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	495357	A. BUILDING _____ B. WING _____	12/08/2016

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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/6/16 through 12/8/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 70 certified bed facility was 67 at the time of the survey. The survey sample consisted of 15 current Resident reviews (Residents 1 through 13 and Residents 19 and 20) and 5 closed record reviews (Residents 14 through 18).	F 000		
F 151 SS=D	RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL CFR(s): 483.10(b)(1)(2) (b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. (b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview, group interview, staff interview, facility document review and clinical record, the facility staff failed to facilitate	F 151	The filing of this plan of correction does not constitute an admission that deficiencies alleged did in fact exist.	1/19/17

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

Electronically Signed | 01/06/2017

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F 151	Continued From page 1 voting privileges for 1 of 20 residents (Resident #11) The findings included: The facility staff failed to facilitate voting privileges for Resident # 11. The clinical record of Resident #11 was reviewed 12/8/16. Resident #11 was admitted to the facility on 3/24/16. Diagnoses included but were not limited to hypertension, diabetes mellitus, status post Clostridium difficile, esophagitis, gastritis, and chronic anemia. Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/10/16 coded the resident with intact cognitive skills with a brief interview for mental status score of 15 out of 15 assessed. There was no evidence of delirium, psychosis or behaviors. On 12/7/16 at 2:00 p.m. the resident council group was interviewed. Resident #11 told the surveyor she had not been able to vote in the recent election because she had moved from Florida in March 2016. On 12/7/16 at 4:55 p.m., the surveyor interviewed the activity director. She acknowledged that she was responsible for voting at the facility. The activity director stated that Resident #11 had not expressed her desire to vote directly to her. The activity director stated she thought Resident #11 had seen the information in the November 2016 monthly activity calendar and decided at that time she wanted to vote but couldn't. During the interview with the activity director, she was asked if voting was discussed with the resident. The	F 151	This plan of correction is filed as evidence of Our Lady of the Valley's desire to comply with the requirements of participation and to continue to provide high-quality resident care. Activity Director will assist Resident #11 in getting registered to vote at the Registrar's Office. Interviews will be conducted by the Activity Director or designee with all current residents regarding their voter status and interest. All current residents with intact cognitive skills will be interviewed regarding their voter status and interest then logged on the Voter Registration Log. Upon admission, voter status will be discussed with each resident and assisted as desired. Voter Registration Log will be kept current by the Activity Director or designee.	

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activity director stated voting would have been discussed with the resident and family on admission. The surveyor asked the activity director for a list of those residents that were asked about voting. The activity director stated she had no documentation of the residents that voted. She stated "Moving forward, I will keep that documentation." The surveyor requested the admission activity assessment when Resident #11 was admitted to the facility and all activity progress notes from admission to present.

The surveyor informed the administrator, the regional quality assurance registered nurse, and the assistant administrator of the above finding on 12/7/16 at 4:35 p.m.

The surveyor requested a copy of the Resident Rights and the facility policy on voting from the administrator on 12/8/16.

The surveyor reviewed the "Resident Guidelines" on 12/8/16. Section IX Resident Rights and responsibilities A. Residents' Rights read "15. To be encouraged and assisted throughout the period of stay to exercise his/her rights as a resident and as a citizen and, to the end, may voice grievances and recommend change in policies and services to any Facility staff and/or outside representatives of the resident's choice, free from restraint, coercion, discrimination, or reprisal. B Resident's Responsibilities 14. Residents are encouraged to vote for the issues and candidates of their choice."

The administrator, assistant administrator, and regional director of quality assurance were informed on 12/8/16 at 4:35 p.m. The administrator stated voting should have been

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F 151	Continued From page 3 addressed with Resident #11.	F 151		
F 155 SS=D	RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES CFR(s): 483.10(c)(6)(8)(g)(12), 483.24(a)(3) 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 155		1/19/17

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F 155	Continued From page 4 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure an accurate code status for 1 of 20 Residents, Resident #12. The findings included: For Resident #12 the facility staff failed to ensure code status was correct on the POS (physician's order summary). Resident #12 was admitted to the facility on 11/29/16. Diagnoses included but not limited to pancreatic cancer, diabetes mellitus, gastroesophageal reflux disease and neuropathy. The admission MDS (minimum data set) had not	F 155	An accurate code status for Resident #12 has been established and corrected on the Physician Order Sheet. DON/Designee will review all current resident records to determine code status and ensure correct code status is placed on Physician Order Sheet. DON/Designee will provide education to Licensed Nurses regarding obtaining Code Status information for each admission and properly placing information on Physicians Order Sheet. DON/Designee will review new admission records to insure appropriate code status	

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F 155	Continued From page 5 been completed at this time. Surveyor spoke with the Resident, who was alert and oriented. Resident #12's clinical record was reviewed on 12/08/16. It contained a Virginia Department of Health DDNR (durable do not resuscitate) form dated 11/29/16 which had been signed by the Resident and the physician. The Resident's clinical record also contained a signed POS dated 12/05/16 which read in part "Code Status: full code" . The concern of the incorrect code status was brought to the attention of the administrative staff during a meeting on 12/08/16 at approximately 4:35 p.m. No further information was provided prior to exit.	F 155	information is located on Physician Order Sheet weekly x 4 weeks. DON/Designee will report results to the QA Committee quarterly x 12 months.	
F 156 SS=C	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156		12/8/16

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(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State

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and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for

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information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon

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admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident

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before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:

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F 156	Continued From page 11 Based on observation and staff interview it was determined that the facility staff failed to prominently display and have readily accessible the Medicare and Medicaid information about how to apply and use Medicare and Medicaid benefits, and how to receive funds for previous payments covered by Medicare and Medicaid for facility residents, families and visitors. The Findings Included: On December 6, 2016 at 12:30 p.m. the survey team entered the facility and the surveyor made an initial tour of the facility. During the initial tour of the facility the surveyor was unable to locate the posting regarding Medicare and Medicaid information, application of Medicare and Medicaid benefits and how to receive refunds for previous payments to Medicare and Medicaid. On December 6, 2016 at 3:30 p.m. the surveyor notified the Administrator (Adm) and Assistant Administrator (AAdm) that the surveyor was unable to locate the posting for Medicare and Medicaid rights and benefits. The Adm stated that the posting was located downstairs on the lower level of the facility. On December 6, 2016 at 3:35 p.m. the surveyor went to the lower level of the facility and searched for the Medicare and Medicaid posting. The surveyor found a document titled, "Utilizing Medicare and Medicaid Benefits" on the top of the nurses' station desk. The document size was 5X7 and had a border around the document. The surveyor observed that the document was not readily accessible to residents confined to wheelchairs or electric scooters. The document provided the address and telephone number of the local City Department of Social Services and the 1-800 telephone number for Medicare. The document also directed for questions to be directed to the Director of Social Services. No	F 156	A notice of rights, rules, services, and charges regarding Medicare/Medicaid information has been posted on each unit in a place where residents, family members, and visitors will be able to visualize it as of 12/6/2016. Administrator visually inspected that notice of rights, rules, services, and charges regarding Medicare/Medicaid information were posted. Administrator/Designee will round weekly x 4 weeks to ensure notices are in place. Administrator/Designee will report findings to the QA Committee quarterly x 12 months.	

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F 156	Continued From page 12 additional information was provided. On December 7, 2016 at 3:50 p.m. the surveyor notified the Adm, AAdm and Corporate Compliance Nurse (CCN) that the Medicare and Medicaid rights and benefits was not readily accessible to residents, families and visitors. The surveyor also notified the Administrative Team (AT) that the document located was not accessible to wheelchair bound residents. No additional information was provided prior to exiting the facility as to why the facility staff failed to prominently display Medicare and Medicaid rights and benefits to residents, families and visitors.	F 156		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all	F 164		1/12/17

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F 164	Continued From page 13 information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure residents confidential health information was protected for 2 of 20 residents (Resident #1 and Resident #12). The findings included: 1. The facility staff failed to ensure Resident #1's privacy and confidentiality of resident health information. The computer screen was left visible when unattended by licensed practical nurse #2. The clinical record of Resident #1 was reviewed 12/6/16 and 12/7/16. Resident #1 was admitted to the facility 10/15/16 and readmitted 12/1/16	F 164	LPN #1, LPN #2, RN #3 in-serviced to not leaved computer screen unattended when personal health information can be viewed. DON/Designee will perform medication and/or treatment observations with Licensed Nurses. Licensed nurses will receive education regarding the protection of resident information during medication and treatment passes. DON/Designee will conduct medication and/or treatment observations with	

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F 164	Continued From page 14 with diagnoses that included but not limited to Clostridium difficle colitis, type 2 diabetes mellitus, hypertension, gastroparesis, coronary artery disease, aortic stenosis, left carotid stenosis, Vitamin B12 deficiency, obstructive uropathy, acute renal failure superimposed on stage 3 chronic kidney disease, bladder cancer, weight loss of 10%-severe protein-calorie malnutrition, severe sepsis with acute organ dysfunction, nephrostomy, urinary tract infection E. Coli (Escherichia coli), ESBL (Extended spectrum beta-lactamase), hydronephrosis, paroxysmal atrial fibrillation, and scabbed area on lateral malleolus of the left ankle. Resident #1's admission minimum data set (MDS) was not completed. The surveyor requested to watch wound care with licensed practical nurse #2 on 12/7/16 at 8:00 a.m. On 12/7/16 at 10:37 a.m., L.P.N. #2 was at the medication cart with the computer screen visible with Resident #1's health information for the treatment that was to be provided. L.P.N. #2 obtained the treatment items and was comparing the order to the package. L.P.N. #2 was called away from the medication cart, leaving the computer screen visible with the surveyor able to see the health information. The surveyor observed Resident #1's date of birth, age, date admitted and the medication to be used for the treatment. The surveyor observed a potential new hire sitting in a chair at the medication cart. Two residents were observed in their chairs near the medication cart. A second nurse, registered nurse #3, approached the computer screen, checked something in the computer, and left the computer screen visible a second time. L.P.N. #2 and R.N. #3 returned to the medication cart and	F 164	Licensed Nurses weekly x 4 weeks. DON/Designee will report findings to the QA Committee quarterly x 12 months.	

