STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/13/18 through 02/15/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 2/13/18 through 2/15/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 70 certified bed facility was 65 at the time of the survey. The survey sample consisted of 16 current Resident reviews and 3 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		3/30/18

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

Electronically Signed | 03/14/2018

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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to notify the physician and the Resident's responsible party (RP) of changes for 1 of 19 Resident's, Resident	F 580	The filing of this plan of correction does not constitute an admission that deficiencies alleged did in fact exist. This plan of correction is filed as evidence	

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F 580	Continued From page 2 #266. The findings included: Resident #266 was admitted to the facility staff on 02/06/18. Diagnoses included but not limited to anemia, syncope and collapse, thrombocytopenia, gastroesophageal reflux disease, history of urinary tract infection, and pain. There is no current MDS (minimum data set) due to Resident being a new admit. Resident is alert and oriented x 3. Resident #266's clinical record was reviewed on 02/13/18. It contained a physician's order summary for the month of February which read in part, "Xifaxan tablet; 550mg; amt: 1 tab; oral [DX (diagnosis): personal history of urinary (tract) infections] Twice a day; 08:00 AM, 04:00 PM". Resident #266's eMAR (electronic medication administration record) was reviewed and contained an entry which read in part, "Xifaxan (rifaximin) tablet; 550 mg; Amount to administer: 1 tab; oral twice a day". The entry for 02/09/18 at 4pm was initialed, with parentheses around initials. A note in the comments section for 02/09/18 read in part "02/09/18 05:06 PM Not administered: Drug/Item unavailable". Surveyor spoke with DON on 02/15/18 at approximately 1500 regarding Resident #266 missing a dose of medication. Surveyor asked DON what should be done if a medication is not available and DON stated the nurse should make sure to reorder medication, notify the physician and Resident's RP, and make a progress note of	F 580	of Our Lady of the Valley's desire to comply with the requirements of participation and to continue to provide high-quality resident care. 1. The attending MD & RP for resident #266 have been notified of missed dose of medication. 2. Those residents who have experienced a change in condition or a change in prescribed medication or treatment plan are at risk for facility failure to notify the attending MD and/or RP of that change. 3. Staff have been and will continue to be educated on need to notify both the resident□s attending MD and their RP of any changes in the resident□s condition, change in prescribed plan or care or treatment. 4. The DON or designee will review the 24-hour report and EMAR daily to ensure licensed nurses have documented that the MD and RP were made aware of changes in the resident□s condition, prescribed plan of care of treatment. The QA Committee will review the findings of the DON or designee regarding compliance of the notification requirements. An amended plan will be initiated if the facility is found to be	

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F 580	Continued From page 3 the same. The surveyor could not locate a note in the clinical record that indicated the physician or the Resident's RP had been notified of the missed dose of medication. The concern of not notifying the physician and Resident's RP of a missed dose of medication was discussed with the administration team during a meeting on 02/15/18 at approximately 1700. No further information was provided prior to exit.	F 580	non-compliant with current plan.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	F 583		3/30/18

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F 583	Continued From page 4 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain resident privacy concerning the care of 1 of 19 residents in the survey sample (Resident #49). The findings included: Resident #49 was readmitted to the facility on 5/9/16 with the following diagnoses of, but not limited to dementia, Parkinson's disease and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #49 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing. On 2/14/18 at approximately 10:30 am, this surveyor went on to Unit 1 nursing station and saw the following note taped to the nurses' station for all staff to see which stated: "_____ (name of Resident #49) must (with 2 lines underlying must) be assisted to bed every day after lunch & then helped up before dinner. Reposition her to make certain she is comfortable. No (with 2 lines	F 583	1. The note regarding resident #49 which was posted at the nurses station was removed. 2. All residents residing in the facility are at risk of experiencing an invasion of their privacy. 3. Notes containing resident information or communication will not be posted in a public area unless requested by the resident or RP. Staff will be educated on maintaining privacy regarding requests and communications involving the care of a resident. Nursing staff will conduct daily rounds to ensure resident info is not posted in public areas. Findings will be reported to the Administrator and/or DON who will initiate necessary counseling or disciplinary actions to ensure compliance. 4. The findings of the daily rounds will be reported to the QA Committee who will initiate further counseling or disciplinary action if deemed necessary to ensure compliance.	

