, was brought to the medication cart for the administration of her medications. Resident # 11 received eight medications and one injection. After administration of her medications, Resident # 11 was returned to the Nurses Station to await transportation to a doctor's appointment. Both RN's indicated they were aware the resident was leaving the facility for the appointment.

At approximately 8:30 a.m. on 3/16/16, the meal cart with breakfast trays arrived on the 200 wing Long Term Care Unit. At 8:45 a.m., CNA # 3 (Certified Nursing Assistant), who was serving breakfast trays from the cart, was asked if there was breakfast tray for Resident # 11 in the meal cart. CNA # 3 looked in the tray cart and removed a meal tray bearing a meal ticket with Resident # 11's name. CNA # 3 took the tray to the resident's room, but returned the tray to the cart when she saw the resident was not in her room.

At 9:20 a.m. on 3/16/16, the Unit Secretary for the Long Term Care Unit was asked about the resident's doctor appointment. According to the Unit Secretary, the resident had a follow-up appointment with her surgeon. Asked when the

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resident left the building, the Unit Secretary said, "She left the building at 9:00 a.m."

CNA # 1, who was assigned to care for Resident # 11 on 3/16/16, was interviewed at 9:30 a.m. Asked if the resident had eaten breakfast, CNA # 1 said, "She should have." When informed Resident # 11's breakfast tray was still on the cart and that she had left the building, CNA # 1 said, "Her daughter was here with a bag of things. I think she had a bag from Hardee's. Maybe she had a sandwich for her."

At 2:45 p.m. on 3/16/16, Resident # 11 was interviewed. Asked if she had eaten breakfast, Resident # 11 said, "No, I didn't eat anything." Asked if her daughter had a sandwich for her when she picked her up to take her to the doctor, Resident # 11 said, "No." Resident # 11 went on to say that when her daughter brought her back to the facility around 1:00 p.m., they shared sandwiches for lunch. Resident # 11 was also asked if she received a snack the previous evening (3/15/16). "Yes," the resident replied. "I had some peaches."

According to the meal time schedule, Dinner trays were scheduled for delivery on the Long Term Care Unit at 5:45 p.m. Since the resident received a snack the previous evening, the facility had a 16 hour window in which to serve the resident her breakfast meal.

Although the breakfast trays arrived on the 200 wing approximately 14 and three-quarter hours after the evening meal on 3/15/16, the resident, who was still in the facility when the trays arrived, was not served breakfast.

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F 386 483.40(b) PHYSICIAN VISITS - REVIEW
SS=E CARE/NOTES/ORDERS

The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to ensure physician order summaries(POS) were signed during physician visits for one of 16 residents in the survey sample: Resident # 5. Resident # 5 was readmitted to the facility 7/12/15, and the resident's physician had not signed any of the resident's POS's since that date.

Findings include:

Resident # 5 was admitted to the facility 4/13/15 with a readmission date of 7/12/15. Diagnoses for Resident # 5 included, but were not limited to: right above knee amputation, left above elbow amputation, chronic respiratory failure, COPD, peripheral artery disease, high blood pressure, cardiomyopathies, GERD, gout, and depression.

The most recent MDS (minimum set) was a quarterly assessment dated 1/19/16. Resident # 5 was coded as having moderate impairment in cognition with a total summary score of 11 out of

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1. The physician order sheets for Resident #5 were signed on March 16th.
2. All resident physician order sheets were reviewed and the signed by the physician.
3. Licensed staff have been reeducated to ensure that the physician order sheets have been signed by the physician monthly.
   The Director of Nursing or designee will verify the monthly signing of the physician order sheets by review for the next two months.
4. The Director of Nursing will report the findings of the review to the Quality Assurance Committee monthly for the duration of the review process for review and recommendation.
5. Completion Date: 4-15-2016

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15.

The clinical record was reviewed 3/15/16 at 4:30 p.m. It was noted the POS for the resident's readmission was dated and signed by the physician 7/14/15. The POS's for August 2015 through March 2016 were not signed despite the fact the physician and/or nurse practitioner had been in the facility and signed other orders for residents.

On 3/16/16 beginning at 9:20 a.m. during a meeting with facility staff, the DON (director of nursing) was asked about the physician signature for the order summary. The DON stated "Well, he has signed order changes that have occurred." This surveyor then asked, without any physician signature on the POS's, what orders were staff to go by. The DON stated that since the July 2015 POS were the only ones signed, then she really wasn't sure.

No further information was provided prior to the exit conference.