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F 164	Continued From page 15	F 164		

proceeded to Resident #1's room for wound care.

The surveyor requested the facility policy on confidentiality of electronic medical records from the administrative staff on 12/7/16 at 4:55 p.m.

The surveyor reviewed the facility policy titled "Security Policy for Electronic Medical Records" on 12/8/16. The policy read in part "Procedure 2.d. Do not leave a computer screen unattended or without logging off."

The surveyor informed the administrator, the regional director of quality assurance and the assistant administrator of the above concern on 12/8/16 at 4:35 p.m.

No further information was provided prior to the exit conference on 12/8/16.

2. For Resident #12 the facility staff failed to close/cover the computer screen containing the Resident ' s private healthcare information during a medication pass and pour observation.

Resident #12 was admitted to the facility on 11/29/16. Diagnoses included but not limited to pancreatic cancer, diabetes mellitus, gastroesophageal reflux disease and neuropathy.

The admission MDS (minimum data set) had not been completed at this time. Surveyor spoke with the Resident, who was alert and oriented.

On 12/07/16 at approximately 1715, during a medication pass and pour observation, the surveyor observed LPN #1 walking away from the medication cart, leaving the computer screen open and uncovered. The computer screen

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F 164	Continued From page 16 contained private healthcare information for Resident #12. The facility administrator provided the surveyor with a copy the facility policy entitled "Security Policy for Electronic Medical Records" on 12/08/16 at approximately 0955 which read in part "Procedure: 2. Orientation to EMR (electronic medical record) will include: d. Do not leave a computer screen unattended or without logging off." The concern of leaving the computer screen open was discussed with the administrative staff during a meeting on 12/08/16 at approximately 1630. No further information was provided prior to exit.	F 164		
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 167		12/8/16

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F 167	Continued From page 17 years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to post signage/notice of the availability of the most recent survey results for residents, families and visitors viewing. The Findings Included: On December 6, 2016 at 12:30 p.m. the survey team entered the facility and the surveyor made an initial tour of the facility. During the initial tour of the facility the surveyor observed the February 2016 survey results in a white binder in a clear file holder mounted to the wall almost behind the nurses' station on the upper level of the facility. The surveyor also noted the February 2016 survey results in a white binder in a clear file holder mounted to the wall near the nurses' station on the lower level of the facility. The surveyor could not locate the signage/posting regarding where the most recent survey results could be located for residents, families and visitors. On December 6, 2016 at 3:30 p.m. the surveyor notified the Administrator (Adm) and Assistant Administrator (AAdm) that the surveyor was unable to locate the signage/posting of where to locate the most recent survey results for residents, families and visitors. The Adm stated	F 167	A notice of the location of the most recent survey results has been posted on each unit in a place where residents, family members, and visitors will be able to visualize it on 12/6/2016. Administrator visually inspected that survey results and notices were posted. Administrator/Designee will round weekly x 4 weeks. Administrator/Designee will report findings to the QA Committee quarterly x 12 months.	

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F 167	Continued From page 18 that the facility had never posted signage regarding where to locate the most recent survey results. On December 7, 2016 at 3:50 p.m. the surveyor notified the Adm, AAdm and Corporate Compliance Nurse (CCN) that signage/posting of where to locate the most recent survey results could not be located for residents, families and visitors. No additional information was provided prior to exiting the facility as to why the facility staff failed to post/display signage of where to locate the most recent survey results for residents, families and visitors.	F 167		
F 222 SS=D	RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR § 483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.	F 222		12/14/16

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F 222	Continued From page 19 (a) The facility must- (2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure residents were free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 20 residents in the survey sample (Resident #10). Resident #10 was admitted to the facility on 2/13/12 with diagnoses including atrial fibrillation, hypertension, heart failure, atherosclerotic heart disease, osteoporosis, , major depression and dementia without behavior disturbance. On the quarterly minimum data set (MDS) assessment with assessment reference date 9/28/16, the resident scored 7/15 on the brief interview for mental status and was assessed with signs of delirium (fluctuating disorganized thinking) and without signs of psychosis or behaviors affecting others. During clinical record review, the surveyor noted a physician order dated 11/1/2016 for Risperdal (risperidone) tablet; 0.25 mg; amt: 0.125 mg; oral Special instructions: severe agitation every 8	F 222	A behavior sheet has been put in place for Resident #10 and CP was updated as of 12/22/2016. DON/Designee will review current residents for orders for Antipsychotic Medications to insure behavior sheets are being utilized and care plans are updated. DON/Designee will request all antipsychotic medications ordered on a PRN basis be evaluated by MD and a stop date be given. Licensed nurses will be educated regarding the use of Antipsychotic Medication and the need to utilize behavior monitoring sheets including the use of non-pharmacological methods. For all PRN anti-psychotics, a stop date will be received from the MD. DON/Designee will review Facility Activity Report weekly x 4 weeks for new orders. When Antipsychotic meds are ordered, the DON/Designee will ensure a behavior sheet is put in to place and PRN orders	

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F 222	Continued From page 20 hours PRN. Orders were also noted for monitoring of antipsychotic side effects: Antipsychotic Medication Use-Observe Closely for significant side effects: [list]. There was no order for monitoring the presence of psychotic behavior (i.e. severe agitation). Medication Administration Record (MAR) review revealed staff documented administration of the antipsychotic medication risperidone 0.125 mg four times during November 2016. 11/2/16 and 11/3/16 MAR indicated administration for Behavior Issue with comment: increased agitation. 11/22/16 MAR indicated administration for Other with comment: increased agitation. 11/23/16 MAR indicated administration for Behavior Issue with comment: out oon w/c insisting on coffee. A nurse's note on 11/23/16 at 2:18 AM noted "Resident up in w/c at about 1:30 am wanting a cup of coffee. Was told that we didn't have any coffee down here, became kind of irate. Given Risperdal and she finally went back to bed. No other behaviors thus far this shift". No non-pharmacological interventions were documented. The resident's comprehensive care plan did not address the use of an antipsychotic medication. The resident's problem list included the use of an antidepressant medication. No mention was made of the use of antipsychotic medication, increased agitation, or interventions to address agitation. The facility's " Restraint Free Policy"stated that "the resident has a right to be free from any physical or chemical restraints imposed for	F 222	have a stop date. DON/Designee will report findings to the QA Committee quarterly x 12 months.	

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F 222	Continued From page 21 purposes of discipline or convenience, and not required to treat the resident's symptoms". The policy defined a chemical restraint as "a psychopharmacologic drug that is not required to treat medical symptoms or symptoms of mental illness or mental retardation". The surveyor discussed the concerns with the administration of antipsychotic medications with the administrator and nursing staff during summary meetings on 12/8/16.	F 222		
F 244 SS=E	LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION CFR(s): 483.10(f)(5)(iv)(A)(B) (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on group interview, staff interview, and facility document review, the facility staff failed to act upon grievances regarding facility care and services, staff behavior, dining service concerns, and activity concerns.	F 244	All areas of concern voiced during the resident council meetings for September, October, and November have been addressed. Social Worker/Designee will distribute	1/4/17

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F 244	Continued From page 22 The surveyor obtained the resident council minutes from September 2016, October 2016, and November 2016 during the entrance conference on 12/6/16 from the administrator. The current resident council had no designated president. On 12/7/16 at 2:00 p.m., the surveyor met with a group of the facility residents. Part of the interview included review of the previous three months resident council minutes and discussion of the minutes with the group. There were four residents included in the group and will be identified as Group #1, Group #2, Group #3, and Group #4. Issues from the September 2016 resident council meeting minutes were: Issues with not having enough wash cloths, breakfast food is delicious, and housekeeper is "nosey" and doesn't clean the bathroom well, and residents want more activities. Issues from the October 2016 resident council meeting minutes were: Residents stated that some staff was "rude" and didn't care about them. Frustration with food addressed. Issues from the November 2016 resident council meeting minutes were: seating in dining area is too close together. One resident wanted to have more book selections. The surveyor asked the group if the concerns identified in the resident council minutes were addressed and followed up with the group. Group #4 stated "Don't think anyone followed up with us." The minutes reflected that Group #4 had attended all three resident council meetings.	F 244	resident council minutes to each department managers. Department managers will be educated regarding follow up to resident council concerns. Administrator/Designee will review the plans of correction after each resident council meeting to ensure all areas of concern have been addressed. The following monthly minutes will document resolutions to concerns from previous meeting. Social Worker/Designee will report findings to the QA Committee quarterly x 1 year.	

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Group #2 stated the issue with wash cloths continues. Group #2 stated "We never have enough wash cloths. I've used the end of a towel as a wash cloth." Group #4 stated the staff put out wash cloths at bedtime but there are no wash cloths the next morning.

Group #2 stated in the dining room, staff have to move people in and out to accommodate wheelchairs, residents, and staff. Group #2 stated there was no follow-up about the seating in the dining room.

On 12/8/16 at 8:00 a.m., the surveyor asked the social worker about resident council grievances and how the facility responded. The social worker stated she informed and follow-up with each department. The social worker asked if the residents in the group were informed of the follow-up to the grievances. She stated she followed-up with residents on regular basis. The surveyor asked the social worker to provide documentation on the follow-up from the grievances from each of the resident council meeting. The social worker stated she didn't keep documentation. She stated she would send emails to the department involved but doesn't now.