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F 583	Continued From page 5 underlying no) exceptions. Thanks." RN #1 was asked by the surveyor who and why this put up here at the nurses' station was. RN #1 stated, "It was here when I came into work this morning. And I don't know why this is up unless her family came in and requested this to be done." The surveyor observed RN #1 removing this note from where it was hanging up in the nurses' station. The surveyor interviewed Resident #49 at 11 am. The surveyor asked the resident if she was sitting up more during the day. The resident stated, "I'm trying to because I believe that what the doctor wants me to do. I just don't know if I can." On 2/14/18 at 5:03 pm, the surveyor notified the administrative team of the above documented findings. The surveyor asked the administrative team what was the expectation of where the staff could put these requests or communications when it involved care of a resident. The administrator stated, "It could be found in the care plan of the resident." The surveyor asked the administrator if it was acceptable for staff to post these kinds of information or communication up in the nurses' station. The administrator stated, "No, it is not acceptable. It should be communicated in the resident's care plan." No further information was provided to the surveyor prior to the exit conference on 2/15/18.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		3/30/18

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F 584	Continued From page 6 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, family interview and staff interview, the facility failed to maintain a clean, comfortable, and homelike environment on one of	F 584	1. The dining room window and carpet in room #408 were cleaned.	

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F 584	Continued From page 7 two floors (floor 1). The findings included: The carpet in room 408 was observed to be stained by a red substance and a window in the dining room had a dried red substance on the bottom pane. During initial tour of the facility on 02/13/18, the surveyor observed a red stain on the carpet in room 408 this stain was observed to be present throughout the survey process. On 02/13/18 at approximately 1:40 p.m., a family member directed the surveyor to the dining room and stated there was a dried red substance on the lower window and it had been there for some time. Immediately after this conversation, the surveyor went to the first floor dining room and was able to observe several small areas of a dried red substance. The surveyor rechecked this window on 02/14/18 at 7:54 a.m. and again at 2:00 p.m. the dried substance was observed at both times. On 02/14/18 at approximately 2:13 p.m., the director of environmental services accompanied the surveyor to the dining area and room 408. After observing the areas, the director of environmental services stated maybe these areas were red jello. The administrative staff of the facility were made aware of the stain on the carpet and the dried red substance on the windowpane in the dining area on 02/14/18 at approximately 4:25 p.m.	F 584	2. Residents residing in the facility are at risk of being exposed to an environment which falls short of providing a clean, comfortable and homelike environment. 3. Nursing or housekeeping staff will initiate immediate cleanup of spills. Spills which cannot be contained and cleaned properly by nursing staff will be reported to housekeeping staff who will perform proper sanitation of the area. Housekeeping department will conduct daily rounds on the nursing units to ensure clean and safe areas. 4. Daily round□s observations will be reported to the QA Committee who will review the information. Areas needing improvement in this plan will be amended to promote compliance.	

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F 584	Continued From page 8 No further information regarding this issue was provided to the survey team prior to the exit conference.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure a current professional license was in good standing for 2 of 25 employees (Employee #7 and #16). The findings included: 1. The facility staff failed to ensure a current professional license was in good standing for Employee #7. This surveyor conducted an employee record review on 2/15/18 at 8:15 am. During this review, it was noted by the surveyor that Employee #7's CNA (Certified Nursing Assistant) license had expired on 1/31/18. There were no other records found in the employee file of a current professional CNA license for this employee.	F 607	1. Both CNA licenses were verified as being active. 2. All professional facility staff, who by law are allowed to practice only with proof of certification or licensure, are at risk of allowing their certificate or licensure to expire. 3. Business Office Manager or Designee, will perform an initial 100% audit of all licenses and certifications. Once initial compliance has been established, all new employee□s certificates/licenses will be verified at time of hire. A monthly report will be reviewed to identify any license/certificate which must be updated in the employee file to ensure regulatory	3/30/18

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F 607	Continued From page 9 At 8:45 am, the surveyor notified the administrator of the above documented findings. The administrator stated, "I will go and talk to Human Resources and get back to you concerning this." The administrator returned to the surveyor at approximately 9 am. The administrator stated, "Here is a copy of the license that had expired on this employee." The administrator provided a copy of the current lookup for Employee #7's CNA license. The surveyor noted the following on the top of the page of the employee's license: "License Lookup Current as of 2/15/18 at 09:10 ..." The surveyor requested a copy of the facility's policy concerning current professional license of a CNA. The administrator provided the surveyor a copy of the facility's policy titled "Right to Dignity from Abuse Neglect and Exploitation" at 11 am. The surveyor noted under the section of "Resident Abuse and Neglect Prevention Program ...Screening ..." which stated, " ...1b. Licensed nurses' and certified nurses' aides must be listed on their respective Board of Nursing registry as having a current license in good standing ..." The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5:03 pm. No further information was provided to the surveyor prior to the exit conference on 2/15/18. 2. The facility staff failed to ensure a current professional license was in current and in good standing for Employee #16.	F 607	compliance. 4. Compliance with these audits and their findings will be reported to QA Committee for their review.	