The survey team met with the administrator, the assistant administrator, and the regional director of quality assurance on 12/7/16 at 3:55 p.m. The group concerns were reviewed. The administrator stated she had not seen the resident council meeting minutes from September 2016, October 2016, and November 2016 until the surveyor had requested them. The administrator stated the social worker addressed

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F 244	Continued From page 24 the issues from resident council with the department involved. The assistant administrator stated the facility ordered wash cloths on monthly basis and kept a "par level" and stated each day two wash cloths per resident per shift were given out. No further information was provided prior to the exit conference on 12/8/16.	F 244		
F 252 SS=E	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 252		1/4/17

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F 252	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to ensure a clean, comfortable and homelike environment on 2 of 2 units in the facility. The Findings Included: On December 6, 2016 at 12:30 p.m. the survey team entered the facility. The surveyor made an initial tour of the facility. The surveyor observed the shower room on the lower level of the facility. The surveyor observed a baseball size hole in one of the walls. The surveyor also observed the pantry room on the upper level of the facility. The surveyor observed brown debris under the ice machine and under the refrigerator. The surveyor also observed that the baseboards were heavily soiled with a greyish/dusty debris. The microwave was soiled as well. The surveyor observed the large dining room on the upper level of the facility. The surveyor observed that four soiled ceiling tiles were discolored and spattered with a brownish debris. The surveyor observed the shower/bath room on the upper level of the facility. The surveyor observed that 2 navy blue shower curtains were soiled with a white substance. The shower room had a wash cloth and two large pieces of toilet tissue lying in the floor. The crevices where the walls met the floors were soiled with a greyish debris. The floors of the showers were soiled with a greyish debris, and the wallpaper had two large areas of torn and lifting wallpaper. On December 7, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), Assistant Administrator) AAdm and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the shower	F 252	All items noted during walkthrough were corrected as of 1/4/2017. Director of Environmental Services and Maintenance will conduct weekly rounds x 4 weeks to ensure compliance. Educate environmental staff on reporting any issues or concerns to supervisor. Director of Environmental Services and Maintenance will report issues to QA committee quarterly x 12 months.	

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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 252	Continued From page 26 room on the upper level had ripped and torn wallpaper and that the shower curtains had a whitish substance on them. The surveyor also notified the AT that the pantry room on the upper level was dirty. The surveyor notified the AT that a brownish debris was noted under the ice machine and the refrigerator. The surveyor also notified the AT that the baseboards were heavily soiled. On December 8, 2016 at 1 p.m. the surveyor made a tour of the facility with the Maintenance Director (MD) and the AAdm. The surveyor, MD and AAdm entered the dining room on the upper level. The surveyor pointed out to the MD and AAdm the four soiled ceiling tiles. The surveyor, MD and AAdm entered the shower/bath room on the upper level and the surveyor pointed out the soiled floor and shower stalls. The surveyor also pointed out the areas where the wallpaper had been torn and ripped. The surveyor, MD and AAdm walked down to the lower level of the facility and entered the shower/bath room. The surveyor pointed out the baseball size hole in the wall. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a clean, comfortable and homelike environment for the facility residents.	F 252		
F 272 SS=D	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The	F 272		1/19/17

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F 272	Continued From page 27 assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.	F 272		

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F 272	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based of staff interview and clinical record review, it was determined that the facility staff failed to ensure complete and accurate Care Area Assessments Summaries (CAA's) for 3 of 20 Residents in the sample survey, Resident #3, Resident #4 and Resident #6. The Findings Included: 1. Resident #3 was a 95 year old female who was admitted on 12/3/15. Admitting diagnoses included, but were not limited to: allergic rhinitis, osteoarthritis, hypothyroidism, dementia with behaviors, depressive disorder, anxiety disorder, hypertension and pain. On December 6, 2016 at 2:40 p.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced the most current Minimum Data Set (MDS) assessment which was an Annual MDS assessment with an Assessment Reference Date (ARD) of 10/29/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 4. The facility staff also coded that Resident #3 required limited (2/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). Review of the Section V.CAA'S Resident documented that #3 "triggered" for Psychosocial Well Being. In the column titled, "Location and Date of CAA documentation" the facility staff documented "11/8/16." (sic) No additional supporting information/documentation regarding the assessment or decision making process for Psychosocial Well Being could be located. The surveyor reviewed the CAA worksheets and no additional supporting documentation/assessment could be located for the decision making regarding care planning of Psychosocial Well Being. Continued review of the clinical record produced	F 272	The CAA□s have been modified for Resident # 3, # 4, and #6 as of 12/8/2016. DON/Designee will review CAA□s for all comprehensive assessments for the past quarter to ensure accuracy. MDSC and other members of the ID team will receive education regarding the accuracy and completion of CAA□s summaries. DON/Designee will review all Comprehensive Assessments for last 90 days to ensure accuracy and completion of CAA□s. DON/Designee will report all findings to the QA Committee quarterly x 12 months.	

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"Progress Notes" from 10/25/16 through 11/19/16. Review of the Progress Notes did not include any Progress Notes dated 11/8/16 regarding an assessment or documentation from the facility staff regarding Resident #3's Psychosocial Well Being.

On December 7, 2016 at 8:10 a.m. the surveyor notified a MDS Nurse, who was a Registered Nurse (RN #2), that Resident #3's CAA'S were incomplete/inaccurate. The surveyor reviewed the Annual MDS with the ARD of 10/29/16 with the MDS Nurse (RN #2). The surveyor reviewed Section V. CAA'S and the CAA worksheets with the MDS Nurse (RN #2). The surveyor pointed out that Resident #3 "triggered" for Psychosocial Well Being. The surveyor also pointed out that the facility staff documented " 11/8/16 " for the location and date of supporting assessment/documentation for Resident #3. The MDS Nurse (RN #2) stated that the Activities Director (AD) had completed that Section of the MDS/CAA's. The surveyor also reviewed the Progress Notes with the MDS Nurse (RN #2).The surveyor pointed out that the Progress Notes did not include any Progress Notes dated 11/8/16 regarding an assessment or documentation from the facility staff regarding Resident #3's Psychosocial Well Being. The surveyor requested to speak with the AD.

On December 7, 2016 at 8:20 a.m. the surveyor spoke with the AD. The surveyor reviewed the Annual MDS with the ARD of 10/29/16 with the AD. The surveyor reviewed Section V. CAA'S and the CAA worksheets with the AD. The surveyor pointed out that the location and date of the supporting documentation/information for Psychosocial Well Being was not documented. The surveyor pointed out that the only notation documented was "11/8/16." (sic)

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On December 7, 2016 at 8:30 a.m. the MDS Coordinator, who was a Licensed Practical Nurse (LPN #1), hand delivered a "correction" to the Annual MDS assessment with the ARD of 10/28/16.
On December 7, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #3's CAA'S were inaccurate/incomplete. The surveyor notified the AT that Resident #3 "triggered" of Psychosocial Well Being and that the AD documented "11/8/16" as the location and date of the supporting assessment/documentation for the care plan decision making on both Section V.CAA'S and the CAA worksheets.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate CAA'S for Resident #3.

2. For Resident #4 the facility staff failed to indicate the date and location of the CAA (care area assessment) information.

Resident #4 was admitted to the facility on 08/27/16. Diagnoses included but not limited to colon cancer, anemia, atrial fibrillation, hypertension, wound infection, hypertension, hyperkalemia, hypothyroidism, and macular degeneration.
The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 09/03/16 coded the Resident as 15 of 15 in section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to

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determine the care plans for "return to community". The only documentation was "interview with Resident".
The administrative staff was informed of the findings during a meeting on 12/07/16 at approximately 1550.
No further information was provided prior to exit.

3. For Resident # 6 the facility staff failed to indicate the date and location of the CAA (care area assessment) information.

Resident #6 was admitted to the facility on 03/12/13 and readmitted on 08/15/16. Diagnoses included but not limited to anemia, atrial fibrillation, congestive heart failure, chronic kidney disease, dementia and gastroesophageal reflux disease.

The most recent comprehensive MDS (minimum data) set with and ARD (assessment reference date) of 09/10/16 coded the Resident as 9 of 15 in section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plans for cognitive loss or mood state. The only documentation was "interview process with Resident".

The administrative staff was informed of the findings during a meeting on 12/07/16 at approximately 1550.
The MDS coordinator provided the surveyor with a corrected copy of the MDS on 12/08/16 at approximately 0845.

No further information was provided prior to exit.

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F 278	Continued From page 32	F 278		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		1/19/17

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F 278	Continued From page 33 Based on staff interview and clinical record review the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) for 1 of 20 Residents, Resident #4. The findings included: For Resident #4 the facility staff failed to correctly code a colostomy on the MDS. Resident #4 was admitted to the facility on 08/27/16. Diagnoses included but not limited to colon cancer, anemia, atrial fibrillation, hypertension, wound infection, hypertension, hyperkalemia, hypothyroidism, and macular degeneration. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 09/03/16 coded the Resident as 15 of 15 in section C, cognitive patterns. Section H, bladder and bowel, subsection H0100, appliances coded the Resident as "none of the above" when the Resident has a colostomy. Subsection H0400, bowel continence also coded the Resident as "frequently incontinent". Resident #4's clinical record was reviewed on 12/06/16 and contained a progress note which read in part "Resident was transported to ... (facility name omitted) by family car. ...Resident has ostomy bag located R (right) side of abdomen." The incorrect MDS was brought to the attention of the administrative staff during a meeting on 12/07/16 at approximately 1550. The MDS coordinator provided the surveyor with a corrected MDS on 12/08/16 at approximately	F 278	MDS for Resident #4 was revised and submitted on 12/8/2016. DON/Designee will review the MDS section H0100 for all comprehensive assessments for the past quarter to ensure accuracy. MDSC will be educated regarding coding of H0100 accurately. DON/Designee will review section H0100 for accuracy upon completion of MDS prior to submission x weeks. DON/Designee will report all findings to the QA Committee quarterly x 12 months.	