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F 607	Continued From page 10	F 607		

This surveyor conducted an employee record review on 2/15/18 at 8:15 am. During this review, it was noted by the surveyor that Employee #16's CNA (Certified Nursing Assistant) license had expired on 1/31/18. There were no other records found in the employee file of a current professional CNA license for this employee.

At 8:45 am, the surveyor notified the administrator of the above documented findings. The administrator stated, "I will go and talk to Human Resources and get back to you concerning this."

The administrator returned to the surveyor at approximately 9 am. The administrator stated, "Here is a copy of the license that had expired on this employee." The administrator provided a copy of the current lookup for Employee #16's CNA license. The surveyor noted the following on the top of the page of the employee's license: "License Lookup Current as of 2/15/18 at 09:10 ..." The surveyor requested a copy of the facility's policy concerning current professional license of a CNA.

The administrator provided the surveyor a copy of the facility's policy titled "Right to Dignity from Abuse Neglect and Exploitation" at 11 am. The surveyor noted under the section of "Resident Abuse and Neglect Prevention Program ...Screening ..." which stated, " ...1b. Licensed nurses' and certified nurses' aides must be listed on their respective Board of Nursing registry as having a current license in good standing ..."

The surveyor notified the administrative team of the above documented findings on 2/15/18 at

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F 607	Continued From page 11 5:03 pm. No further information was provided to the surveyor prior to the exit conference on 2/15/18.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment for one of 19 Residents, Resident #68. The findings included. For Resident #68, the MDS coordinator coded the Resident as being discharged to an acute hospital when in fact he had been discharged home. The record review revealed that Resident #68 had been admitted to the facility 12/05/17. Diagnoses included, but were not limited to, psychotic disorder and malnutrition. Section C (cognitive patterns) of the Residents admission MDS assessment with an ARD (assessment reference date) of 12/12/17 was coded to indicate the Resident had memory problems. The Resident had been discharged home on 12/23/17.	F 641	1. The MDS for resident #68 was amended to provide accurate place of discharge. 2. All residents requiring MDS assessment are at risk for inaccurate coding. 3. The MDS assessment for residents who are discharged from the facility for the last six months were reviewed for accurate place of discharge. Any corrections needed to be made were corrected at that time. The MDS nurse will review MDS assessments of all residents being discharged for proper coding. Any errors found will be corrected at that time. 4. The MDS nurse will report audit findings to the QA committee.	3/30/18

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F 641	Continued From page 12 The Residents discharge MDS assessment with an ARD of 12/23/17 had been coded to indicate the Resident had been discharged to an acute hospital. The clinical record included a physician telephone order dated 12/22/17 to "Discharge home with Daughter on 12/23/17 at 1:00 pm." On 02/15/18 at 10:43 a.m., the surveyor reviewed the discharge MDS with the MDS coordinator. After reviewing the MDS, the MDS coordinator stated she had marked acute hospital in error and she would find out how to fix it. The administrative staff were notified of the inaccurate MDS assessment during a meeting with the survey team on 02/15/18 at approximately 5:00 p.m. Prior to the exit conference on 02/15/18 the MDS coordinator provided the surveyor with a copy of a corrected MDS indicating the Resident had been discharged to the "community." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		3/30/18

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F 655	Continued From page 13 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident interview and clinical record review the facility staff failed to	F 655	1. The baseline care plan for resident #266 was updated to reflect falls and the	