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F 278	Continued From page 34 0840. No further information was provided prior to exit.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279		1/19/17

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F 279	Continued From page 35 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to develop a comprehensive care plan for 2 of 20 Residents, Resident #4 and Resident #6. The findings included: 1. For Resident #4 the facility staff failed to develop a comprehensive care plan (CCP) for "return to community". Resident #4 was admitted to the facility on	F 279	Care plans were revised for Resident #4 and Resident #6 as of 12/8/2016. DON/Designee will review current resident care plans to ensure mood state and return to the community are in place. Education will be provided to the Interdisciplinary team regarding completion of comprehensive care plans. Licensed nurses will receive education regarding updating care plans.	

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F 279	Continued From page 36 08/27/16. Diagnoses included but not limited to colon cancer, anemia, atrial fibrillation, hypertension, wound infection, hypertension, hyperkalemia, hypothyroidism, and macular degeneration. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 09/03/16 coded the Resident as 15 of 15 in section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The CAA indicated that a care plan would be developed for "return to community". Resident #4's CCP was reviewed and the surveyor could not locate a care plan for "return to community". The concern of the missing care plan was discussed with the administrative team during a meeting on 12/07/16 at approximately 1550. No further information was provided prior to exit. 2. For Resident #6 the facility staff to develop a comprehensive care plan for "mood state". Resident #6 was admitted to the facility on 03/12/13 and readmitted on 08/15/16. Diagnoses included but not limited to anemia, atrial fibrillation, congestive heart failure, chronic kidney disease, dementia, and gastroesophageal reflux disease. The most recent comprehensive MDS (minimum data) set with and ARD (assessment reference date) of 09/10/16 coded the Resident as 9 of 15 in section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also	F 279	DON/Designee will review new admission care plans to ensure the care plans reflect all current needs x 4 weeks. DON/Designee will report findings to the QA Committee quarterly x 12 months.	

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F 279	Continued From page 37 reviewed. The CAA indicated that a care plan would be developed for "mood state". Resident #6's CCP was reviewed and the surveyor could not locate a care plan for "mood state". The concern of the missing care plan was discussed with the administrative team during a meeting on 12/07/16 at approximately 1550. The MDS coordinator provided the surveyor with a copy of a care plan for mood state on 12/08/16 at approximately 0845. No further information was provided prior to exit.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items	F 280		1/19/17

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included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

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

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

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

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

(A) The attending physician.

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

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

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F 280	Continued From page 39 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary 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 it was determined that the facility staff failed to review and revise the Comprehensive Care Plan (CCP) for 3 of 20 Residents in the sample survey, Resident #9, Resident #5 and Resident #10. The Findings Included: 1. Resident #9 was an 85 year old female who was admitted on 12/28/15. Admitting diagnoses included, but were not limited to: weight loss, dementia with behavioral disturbances, hypertension, depression, pain and edema. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 9/22/16. The facility staff coded that Resident #9 had a Cognitive Summary Score of 13. The facility staff also coded that Resident	F 280	Care plans were revised for Resident #9, Resident #5, and Resident #10 on 12/9/2016. DON/Designee will review all current resident care plans to ensure they are accurate and updated with changes of condition. Licensed nurses will be educated on updating and revising care plans. DON/Designee will review Facility Activity report weekly x 4 weeks to determine change in residents condition and review care plans to ensure they have been updated. DON/Designee will report findings to the QA Committee quarterly x	

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F 280	Continued From page 40 #9 required set up (1/2) to limited assistance (2/2) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff did not document that Resident #9 received any antidepressants. On December 7, 20016 at 1:05 p.m. the surveyor reviewed Resident #9's clinical record. Review of the clinical record produced a physician telephone order dated 6/17/16 that read ... "Citalopram 2.5mg po (by mouth) qd (everyday) X (times) 2 weeks then D/C (discontinue).-depression." (sic) Citalopram (Celexa) is an antidepressant. Continued review of the clinical record produced the July 2016 Medication Administration Records (MAR's). Review of the July 2016 MAR's documented that the Citalopram 2.5mg was discontinued on 7/1/16. Further review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP included an active care plan for "Psychotropic Drug Use." (sic) The care plan read in part ... "Resident receives antidepressant medication for depression. " (sic) The CCP identified that the care plan was reviewed and revised on 10/5/16. On December 7, 2016 at 2 p.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN #2), that Resident #9's CCP had not been reviewed and revised. The surveyor reviewed Resident #9's clinical record with the MDS Nurse (RN#2). The surveyor pointed out the specific physician order to discontinue the Citalopram. The surveyor also reviewed the July 2016 MAR's with the MDS Nurse (RN #2). The surveyor pointed out that Resident #9's Citalopram (Celexa) was discontinued on 7/1/16. The surveyor then reviewed the CCP with the MDS Nurse (RN#2). The surveyor pointed out that the CCP still contained an active care plan	F 280	12 months.	

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for psychotropic drug use/antidepressant use (Citalopram).
On December 7, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to review and revise the CCP for Resident #9. The surveyor notified the AT that Resident #9 had been on Citalopram, an antidepressant, and that the medication was discontinued on 7/1/16. The surveyor notified the AT that the active CCP still included a care plan that addressed Resident #9 receiving an antidepressant.
No additional information was provided prior to exiting the facility as to why the facility staff failed to review and revise Resident #9's CCP.
2. For Resident #5, facility staff failed to revise the resident's comprehensive care plan to include use of non-pharmacologic interventions in the care plan for antipsychotic medication use.

Resident #5 was admitted to the facility on 4/29/15 with diagnoses including cerebral infarct, cognitive deficits, cerebral vertebra fracture, pain, diabetes mellitus, and hypertension.

On the significant change minimum data set (MDS) assessment with assessment reference date 10/5/16, the resident scored 6/15 on the brief interview for mental status and was assessed without signs of delirium and without signs of psychosis or behaviors affecting others.

During clinical record review, the surveyor noted a physician order dated 11/21/2016 for Seroquel (quetiapine) tablet; 25 mg; amount to administer: 12.5 mg; oral Special instructions: agitation/psychosis Once a day PRN. Orders

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were not noted for monitoring of antipsychotic side effects. There was no order for monitoring the presence of psychotic behavior (i.e. agitation/psychosis).

Medication Administration Record (MAR) review revealed staff documented administration of the antipsychotic medication quetiapine 12.5 mg on November 22 2016 and 12/7/2016. ON 11/22/16 MAR indicated administration for Other with comment: agitation, rsd yelling at staff. 12/7/16 MAR indicated administration for Behavior Issue with comment: resident yelling and striking at staff.

Nurse's notes on the dates of administration of the antipsychotic medication were as follows: 11/22/16 nurse's note at 11:51 AM documented the resident was trying to ambulate in room and yelled and swatted at staff when trying to redirect. Seroquel was administered and was effective and a urinalysis sent (on 11/21) and was negative. 12/7/16 12:53 PM After lunch resident thought she had a meeting to go to and when staff tried to redirect her resident started yelling at nurse. Nurse tried to redirect with snacks and TV without success. PRN Seroquel given.

The resident's comprehensive care plan listed the use of an antipsychotic medication. The resident's problem list included 11/21/16 Rsd started on antipsychotic for agitation/psychosis. Psych consult ordered. The comprehensive care plan did not include non-pharmacologic interventions.

The surveyor discussed the concerns with the administration of antipsychotic medications with the administrator and nursing staff during

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summary meetings on 12/8/16.

3. For Resident #10, facility staff failed to ensure the resident's comprehensive care plan addressed the use of antipsychotic medication, and provided for non-pharmacological interventions for symptoms to ensure the resident received antipsychotic medication only when clinically indicated.

Resident #10 was admitted to the facility on 2/13/12 with diagnoses including atrial fibrillation, hypertension, heart failure, atherosclerotic heart disease, osteoporosis, , major depression and dementia without behavior disturbance.

On the quarterly minimum data set (MDS) assessment with assessment reference date 9/28/16, the resident scored 7/15 on the brief interview for mental status and was assessed with signs of delirium (fluctuating disorganized thinking) and without signs of psychosis or behaviors affecting others.

During clinical record review, the surveyor noted a physician order dated 11/1/2016 for Risperdal (risperidone) tablet; 0.25 mg; amt: 0.125 mg; oral Special instructions: severe agitation every 8 hours PRN. Orders were also noted for monitoring of antipsychotic side effects: Antipsychotic Medication Use-Observe Closely for significant side effects: [list]. There was no order for monitoring the presence of psychotic behavior (i.e. severe agitation).

Medication Administration Record (MAR) review revealed staff documented administration of the antipsychotic medication risperidone 0.125 mg four times during November 2016. 11/2/16 and

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11/3/16 MAR indicated administration for Behavior Issue with comment: increased agitation. 11/22/16 MAR indicated administration for Other with comment: increased agitation. 11/23/16 MAR indicated administration for Behavior Issue with comment: out oon w/c insisting on coffee.

Nurse's notes on the dates of administration of the antipsychotic medication were as follows:
11/2/16 (late entry written on 11/3/16 at 6:36 PM) noted the medication was administered for agitation and was effective. No non-pharmacological interventions were documented.
11/3/16 noted the medication was administered for confusion and agitation and was effective. No non-pharmacological interventions were documented.
11/22/16 two nurse's notes at 11:41 AM and 9:37 PM documented no behaviors noted on those shifts. Administration of the antipsychotic medication risperidone 0.125 mg at 3:05 PM was not mentioned in the nurse's notes.
11/23/16 at 2:18 AM noted "Resident up in w/c at about 1:30 am wanting a cup of coffee. Was told that we didn't have any coffee down here, became kind of irate. Given Risperdal and she finally went back to bed. No other behaviors thus far this shift". No non-pharmacological interventions were documented.

The resident's comprehensive care plan did not address the use of an antipsychotic medication. The resident's problem list included the use of an antidepressant medication. No mention was made of the use of antipsychotic medication, increased agitation, or interventions to address agitation.

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F 280	Continued From page 45 The surveyor discussed the concerns with the administration of antipsychotic medications with the administrator and nursing staff during summary meetings on 12/8/16.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review the facility staff failed to follow professional standards of nursing practice for the administration of medications for 2 of 20 Residents, Resident #19 and Resident #8. The findings included: 1. For Resident #19 the facility staff failed to follow professional standards of nursing practice for the administration of the medication digoxin. Resident #19 was admitted to the facility on 11/102/16. Diagnoses included but not limited to bradycardia, hypotension, hyponatremia, dementia, atrial fibrillation congestive heart failure anemia and gastroesophageal reflux disease. The most recent MDS (minimum data set) with	F 281	MD was contacted on 12/8/2016 regarding clarification orders for resident #19. No changes were made to original order. MD was contacted on 12/7/2016 to obtain order for resident #8. Telephone order for UA documented on 12/7/2016. LPN #8 was in-serviced on professional nursing standards and transcribing physician orders. DON/Designee has audited current orders for residents□ receiving Digoxin and modified order to include obtaining apical HR prior to administration. DON/Designee will conduct an audit of all lab results to verify physician orders have been obtained. All licensed nurses will be in-serviced on professional nursing standards and	1/19/17

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F 281	Continued From page 46 an ARD (assessment reference date) of 11/09/16 coded the Resident as 5 out of 15 in section C, cognitive patterns. This is an admission MDS. Resident #19's clinical record contained a signed POS (physician's order summary) dated 12/05/16 which read in part "Lanoxin (digoxin) tablet; 125mcg; amt: 125mg; oral Dx (diagnosis) cardiac Once A day; 09:00 AM". According to Mosby's 2016 Nursing Drug Reference, digoxin is a cardiac medication used for the treatment of heart failure and atrial fibrillation. The surveyor observed LPN #8 (licensed practical nurse) during a medication pass and pour observation on 12/07/16 at approximately 0800. LPN #8 was observed checking Resident #19's pulse radially (on the wrist) for 1 minute prior to the administration of the cardiac medication digoxin. The surveyor requested a copy of the facility standards of practice for the administration of the medication digoxin and was provided with the facility policy on "Administration of Medications" on 12/07/16 at approximately 1045. The policy read in part "Policy: Licensed nurses or registered medication aides will observe approved protocols for administration and documentation of prescribed medications. Procedure: 3. Professional practice standards should be utilized for all medication administration." The surveyor requested a copy of the drug handbook utilized by the facility. The drug handbook entitled "Mosby's 2016 Nursing Drug	F 281	transcribing physician orders. DON/Designee will review Facility Activity Report to determine if new physician orders are being executed to professional nursing standards. DON/Designee will report findings to the QA Committee quarterly x 12 months.	

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Reference 29th edition" was provided to the surveyor on 12/07/16 at approximately 1030. Under nursing considerations for the administration of digoxin, the drug handbook read in part "Assess: Apical (over the heart) pulse for 1 min before giving product".

The concern of the not taking the pulse according to professional standards was discussed during a meeting with the administrative team on 12/08/16 at approximately 1630.

Nor further information was provided prior to exit.
2. The facility staff failed to write a physician order for a urinalysis order received on 6/4/16 and a urinalysis order received on 8/11/16 for Resident #8.
The clinical record of Resident #8 was reviewed 12/7/16. Resident #8 was admitted to the facility on 4/12/10 with diagnoses that included, but not limited to diabetes mellitus, cerebral infarction, depression, osteoarthritis, hypertension, hyperlipidemia, pain, gastroesophageal reflux disease, constipation, dysuria, and candida stomatitis.
Resident #8's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/26/16 coded the resident with a cognitive summary score of 14 out of 15 in Section C0500.
The surveyor found the results of a urinalysis obtained 6/4/16 and 8/11/16 in the laboratory section of the clinical record. The surveyor reviewed the physician orders for June 2016 and August 2016 but was unable to locate the physician orders.
The surveyor informed licensed practical nurse #4 on 12/7/16 at 3:30 p.m. that orders for the urinalysis obtained 6/4/16 and 8/11/16 were not found in the clinical record. L.P.N. #4 stated she

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would check the progress notes.
L.P.N. #4 provided the surveyor with the progress note dated 6/4/16 5:43 p.m. The progress note read "C/O (complaints of) dysuria/polyuria, afebrile at 97.6. Denies abdominal pain/discomfort. Telephone order received and ntd (noted) from Dr.____ (name omitted), obtain urine specimen via clean catch for U/A (urinalysis) with C&S (culture and sensitivity) if indicated. Urine obtained and sent to lab."
L.P.N. #4 also provided a progress note dated 8/10/16 at 12:28 p.m. that read "Resident had complaint of strong urine with cloudiness MD (medical doctor) aware order for UA C&S RP (responsible party) aware."
The surveyor interviewed licensed practical nurse /MDS coordinator #1 on 12/8/16 at 8:40 a.m. L.P.N. #1 stated when the nurses receive a telephone order from the physician, the order needs to be written.
The surveyor informed the administrator, the assistant administrator, and the regional director of quality assurance of the above concern on 12/7/16 at 3:55 p.m. and requested the facility policy on standards of nursing practice related to writing physician orders. The regional QA nurse when asked stated nurses need to write orders when one was received from the doctor.
The surveyor reviewed the facility's standard of practice with regard to physician orders. The policy titled "Administration of Medications" read "Verbal or telephone orders shall be taken only by a licensed nurse. Verbal/telephone orders are always recited back to the physician to validate accuracy before transcribing onto the telephone order, order sheet, MAR (medication administration record) or entering into the computer. Notation of orders always includes date, time, and nurse receiving the order."

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F 281	Continued From page 49 No further information was provided prior to the exit conference on 12/8/16.	F 281		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered	F 309		1/19/17

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F 309	Continued From page 50 care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review the facility staff failed to follow physician's orders for 2 of 20 Residents, Resident #10 and Resident #1. The findings included: 1. For Resident #10 the facility staff failed to follow physician's orders for the administration of the inhaled medication Advair. Resident #10 was admitted to the facility on 02/13/16. Diagnoses included but not limited to dementia, major depression, cardiopulmonary disease, hypertension, atrial fibrillation, and congestive heart failue. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/28/16 coded the Resident as 7 of 15 in section C, cognitive patterns. The surveyor observed LPN (licensed practical nurse) #7 during a medication pass and pour observation on 12/08/16 at approximately 1525. LPN #7 administered the inhaled medication Advair, then gave Resident #7 a cup of water and stated to Resident "here's you some water". The Resident took the water and swallowed it. . Resident #10's medications were reconciled with the clinical record on 12/08/16 at approximately 1530. The clinical record contained a signed POS (physician's order summary) dated 12/02/16 which read in part "Advair HFA (fluticasone-salmeterol) HFA aerosol inhaler; 115-21 mcg/actuation; amt; 2 puffs; inhalation.	F 309	MD and RP notified of resident #10 swallowing water after receiving Advair instead of rinsing mouth and spitting out the water. MD and RP notified of resident #1 not having a weight obtained per MD order and not having pain scale included in the pain assessment. LPN #7 received in-service training. DON/Designee will review current residents with orders for Advair and to ensure the physicians orders are followed. DON/Designee will review current resident orders to ensure weights have been obtained per MD orders. Licensed nurses will be educated on following physician s orders. DON/Designee will review Facility Activity Report to determine if new physician orders are being executed to professional nursing standards. DON/Designee will report findings to the QA Committee quarterly x 12 months.	

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Special instructions: Inhale 2 puffs by mouth twice daily-COPD (Rinse mouth with water after use, do not swallow)".

The surveyor was provided a copy of the facility policy for "Administration of Medications" on 12/07/16 at approximately 1045 which read in part "All medications will be administered per physician, nurse practitioner (NP) or physician assist (PA) written, verbal or telephone order and shall not be started, changed or discontinued by the faculty without an order form the physician, NP, or PA.".

The concern of not following the physician's order was discussed with the administrative staff during a meeting on 12/08/16 at approximately 1630.

No further information was provided prior to exit.
2. The facility staff failed to obtain a physician ordered weight on Resident #1 and failed to ensure the pain assessment included the pain scale for Resident #1.

The clinical record of Resident #1 was reviewed 12/6/16 and 12/7/16. Resident #1 was admitted to the facility 10/15/16 and readmitted 12/1/16 with diagnoses that included but not limited to Clostridium difficle colitis, type 2 diabetes mellitus, hypertension, gastroparesis, coronary artery disease, aortic stenosis, left carotid stenosis, Vitamin B12 deficiency, obstructive uropathy, acute renal failure superimposed on stage 3 chronic kidney disease, bladder cancer, weight loss of 10%-severe protein-calorie malnutrition, severe sepsis with acute organ dysfunction, nephrostomy, urinary tract infection E. Coli (Escherichia coli), ESBL (Extended spectrum beta-lactamase), hydronephrosis,

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paroxysmal atrial fibrillation, and scabbed area on lateral malleolus of the left ankle.

Resident #1's admission minimum data set (MDS) was not completed.

(a) The interim care plan dated 12/1/16 identified Resident #1 at risk for weight loss. Interventions: weekly weights times 4 weeks or until stable. Monitor meal intake, reinforce proper nutrition and hydration, monitor oral/dental health, dietician consults as indicated, keep physician, family, resident updated, and document outcome.

The December 2016 signed physician orders were reviewed. Included was the order that read "Weight every week for 4 weeks start 12/1/16."

The surveyor reviewed the vital report and was unable to locate a December 2016 weight and requested assistance from licensed practical nurse #4 on 12/7/16 at 9:55 a.m. L.P.N. #4 stated upon review of the clinical record that she was unable to locate a weight. L.P.N. #4 stated weights are to be done the day of admission or the next day. "He hasn't been weighed since admission." L.P.N. #4 stated Wednesday was the day Resident #1 was to be weighed and a weight would be done today.

The surveyor interviewed the registered dietician on 12/7/16 at 10:05 a.m. if she had any recorded weights. The RD stated none since the current admission.