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F 655	Continued From page 14 initiate a baseline care plan for 1 of 19 Residents, #266. The findings included: For Resident #266, the facility staff failed to initiate a baseline care plan for falls and risk of incontinence. Resident #266 was admitted to the facility staff on 02/06/18. Diagnoses included but not limited to anemia, syncope and collapse, thrombocytopenia, gastroesophageal reflux disease, history of urinary tract infection, and pain. There is no current MDS (minimum data set) due to Resident being a new admit. Resident is alert and oriented x 3. Surveyor spoke with Resident on 02/13/18 at approximately 1400. Resident stated that she had fallen at previous facility. Resident also stated that she was recently on contact precautions for urinary tract infection and was still taking an antibiotic. Resident #266's baseline care plan was reviewed on 02/15/18. Surveyor could not locate a care plan for falls or risk of incontinence. Surveyor spoke to the MDS coordinator on 02/15/18 at approximately 1335 regarding Resident #266's baseline care plan. MDS coordinator stated that if Resident has had a recent fall, then a baseline care plan should have been initiated. MDS coordinator also stated that a baseline care plan for risk for incontinence should have been initiated due to urinary tract infection.	F 655	risk of incontinence. 2. All residents who are admitted to the facility are at risk for not having their needs addressed on the baseline care plan. 3. Staff have been and will continue to be educated on timely completion of baseline care plan. The DON or designee will audit all new admission baseline care plans weekly to ensure baseline care plans are complete. 4. Baseline care plan audit findings will be reviewed in the quarterly QA committee.	

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F 655	Continued From page 15 Resident #266's clinical record was reviewed and contained a progress note dated 02/12/18 1:49 PM which read in part "CNA was transferring Resident to toilet. When Resident legs gave away. Resident was lowered to floor. Denies any pain and discomfort at this time. Denies hitting head. Able to move all extremities x 4 well. MD and RP (responsible party) made aware". The concern of not having a complete baseline care plan was discussed with the administrative team during a meeting on 02/15/17 at approximately 1700. No further information was provided prior to exit.	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		3/30/18

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F 657	Continued From page 16 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the person centered comprehensive care plan for 6 of 19 residents in the survey sample (Resident #46, #7, #49, #6, #5, #219). The findings included: 1. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #46. Resident #46 was admitted to the facility on 11/2/16 with the following diagnoses of, but not limited to anemia, heart failure and high blood pressure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and being totally dependent on 1 staff member for bathing. The surveyor conducted a review of Resident #46's clinical record on 2/14 and 2/15/18. During this review, it was noted by the surveyor that Resident #46 had a fall on 11/7/17. When the surveyor reviewed the care plan, the care plan did not reflect the fall that the resident had on	F 657	1. The care plans for residents #46, 7, 49, 6, 5 and 219 were revised to instruct staff on the new wound care orders, falls, eye treatment orders, inappropriate behaviors and frequency of safety checks. 2. All residents who have new orders for falls, other unusual incidents, behaviors or any other changes in condition are at risk for not having their care plans updated. 3. The 11-7 charge nurse will review new orders for falls and other occurrences as listed on the 24 hour report to check for appropriate entries being entered on the individual care plan. Charge nurses will be educated on the timely documentation of care plan updates. 4. The results of the 11-7 audits will be reviewed and any necessary actions will be taken to ensure compliance. Findings will be reviewed in quarterly QA.	

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11/7/17.

On 2/15/18 at 5:03 pm, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 2/15/18.

2. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #7.

Resident #7 was readmitted to the facility on 10/16/17 with the following diagnoses of, but not limited to heart failure, dementia, anxiety disorder, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/13/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #7 was also coded as requiring extensive assistance of 1 staff member for dressing and being totally dependent on 1 staff member for bathing.

The surveyor conducted a review of Resident #7's clinical record on 2/14 and 2/15/18. During this review, the surveyor noted that on 2/8/18 the physician had ordered the resident to receive an antibiotic twice a day for an infection to the resident's left lower extremity. The surveyor also noted that on 2/8/18, the physician has also ordered the wound to be cleansed daily with hibaclens cleanser. The surveyor also reviewed Resident #7's care plan. The surveyor noted that the resident's care plan had not be updated to reflect the physician orders on 2/8/18.

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The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5:03 pm in the conference room.

No further information was provided to the surveyor prior to the exit conference on 2/15/18.

3. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #49.

Resident #49 was readmitted to the facility on 5/9/16 with the following diagnoses of, but not limited to dementia, Parkinson's disease and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #49 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

The surveyor conducted review of Resident #49's clinical record on 2/15/18. During this review, the surveyor noted that the physician ordered antibiotics to be placed in the resident's eyes three times a day for 14 days and the eyelids to be washed with baby shampoo at bedtime each night. The physician ordered these on 2/9/18. The surveyor reviewed the care plan for Resident #49. It was noted by the surveyor that the resident's care plan had not be updated to reflect the physician orders on 2/8/18.

The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5:03 pm.

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No further information was provided to the surveyor prior to the exit conference on 2/15/18.
4. For Resident #6 the facility staff failed to review and revise the care plan for falls to include recent falls.

Resident #6 was admitted to the facility on 05/15/13. Diagnoses included but not limited to depression, osteoporosis, rheumatoid arthritis, dementia, macular degeneration, gastroesophageal reflux disease, anemia, glaucoma and hypertension.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/ 17 coded the Resident as 3 of 15 in section C, cognitive status.

Resident's clinical record was reviewed and contained nurse's progress notes which read in part "02/09/18 02:56 AM Rsd (Resident) had a fall 02/08 no injuries observed...", "02/04/18 10:28 AM Resident did have a fall today in her bathroom on the 7 to 3 shift, Resident was un-harmed....", "12/25//17 03:50 AM Resident was sleeping in her bed, the CNA (certified nurses aid) heard thumping coming from her room and the bed alarm going off. When the aide went to check on Resident, she found the Resident laying on the floor banging her hand on the floor to get help Resident stated that she rolled out of bed....", and "12/01/17 06:15 PM Resident found on floor by CNA, laying on back beside her bed....".

Resident #6's care plan was reviewed and contained a plan for falls, with multiple falls listed. The last fall listed on the care plan was on 12/01/17. The aforementioned falls were not

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included in the care plan.

Surveyor spoke with the MDS coordinator on 02/15/18 at approximately 0910 regarding care plan for Resident #6. MDS coordinator stated that care plans are reviewed and revised quarterly. Also stated that the nurses on the floor and the unit coordinators helped out with updating care plans. Surveyor asked if a Resident had a fall, how soon should it be put on the care plan, and MDS stated that she tries to put it on as soon as possible. Surveyor asked if a Resident had a fall in December, if it should be on care plan by now and she stated that it should.

The concern of not reviewing and updated the care plan was discussed with the administrative team during a meeting on 02/15/18 at approximately 1700.

No further information was provided prior to exit.
5.The facility staff failed to review and revise the comprehensive care plan for Resident #5 to reflect the resident removes her clothing in public.

Resident #5, was admitted to the facility on 07/12/12, and readmitted on 12/2/13, with the following diagnoses: dementia with behaviors, high blood pressure, depression, angina pectoris, arthritis, and hypothyroidism.

Resident #5's most recent MDS (minimum data set) assessment completed on this resident was an annual assessment with an ARD (assessment reference date) of 11/09/17. Section C (cognitive patterns) of this assessment scored the resident to have both short and long-term memory problems. Section B coded Resident #5 to sometimes understand and to sometimes be

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understood. She was also coded requiring assistance of two persons for bed mobility, dressing, toileting, bathing, and hygiene.

02/13/18 11:45 AM Resident #5 was observed without her top in the dining room at lunch. The staff replaced it, CNA #1, told the surveyor "she removes her top when she gets hot."

The surveyor reviewed the comprehensive care plan on 2/13/18. The care plan revealed the resident incontinent and requires assistance with all activities of daily living. It also indicated she had behaviors of wandering. The care plan did not contain a information of the residents removing her own clothing in public.

The administrator and director of nursing were informed of the findings during a meeting with the survey team on 2/14/16 at 4:30 p.m.

Prior to exit updated care plan information was provided to the surveyor related to the resident removing her clothes.
6. For Resident #219, the facility staff failed to review and revise the Residents care plan to indicate the Resident was on 15-minute checks.

The record review revealed that Resident #219 had been admitted to the facility 02/09/18. Diagnoses included, but were not limited to, left partial infarct, acute renal failure, chronic pain syndrome, essential hypertension, and Alzheimer's disease.