The surveyor informed the administrator, the regional director of quality assurance and the assistant administrator of the above concern on 12/7/16 at 3:55 p.m. and requested the facility

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policy on obtaining weights.

The surveyor reviewed the facility policy titled "Vital Signs Weight Record" on 12/8/16. The policy read in part "Procedure 2. Record resident's height and weight upon admission. The consulting dietician or Food Service Director will calculate resident ' s Ideal Body Weight (IBW)."

(b). The admission physician orders dated 12/1/16 through 12/31/16 and signed 12/2/16 included orders for pain assessment that read "Assess level of pain and document on scale of 1-10 every shift (1-3=mild, 4-7=moderate, 8-10=severe Every shift; 7a-3p, 3p-11p, 11p-7a)."

The surveyor reviewed the December 2016 medication administration record (MAR). Pain was documented assessed on 12/2/16 through 12/6/16 as documented by nurse's initials in each box. However, the assessment did not include a pain level.

The surveyor discussed the pain assessment with licensed practical nurse #4 on 12/7/16 at 10:00 a.m. L.P.N. #4 reviewed the December 2016 MAR and stated someone had failed to tag the task to document the pain level. L.P.N. #4 stated that it was easy to fix.

The surveyor informed the administrator, the regional director of quality assurance and the assistant administrator of the above concern on 12/7/16 at 3:55 p.m. and again on 12/8/16 at 4:35 p.m.

No further information was provided prior to the exit conference on 12/8/16.

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F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to assess and treat an unstageable pressure ulcer for 1 of 20 residents (Resident #1). The findings included: The facility staff failed to assess and treat an unstageable pressure ulcer located on Resident #1's left lateral ankle. The clinical record of Resident #1 was reviewed 12/6/16 and 12/7/16. Resident #1 was admitted to the facility 10/15/16 and readmitted 12/1/16 with diagnoses that included but not limited to Clostridium difficle colitis, type 2 diabetes mellitus, hypertension, gastroparesis, coronary	F 314	Wound MD assessed resident #1 on 12/8/2016. On 12/8/2016, MD and RP were notified of area on ankle. No new orders were written. DON/Designee will perform a skin sweep on current residents to ensure there are no unaddressed skin impairments. DON/Designee will create a skin assessment schedule to ensure all residents skin will be assessed weekly. Nursing staff will be educated regarding the prevention of pressure ulcers. DON/Designee will review skin assessments weekly x 4 weeks.	1/19/17

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F 314	Continued From page 55	F 314	DON/Designee will round weekly x 4 weeks to ensure preventive devices are in place. DON/Designee will report findings to QA Committee quarterly x 12 months.	

artery disease, aortic stenosis, left carotid stenosis, Vitamin B12 deficiency, obstructive uropathy, acute renal failure superimposed on stage 3 chronic kidney disease, bladder cancer, weight loss of 10%-severe protein-calorie malnutrition, severe sepsis with acute organ dysfunction, nephrostomy, urinary tract infection E. Coli (Escherichia coli), ESBL (Extended spectrum beta-lactamase), hydronephrosis, paroxysmal atrial fibrillation, and scabbed area on lateral malleolus of the left ankle.

Resident #1's admission minimum data set (MDS) was not completed.

Resident #1's interim care plan dated 12/1/16 identified that the resident was at risk for skin breakdown. Interventions included skin checks weekly, pressure reduction mattress, observe for redness and report to nurse, monitor meal intake, cushion to wheelchair as indicated, treatment per physician ' s orders, document outcome Braden scale on admission, weekly x 4 weeks, then quarterly thereafter, position change every 2 hours and prn (as needed), and manage incontinence, change every 2 hours and as needed.

The admission physician's orders 12/01/16 through 12/31/16 were signed 12/2/16. Orders included APP mattress to bed Dx (diagnosis) skin prevention due to poor skin turger (sic), Miracle cream topically to sacrum and perineum every shift and as needed, and heel boots while in bed.

The surveyor entered Resident #1's room 12/7/16 at 8:25 a.m. Resident #1 was observed in bed. Heel boots were not observed to be on the resident. The heel boot was observed to be in a

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chair.

The surveyor observed Resident #1 on 12/8/16 at 1:10 p.m. with licensed practical nurse #1. L.P.N. #1 and the surveyor observed Resident #1's left lateral ankle. Resident #1 had a dime size area with a tan center that measured approximately ¼ inch in diameter with redness noted around the outer part of the wound. L.P.N. #1 stated the area was unstageable. "You can't see what's under the scabbed area and he doesn't have his boot on either." L.P.N. #1 stated she was unable to find any orders from the hospital regarding care and treatment of the left lateral ankle wound. L.P.N. #1 stated the nurse may have gotten orders in report. L.P.N. #1 stated if the nurse received orders from the hospital, the orders should have been written.

The admission progress note dated 12/1/16 at 8:18 p.m. read in part "Skin W (warm), D (dry) with healing abrasions on left hip, R (right) forearm, Stg (stage) 2 pressure injury to his coccyx, unstageable to his left lat (lateral) ankle, stg 1 to his left heel." The clinical record contained detailed skin assessments for the coccyx, left heel, left shin, and right forearm but none for the pressure ulcer on the left lateral ankle.

The skin assessment provided by the facility for the left lateral ankle unstageable pressure injury gave only measurements and character of tissue. The skin assessment provided did not identify exudate if any, odor, tunneling, undermining, or sinus tract, description of surrounding tissue, if edema present, pain, or any skin and ulcer treatments.

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The surveyor interviewed the admission nurse registered nurse #1 on 12/8/16 at 3:30 p.m. R.N. #1 stated she could not locate the order for the ankle treatment. R.N. #1 stated usually for an unstageable wound, the area was left open to air.

The surveyor requested the facility policy on skin assessments/wound care from the regional director of quality assurance on 12/8/16.

The policy titled "Wound Care" read "The facility will ensure that the skin care needs of residents are met. The facility will assure appropriate prevention and treatment of skin breakdown and wounds. Procedure: 1. The Director of Nursing shall be responsible for ensuring that the skin care needs of residents are met by: a. Nursing staff of the facility providing appropriate preventative skin care. b. Nursing staff observing skin condition during routine care services and immediately reporting changes to the Director of Nursing and/or designee. d. Making appropriate arrangements for skin/wound care services as appropriate. e. Licensed health care professionals assessing all wounds on a consistent basis and monitoring for change in condition. 2. Residents noted to have a skin tear or open wound will be observed daily until healed. 3. Licensed health care professional shall document observed progress, condition or treatment of the skin tear or wound daily."

The policy titled "Pressure Ulcer Record" read in part "A pressure sore record will be utilized to provide a format for recording and monitoring the treatment and progress of decubiti. Procedure: 1. When a pressure sore is reported, the charge nurse is responsible for: a. Checking the affected area of the resident. c. Photographing the

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F 314	Continued From page 58 pressure sore and include date on photo. D. Completing one pressure sore record for each sore and identifying the area on the human diagram. The information at the top of the page must be filled out completely. Dietary must be notified of all sores and include in the wound and weight committee. e. Notifying the physician and obtaining an order for treatment. f. Notifying the family. g. Recording all pertinent information in the nurses ' note. h. Placing the pressure sore record in the clinical record." The surveyor informed the administrator, the assistant administrator, and the regional director of quality assurance of the above concern with the assessment and care of Resident #1's left lateral ankle unstageable pressure ulcer on 12/7/16 at 3:55 p.m. and again on 12/8/16 at 4:35 p.m. No further information was provided prior to the exit conference on 12/8/16.	F 314		
F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		1/19/17

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F 323	Continued From page 59 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to ensure an environment free of accident hazards on 2 of 2 units in the facility. The Findings Included: On December 6, 2016 at 12:30 p.m. the survey team entered the facility. The surveyor made an initial tour of the facility. The surveyor observed the shower/bath room on the lower level of the facility. The surveyor observed the 2 exterior corners of a shower stall taped with red tape. The surveyor observed broken and jagged edge tiles on the two exterior corners of the shower stall. The surveyor also observed a wooden door that opened to enter the bathroom/toilet area. The surveyor observed that the finish of the door was missing and exposed a raw edge of rough wood. The area was approximately 2 feet long by 1 to 1 ½ inches wide. Lastly the surveyor observed the stall that housed the whirlpool tub in the shower/bath room. The surveyor observed that a Hoyer lift was being stored in front of the whirlpool tub. The surveyor observed that the right wall had a large area of jagged wood at the baseboard.	F 323	The tile and baseboard in the lower level shower room will be repaired. The door leading into the bathroom will be replaced. Breakaway locked were placed on crash cart on 12/21/2016. Coffee pot and hot water dispenser were removed immediately on 12/6/2016. Director of Environmental Services and Maintenance and Assisted Administrator conducted rounds to ensure no environmental concerns. Director of Environmental Services and Maintenance/Designee will conduct weekly rounds x 4 weeks to ensure compliance. Educate environmental services staff to report any issues or concerns noted to supervisor. Director of Environmental Services and Maintenance will report issues to QA committee quarterly x 12 months.	