There was no completed MDS (minimum data set) assessment on this Resident. The Resident was alert and orientated to self. Numerous observations were made of the Resident during

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F 657	Continued From page 22 the survey process. The Resident would present as confused at times. Per the clinical record review, the Resident was placed on 15-minute checks on 02/11/18 after attempting to leave the facility. A review of the Residents baseline care plan revealed that the care plan had not been revised to include the 15-minute checks. On 02/15/18 at 1:50 p.m., during an interview with the DON (director of nursing), the DON verbalized to the surveyor that she would expect to see the 15-minute checks on the care plan. The administrative staff were notified that the facility staff had failed to review and revise the Residents care plan in regards to 15-minute checks during a meeting with the survey team on 02/15/18 at approximately 5:00 p.m. Prior to the exit conference, the DON provided the surveyor with a copy of an updated care plan that included the 15-minute checks. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive	F 740		3/30/18

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F 740	Continued From page 23 assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide the necessary behavioral health care and services to attain the highest practical of well-being for 1 of 19 residents in the survey sample (Resident #7). The findings included: Resident #7 was readmitted to the facility on 10/16/17 with the following diagnoses of, but not limited to heart failure, dementia, anxiety disorder, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/13/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #7 was also coded as requiring extensive assistance of 1 staff member for dressing and being totally dependent on 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #7 on 2/15/18. During this review, the surveyor noted that on 9/27/17 documentation on the "Nursing Communication Form" notified the physician of Resident #7 exhibiting increased behaviors and anxiety at night. The physician ordered the resident to have medication changes to help in decreasing these behaviors and anxiety at night. The surveyor also noted on the physician order sheet during September 2017, the resident had an order for a " ...psychiatric	F 740	1. Resident #7 will be evaluated and assessed by behavioral health professionals on an as needed basis. 2. Those residents exhibiting behavior signs and symptoms are at risk of not being provided with timely behavioral health care services. 3. An audit will be preformed by the DON or Designee of each resident□s electronic physician□s orders to ensure that those residents who have orders to be evaluated by behavioral health professional have been seen. New telephone orders indicating the need for behavioral consults will be reviewed by 11 -7 charge nurse, who will assure that there is documented evidence that a behavioral health professional has been contacted to evaluate residents. 4. The results of the 11-7 shift telephone audits for new behavioral health referrals will be reviewed by the QA committee.	

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F 740	Continued From page 24 consult prn (as needed)". The surveyor noted a psychiatric consult that was dated for 11/14/17. On 2/15/18 at approximately 10:30 am, the surveyor notified the administrator of the above documented findings. The surveyor asked the administrator how soon a resident should be seen for a psychiatric consult once increased behaviors and anxiety has been seen in a resident with a diagnosis of psychotic disorder, anxiety disorder and dementia. The administrator stated, "The resident should be seen within a month." The surveyor pointed out to the administrator that Resident #7 had increased behaviors and anxiety noted by the staff in September, 2017 and the resident was not seen for a psychiatric consult until November, 2017. The administrator stated, "That resident should have been seen in October." The surveyor notified the administrative team of the above documented findings by the surveyor at 5:03 pm on 2/15/18. No further information was provided to the surveyor prior to the exit conference on 2/15/18.	F 740		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		3/30/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 25 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure medications were available for administration for 1 of 16 Residents, Resident #266. The findings included: For Resident #266 the facility staff failed to ensure the medication Xifaxan was available for administration. According to the Physician's Desk Reference, Xifaxan is an antibiotic used to treat traveler's diarrhea due to non-invasive strains of E. coli, irritable bowel disease with diarrhea and to	F 755	1. The Xifaxan for resident #266 has been administered since the date of the survey exit with no further documented entries of medication unavailable. 2. Residents receiving any type of medication or medicated treatment are at risk of missing a dose of prescribed medication or treatment. 3. 3. If a 4-day supply of pills or capsules are counted as remaining, the licensed nurses will re-order it from the pharmacy. If a medication is not available for administration, the charge nurse will	

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F 755	Continued From page 26 reduce the risk of hepatic encephalopathy. Resident #266 was admitted to the facility staff on 02/06/18. Diagnoses included but not limited to anemia, syncope and collapse, thrombocytopenia, gastroesophageal reflux disease, history of urinary tract infection, and pain. There is no current MDS (minimum data set) due to Resident being a new admit. The Resident is alert and oriented x 3. Resident #266's clinical record was reviewed on 02/13/18. It contained a physician's order summary for the month of February which read in part, "Xifaxan tablet; 550mg; amt: 1 tab; oral [DX (diagnosis): personal history of urinary (tract) infections] Twice a day; 08:00 AM, 04:00 PM". Resident #266's eMAR (electronic medication administration record) was reviewed and contained an entry which read in part, "Xifaxan (rifaximin) tablet; 550 mg; Amount to administer: 1 tab; oral twice a day". The entry for 02/09/18 at 4pm was initialed, with parentheses around initials. A note in the comments section for 02/09/18 read in part "02/09/18 05:06 PM Not administered: Drug/Item unavailable". Surveyor spoke with DON on 02/15/18 at approximately 1500 regarding Resident#266 missing a medication. Surveyor asked DON what should be done if a medication is not available and DON stated the nurse should make sure to reorder medication, notify the physician and Resident's RP, and make a progress note of the same.	F 755	get the medication from the stat box or by stat delivery from the pharmacy. Licensed nurses will be in serviced on the medication reordering policy and procedure. The DON or Designee will audit 10% of the resident□s medications weekly to ensure that all medications are available for administration per MD orders. 4. The findings of medication availability audit will be reported to the QA committee and the pharmacy for any necessary interventions.	