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The area was approximately 1 foot long by 6 inches wide. The surveyor surmised that facility staff had repeatedly hit the wall with the Hoyer lift carriage when being stored, causing the baseboard area to be sheared and roughened.
On December 8, 2016 at 7:50 a.m. the surveyor observed a crash cart on the upper floor of the facility. The surveyor observed that the crash cart was not locked. The surveyor opened the top drawer. The top drawer contained 3 syringes with needles attached and 2 needles.
On December 8, 2016 at 8:05 a.m. the surveyor requested for the Administrator (Adm) to accompany the surveyor over to the crash cart. The surveyor and Adm walked to the crash cart. The surveyor opened the top drawer and pointed to the 3 syringes with attached needles and to the 2 needles. The surveyor informed the Adm that the needles and syringes were available for use to residents, families and visitors. The surveyor notified the Adm that the availability of the syringes and needles to the residents, families and visitors was a safety hazard.
On December 8, 2016 at 1 p.m. the surveyor made a tour of the facility with the Maintenance Director (MD) and the Assistant Administrator (AAdm). The surveyor, MD and AAdm entered the shower/bath room on the lower level of the facility. The surveyor pointed out the corners of the shower stall that had red tape on them. The surveyor pointed out that the tiles were broken and jagged. The surveyor also pointed out the wooden door that entered into the toilet area. The surveyor pointed out that the finish on the door was missing, exposing rough, sharp edges. Lastly, the surveyor pointed out the jagged and roughened edge at the baseboard area at the whirlpool tub. The surveyor informed the MD and AAdm that the areas in the shower were of a

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safety concern to the surveyor.
On December 8, 2016 at 4:30 p.m. the survey team met with the Adm, AAdm and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that needles and syringes were available for use for residents, families and visitors in the crash cart. The surveyor also notified the AT that the shower on the lower level had broken tiles, a rough door and a rough and jagged baseboard. The surveyor notified the AT that the areas described were a safety concern for the surveyor.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure an environment free of accident hazards for the facility residents, families and visitors.
2. The facility staff failed to ensure a hazard free environment in the Sullivan Center dining room.

The surveyor entered the Sullivan Center dining room on 12/6/16 at 2:55 p.m. Two residents were observed sitting at a table reading. The surveyor observed that the dining room was not supervised by staff while residents were there. As one entered the dining area to the right of the entrance door, a long metal table contained a BUNN coffee pot currently holding coffee and with the burner on and a tab for hot water on the coffee pot that could be pulled to dispense hot water. This tab was bright orange. A juice machine was also on the table as well as cups and glasses.

The surveyor interviewed licensed practical nurse #2 regarding staff in the dining room. L.P.N. #2 stated nursing staff are in the dining room at meal times and activity staff when activities are held. All other times, residents can come and go in

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F 323	Continued From page 62 anytime. "The dining room is not supervised all the time when residents are in here", L.P.N. #2 stated. The surveyor informed the administrator of the concern with the hot water dispenser and the coffee pot currently on with coffee in the pot and the dining room not supervised by staff and currently with two residents in the area of the dispenser and the coffee pot on 12/6/16 at 3:00 p.m. The administrator stated the hot water dispenser and coffee pot had been here when the building was set up but stated "I see your point." The administrator stated there had been no incidents of resident burns/injuries. The surveyor interviewed the food service director on 12/6/16 at 3:05 p.m. The food service director stated carafes would be provided for coffee. The surveyor had received no Facility Reported Incidents for burns since the last standard/licensure survey in February 2016. A review of the facility incident log did not reveal any resident burns. The surveyor informed the administrator, the assistant administrator, and the regional director of quality assurance of the above concern on 12/7/16 at 3:55 p.m. No further information was provided prior to the exit conference on 12/8/16.	F 323		
F 328 SS=D	TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive	F 328		1/19/17

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proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

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

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

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

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care,

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F 328	Continued From page 64 including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to administer oxygen as physician prescribed and failed to maintain respiratory equipment in a cleanly fashion for 1 of 20 residents (Resident #1). The findings included: The facility staff failed to ensure the amount of oxygen as ordered by the physician was accurate and failed to ensure the oxygen concentrator filters were clean for Resident #1. The clinical record of Resident #1 was reviewed 12/6/16 and 12/7/16. Resident #1 was admitted to the facility 10/15/16 and readmitted 12/1/16 with diagnoses that included but not limited to Clostridium difficile colitis, type 2 diabetes mellitus, hypertension, gastroparesis, coronary artery disease, aortic stenosis, left carotid stenosis, Vitamin B12 deficiency, obstructive uropathy, acute renal failure superimposed on	F 328	Oxygen setting was corrected for Resident #1 and concentrator was cleaned on 12/7/2016. DON/Designee will audit current residents receiving Oxygen to ensure the settings are utilized per MD order and to ensure the concentrator filter is clean. All nursing staff were educated regarding administration of oxygen as well as cleaning oxygen concentrator filters as of 1/4/2017. DON/Designee will review Facility Activity Report daily to review physician orders and ensure they are executed to professional nursing standards. DON/Designee will round weekly x 4 weeks to ensure oxygen settings are correct and concentrator filters are clean. DON/Designee will report findings to the QA Committee quarterly x 12 months.	

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stage 3 chronic kidney disease, bladder cancer, weight loss of 10%-severe protein-calorie malnutrition, severe sepsis with acute organ dysfunction, nephrostomy, urinary tract infection E. Coli (Escherichia coli), ESBL (Extended spectrum beta-lactamase), hydronephrosis, paroxysmal atrial fibrillation, and scabbed area on lateral malleolus of the left ankle.

Resident #1's admission minimum data set (MDS) was not completed.

Resident #1's admission physician orders had orders for oxygen that read " Oxygen @ (at) 2 l/NC (liters per nasal cannula) continuous Dx (diagnosis): anemia. "

The surveyor first observed Resident #1 on 12/6/16 at 2:40 p.m. Resident #1 was lying in bed, oxygen at 2 l/NC. Filter located on the right side of the oxygen concentrator had an accumulation of white lint/dust on the black filter.

The surveyor observed Resident #1 again on 12/7/16 at 8:25 a.m. Resident #1 was lying in bed, attended by the speech therapist and a student. Oxygen concentrator was observed to be at 1L/NC.

The surveyor observed Resident #1 again during a wound care observation on 12/7/16 at 10:45 a.m. Oxygen concentrator noted to be set at 1L/NC. The air filter on the right side of the concentrator appeared to have an accumulation of white lint/dust on the filter.

The surveyor asked licensed practical nurse #2 what amount of oxygen was ordered for Resident #1. L.P.N. #2 stated the amount was 2. L.P.N.

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F 328	Continued From page 66 #2 stated the filter needed to be cleaned. The surveyor requested the facility policy on care of oxygen equipment from the regional director of quality assurance on 12/8/16. The surveyor informed the administrator, the assistant administrator, and the regional director of quality assurance of the above concern with oxygen on 12/8/16 at 4:35 p.m. The surveyor reviewed the facility policy titled "Oxygen therapy" on 12/8/16. The policy read in part "1. The facility shall have a valid physician or other prescriber's order that included the following: a. The oxygen source (such as compressed gas or concentrators); b. The delivery source (such as nasal cannula, reservoir cannula or mask); and c. The flow rate as ordered." No further information was provided prior to the exit conference on 12/8/16.	F 328		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		1/19/17

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F 329	Continued From page 67 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that 3 of 20 Residents in the sample survey were free of necessary medications, Resident #7, Resident #5 and Resident #10. For the Residents identified, the facility staff failed to monitor for psychotropic, antidepressant and antianxiety drug use. The Findings included: 1. For Resident #7 the facility staff failed to	F 329	A behavior sheet have been implemented for Resident # 5, 7, and 10 to ensure non-pharmacological interventions prior to administering Antipsychotic/Antidepressant/Antianxiety Medications and the care plans updated as of 12/22/2016. DON/Designee has audited all residents receiving Antipsychotic/Antidepressant/Antianxiety	

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F 329	Continued From page 68 monitor for antidepressant and antianxiety drug use to include specific behaviors, effectiveness, side effects and interventions. Resident #7 was an 84 year old female who was admitted on 7/27/16. Admitting diagnoses included, but were not limited to: fractured radius, cognitive deficit, hypertension, major depression, anxiety, trans-ischemic attacks (TIA's) and a Vitamin D deficiency. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 10/26/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #7 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #7 received 7 days of antianxiety and antidepressant medications. On December 7, 2016 at 9:55 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced signed physician orders dated 11/7/16. Review of the signed physician orders included, but were not limited to: "Xanax (alprazolam)-Schedule IV tablet; 0.25mg; amt (amount): 0.25; oral Special Instructions: DX (diagnoses): anxiety Three Times a Day; 06:00 AM, 02:00 PM, 10:00 PM. Lexapro (escitalopram oxalate) tablet; 20 mg; amt: 20mg; oral Special Instructions: DX: anxiety Once a Day; 08:00 AM." (sic) The Xanax was initiated on 9/10/16. The Lexapro was initiated on 10/8/16. Xanax is an antianxiety medication and Lexapro is an antidepressant. Continued review of the clinical record produced the November and December 2016 Medication Administration Records (MAR's). Review of the November and December 2016 MAR's	F 329	medications to ensure behavior sheets are being utilized and care plans are updated. DON/Designee will request all Antipsychotic/Antidepressant/Antianxiety medications ordered on a PRN basis be evaluated by MD and a stop date be given. Licensed nurses will be educated regarding the use of Antipsychotic/Antidepressant/Antianxiety Medication and the need to utilize behavior monitoring sheets including the use of non-pharmacological. DON/Designee will review Facility Activity weekly x 4 weeks. When Antipsychotic/Antidepressant/Antianxiety meds are ordered, the DON/Designee will ensure a behavior sheet is put in to place and PRN orders have a stop date. DON/Designee will report findings to the QA Committee quarterly x 12 months.	

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documented the administration of the Xanax and Lexapro and monitoring for side effects for the medications. The November and December 2016 MAR's did not document specific behaviors, effectiveness or interventions.
On December 7, 2016 at 11 a.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN #2), that Resident #7 was receiving an antianxiety and antidepressant medication. The surveyor notified the MDS Nurse (RN #2) that review of the clinical record failed to produce monitoring for the antianxiety and antidepressant medications. The surveyor notified the MDS Nurse (RN #2) that specific behaviors, effectiveness and interventions could not be located in the clinical record. The surveyor reviewed the clinical record with the MDS Nurse (RN #2). The surveyor specifically pointed out the signed physician orders and the November and December 2016 MAR's. The MDS Nurse (RN #2) reviewed the clinical record and could not locate monitoring of antianxiety and antidepressant drug use to include specific behaviors, effectiveness and interventions.
On December 7, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #7 was receiving Xanax and Lexapro (an antianxiety and an antidepressant). The surveyor notified the AT that the facility staff failed to monitor Resident #7 for the antianxiety and antidepressant drug use to include specific behaviors, effectiveness and interventions.
No additional information was provided prior to exiting the facility as to why the facility staff failed to provide medication monitoring for Resident #7.
2. For Resident #5, facility staff failed to ensure

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the resident received antipsychotic medication only when clinically indicated.