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F 755	Continued From page 27 Surveyor requested and was provided with a policy entitled "Administration of Medications" which read in part, "12. Medication fills and refills shall be timely to avoid missed dosages. Medications should be reordered according to the pharmacy procedures or electronic record vendor procedures. If a medication that is ordered does not arrive as scheduled, the Director of Nursing or designee shall be notified so that the pharmacy can be contacted via telephone for a stat deliver or follow electronic record for policy for checking status". The concern of the medication not being available was discussed with the administrative team during a meeting on 02/15/16 at approximately 1700. No further information was provided prior to exit.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		3/30/18

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F 761	Continued From page 28 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure medications were stored securely on 1 of 2 units. The findings included: The surveyor observed one box of culturelle on top of the medication cart. Culturelle is a probiotic/dietary supplement. On 02/13/18 at 3:57 p.m., the surveyor entered the unit. Upon entering, the unit the surveyor observe LPN (licensed practical nurse) #4 at the medication cart. The surveyor informed LPN #4 that she would be observing her give medications. After the administration of medication to the second resident, the surveyor and LPN #4 both approached the medication cart. Upon reaching this cart, the surveyor was able to observe one box of culturelle. The surveyor asked LPN #4 if she had intended to leave this medication on top of the cart to which LPN #4 stated that she did not intend to leave the medication on top of her cart. The surveyor observed a Resident in the vicinity of the medication cart.	F 761	1. The LPN who left the Culturelle on top of the medication cart has been in serviced. 2. Any medications received from the pharmacy could be improperly stored. 3. Administrative staff will note any items stored on top of medication carts during their daily rounds. Licensed staff who are noted to be improperly storing mediations on the medication carts will be in-serviced at the time of discovery. The medication will be immediately stored in its proper place. 4. Medication storage compliance will be reviewed with the members of the QA committee.	

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F 761	Continued From page 29 The administrative staff was notified of the unsecured medications during a meeting with the survey team on 02/14/18 at approximately 11:05 a.m.	F 761		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the medical director or their designee was present at the QA (quality assurance) meeting in January 2017. The findings included. The facility failed to ensure the medical director or their designee attended the QA meeting held 01/09/17 (1st quarter). This was the QA meeting held after the FOSS (federal oversight survey)	F 868	1. The Medical Director has attended all QA meetings in the last six months. 2. The Quarterly QA Meetings cannot effectively identify and address issues when not represented by a physician. 3. The Medical Director was educated on the necessity of her presence at each QA Meeting. If she is unable to attend, she will appoint an appropriate representative.	3/8/18

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F 868	Continued From page 30 completed December 2016. On 02/15/18 at approximately 2:50 p.m., the surveyor requested of the administrator documentation that would indicate the medical director and/or designee was present at the quarterly QA meetings that had been held since the last survey (December 2016). The administrator provided the surveyor with documentation to indicate the medical director or their designee was present at all the QA meetings except the one held on 01/09/17. When asked about the missing signature the administrator verbalized to the surveyor that no physician was present at this meeting. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 868	4. The QA attendance sheet will be reviewed by the facility Administrator or Designee after each quarterly meeting.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's 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 representative has the opportunity to refuse immunization; and	F 883		3/30/18

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F 883	Continued From page 31 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding 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. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's 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 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 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. This REQUIREMENT is not met as evidenced by:	F 883		

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F 883	Continued From page 32 Based on staff interview and clinical record review, the facility staff failed to obtain the Residents flu and pneumonia vaccine status for two of 19 Residents, Residents #217 and #218. The findings included. 1. For Resident #217, the facility staff failed to obtain the Residents flu and pneumonia vaccine status until asked by the surveyor. The record review revealed that Resident #217 had been admitted to the facility 12/20/17. Diagnoses included, but were not limited to, adult failure to thrive, malignant neoplasm, depressive disorder, gastro-esophageal reflux disease, and altered mental status. Section O (special treatments, procedures, and programs) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/27/17 had been coded "Not offered" for the influenza vaccine. For the questions "Is the resident's Pneumococcal vaccination up to date?" and "If Pneumococcal Vaccine not received, state reason." The facility staff had documented "Not assessed/no information." The facility policy/procedure titled "Immunization Influenza and Pneumococcal" read in part "...The influenza vaccine will be offered annually by the community (facility) during the influenza season, October through March...The Pneumococcal vaccines...will be offered on admission...The community will document the acceptance or refusal of immunization..." The interim DON was asked about the Residents	F 883	1. Resident #217has documentation signed by his responsible party which indicates refusal of the flu vaccine. Resident #218 has documentation indicating that the resident had received both the flu and pneumonia vaccines during the fall of 2017. 2. Residents already residing in or newly admitted to the facility are at risk of not being provided the opportunity to receive the flu or pneumonia vaccine 3. The Admissions Nurse or designee will interview the residents or the residents responsible party to ask if and when the resident was offered the flu and/or pneumonia vaccines. The Admissions Nurse will document the acceptance or refusal of the vaccines. The DON or Designee will review all new admissions charts for the appropriate immunization documentation. 4. The results of the audit will be presented to the QA committee. Additional interventions will be initiated if the audit indicates necessity.	

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pneumonia/flu vaccine status on 02/13/18.

The clinical record included the following nursing progress noted dated 02/13/18 at 6:06 p.m., "Called wife _____ about PNE/Flu immunization. Declined but wanted me to speak to _____ (Resident) to see if he agreed. Spoke with _____ (Resident) and he declined to be immunized. Consent form signed by this nurse documenting conversation with both _____ (Resident) and _____ (spouse)."

During an interview with the interim, DON on 02/14/18 at 9:56 AM the interim DON verbalized to the surveyor that the facility did not know the Residents flu status until yesterday.

On 02/15/18 at 1:20 p.m., the interim DON verbalized to the surveyor that the Resident's spouse came in last night and signed consent regarding flu/pneumonia vaccine and declined.

The administrative team were notified of the issues regarding the Residents pneumonia/flu vaccine status during a meeting with the survey team on 02/14/18 at 4:25 p.m. and again on 02/15/18 at 5:00 p.m.

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

2. For Resident #218, the facility staff failed to obtain the Residents flu and pneumonia vaccine status until asked by the surveyor.

The record review revealed that Resident #218 had been admitted to the facility 02/02/18. Diagnoses included, but were not limited to,

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essential hypertension, congestive heart failure, gastro-esophageal reflux disease, history of acute myocardial infarction, and anxiety disorder.

There was no completed MDS (minimum data set) assessment for this Resident.

The Residents clinical record included the following documentation dated 02/02/18 (admission date). "...Daughter unsure of flu and pne (pneumonia) vaccination history. Will need to speak with son regarding history since he has been historic care giver."

The clinical record did not include any further documentation until the Residents flu/pneumonia status was questioned by the surveyor.

02/14/18 at 12:53 p.m., per an interview with the interim DON (director of nursing) in regards to the Resident's flu and pneumonia vaccine/status. The interim DON stated they (the facility) had checked with the Resident's previous facility and the Resident had not been vaccinated there.

On 02/14/18 the facility nursing staff documented "Call placed to POA (power of attorney) this morning to check if she has talked to her brother about immunization status of resident...Message left to call facility..."

The administrative staff were made aware of the concerns regarding the Residents pneumonia and flu vaccine status during a meeting with the survey team on 02/14/18 at 4:25 p.m.

The facility policy/procedure titled "Immunization Influenza and Pneumococcal" read in part "...The influenza vaccine will be offered annually by the

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F 883	Continued From page 35 community (facility) during the influenza season, October through March...The Pneumococcal vaccines...will be offered on admission...The community will document the acceptance or refusal of immunization..." On 02/15/18, the nursing staff documented "PT (physical therapist) to nursing station with message that POA was transferred to their department instead of nursing. Message given this nurse that POA had stated that resident received both PNE/FLU vaccine this fall..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 883		