Resident #5 was admitted to the facility on 4/29/15 with diagnoses including cerebral infarct, cognitive deficits, cerebral vertebra fracture, pain, diabetes mellitus, and hypertension.

On the significant change minimum data set (MDS) assessment with assessment reference date 10/5/16, the resident scored 6/15 on the brief interview for mental status and was assessed without signs of delirium and without signs of psychosis or behaviors affecting others.

During clinical record review, the surveyor noted a physician order dated 11/21/2016 for Seroquel (quetiapine) tablet; 25 mg; amount to administer: 12.5 mg; oral Special instructions: agitation/psychosis Once a day PRN. Orders were not noted for monitoring of antipsychotic side effects. There was no order for monitoring the presence of psychotic behavior (i.e. agitation/psychosis).

Medication Administration Record (MAR) review revealed staff documented administration of the antipsychotic medication quetiapine 12.5 mg on November 22 2016 and 12/7/2016. ON 11/22/16 MAR indicated administration for Other with comment: agitation, rsd yelling at staff. 12/7/16 MAR indicated administration for Behavior Issue with comment: resident yelling and striking at staff.

Nurse's notes on the dates of administration of the antipsychotic medication were as follows: 11/22/16 nurse's note at 11:51 AM documented the resident was trying to ambulate in room and

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yelled and swatted at staff when trying to redirect. Seroquel was administered and was effective and a urinalysis sent (on 11/21) and was negative. 12/7/16 12:53 PM After lunch resident thought she had a meeting to go to and when staff tried to redirect her resident started yelling at nurse. Nurse tried to redirect with snacks and TV without success. PRN Seroquel given.

The resident's comprehensive care plan listed the use of an antipsychotic medication. The resident's problem list included 11/21/16 Rsd started on antipsychotic for agitation/psychosis. Psych consult ordered. The comprehensive care plan did not include non-pharmacologic interventions.

The surveyor discussed the concerns with the administration of antipsychotic medications with the administrator and nursing staff during summary meetings on 12/8/16.

3. For Resident #10, facility staff failed to ensure the resident received antipsychotic medication only when clinically indicated.

Resident #10 was admitted to the facility on 2/13/12 with diagnoses including atrial fibrillation, hypertension, heart failure, atherosclerotic heart disease, osteoporosis, , major depression and dementia without behavior disturbance.

On the quarterly minimum data set (MDS) assessment with assessment reference date 9/28/16, the resident scored 7/15 on the brief interview for mental status and was assessed with signs of delirium (fluctuating disorganized thinking) and without signs of psychosis or behaviors affecting others.

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During clinical record review, the surveyor noted a physician order dated 11/1/2016 for Risperdal (risperidone) tablet; 0.25 mg; amt: 0.125 mg; oral Special instructions: severe agitation every 8 hours PRN. Orders were also noted for monitoring of antipsychotic side effects: Antipsychotic Medication Use-Observe Closely for significant side effects: [list]. There was no order for monitoring the presence of psychotic behavior (i.e. severe agitation).

Medication Administration Record (MAR) review revealed staff documented administration of the antipsychotic medication risperidone 0.125 mg four times during November 2016. 11/2/16 and 11/3/16 MAR indicated administration for Behavior Issue with comment: increased agitation. 11/22/16 MAR indicated administration for Other with comment: increased agitation. 11/23/16 MAR indicated administration for Behavior Issue with comment: out oon w/c insisting on coffee.

Nurse's notes on the dates of administration of the antipsychotic medication were as follows:
11/2/16 (late entry written on 11/3/16 at 6:36 PM) noted the medication was administered for agitation and was effective. No non-pharmacological interventions were documented.
11/3/16 noted the medication was administered for confusion and agitation and was effective. No non-pharmacological interventions were documented.
11/22/16 two nurse's notes at 11:41 AM and 9:37 PM documented no behaviors noted on those shifts. Administration of the antipsychotic medication risperidone 0.125 mg at 3:05 PM was

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F 329	Continued From page 73 not mentioned in the nurse's notes. 11/23/16 at 2:18 AM noted "Resident up in w/c at about 1:30 am wanting a cup of coffee. Was told that we didn't have any coffee down here, became kind of irate. Given Risperdal and she finally went back to bed. No other behaviors thus far this shift". No non-pharmacological interventions were documented. The resident's comprehensive care plan did not address the use of an antipsychotic medication. The resident's problem list included the use of an antidepressant medication. No mention was made of the use of antipsychotic medication, increased agitation, or interventions to address agitation. The surveyor discussed the concerns with the administration of antipsychotic medications with the administrator and nursing staff during summary meetings on 12/8/16.	F 329		
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		1/12/17

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F 371	Continued From page 74 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. During initial tour on 12/6/16 at approximately 12:45 PM with the dietary services manager, the surveyor observed a direct care staff member filling an ice cooler from the ice machine near the assisted living cafeteria line. The staff member propped the cooler on the edge of the door opening and dropped the cooler into the ice bin, then removed it and finished filling the cooler. In the freezer, frozen bread sticks were open, undated and with loose bread sticks lying on top of the bag. On the bread storage rack, a loaf of bread was open and undated. In the tray line room, unlabeled food and drink were on the tray line shelf, behind a stack of clean trays. One eye wash bottle on the eye wash station was expired and the second bottle was absent. The dietary services manager stated	F 371	All items noted were corrected as 12/7/2016. Dining Services Director/Designee conducted rounds to ensure compliance. Dining services staff were in-serviced on all items on 12/8/2016. Facility staff will be in-serviced on infection control by 1/12/2017. Dining Services Director/Designee will conduct daily rounds x 2 weeks to ensure compliance.	

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she had asked for a new station.

In the freezer inside the cook's refrigerator, there were apple fritters (per the dietary manager) and bread in unlabeled, open containers.

The prep cook was spreading potatoes on sheet pans with bare hands, writing labels for the pans, placing them on racks and returning to spread potatoes without washing hands between labeling and touching food.

The drain tube from the steamer was touching the ground and water was running across the floor. There was accumulated dirt and grease on the floor beside and under the fryer.

The sugar bin had a drinking cup sitting in the sugar. The miscellaneous shelves had a box of bananas on the bottom shelf with jugs of sauces and condiments stored above them. one jug of vinegar sat on the floor beside the shelves.

During tray line service on 12/7/16 in the presence of the dietary manager, Cook #1 (C1) left the tray line for a new tray of bowls and touched the menus taped to the wall repeatedly during service. Cook #2 (C2) scooped mashed potatoes, lidded plates and placed them on carts, retrieved stacks of dome lids, rolled plates down the line by placing hand in the center of the plate, took a sanitizer bucket from another employee and set it down, wiped hands on apron, and returned to scooping food onto plates without changing gloves. C1 pulled a sectioned plate from a stack below the steam table. C2 told her to use the sectioned plates on a nearby table. Those plates were already placed in chargers and a dishwasher rack of bowls was sitting

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directly on plates. C2 put the plate she was holding back on the stack under the tray table and slid a plate from under the rack of bowls. C2, still wearing the same gloves, took plates with sandwiches from a coworker, cradled the plates in one arm, pulled back the plastic wrap from one plate, scooped mashed potatoes, and recovered the plate then put in on a charger with a lid and put it on a tray. C2 then left the area, returned carrying a pan of food with hot mitts, put the pan on the steam tray, removed the empty pan and returned pushing up sleeves with gloved hands. C2 closed the doors on a food cart and pushed it out of the area, then returned to the food line pushing up her sleeves again.

The surveyor reported concerns with food storage, kitchen cleanliness, and hand hygiene to the administrative team during a summary meeting on 12/7/16.

2. The facility staff failed to label, date and store opened and used foods in a sanitary manner in the two facility pantries.

On December 6, 2016 at 12:30 p.m. the surveyor made an initial tour of the facility with the Assistant Director of Nursing (ADON). The surveyor and ADON entered the pantry on the lower level of the facility. The surveyor observed a Wendy's frosty, a quart container of Homestead vanilla ice cream, a brown bottle of chocolate syrup and a piece of cake in the refrigerator. The surveyor did not observe a label or date on any of the opened food items. The surveyor pointed out the opened food items to the ADON. The ADON stated the items were supposed to be labeled and dated when opened. The surveyor asked for the facility policy and procedure for storing, labeling and dating opened food items.

The surveyor also observed the pantry on the

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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 371	Continued From page 77 upper level of the facility. The surveyor observed an opened and used bottle of chocolate syrup, a quart size container of deluxe chocolate ice cream and a Carvel cake in the freezer (the box was opened and the cake was cut). On December 6, 2016 at 3:30 p.m. the surveyor notified the Administrator (Adm) and Assistant Administrator (AAdm) that the two pantries had opened, unlabeled and undated foods items in the refrigerators and freezers. The Adm stated that the food items were supposed to be labeled and dated. On December 7, 2016 at 9:40 a.m. the surveyor observed a policy and procedure titled, "Food Service Guidelines," that had been left in the conference room. The policy and procedure read in part ... "...Any opened food item must be stored in clearly labeled containers with a clearly labeled lid." On December 7, 2016 at 3:30 p.m. the surveyor team met with the Adm, AAdm and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to label, date and store opened food items in a sanitary manner in the two facility pantries. No additional information was provided as to why the facility staff failed to label, date and store opened food items in the two facility pantries.	F 371		
F 425 SS=E	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		1/19/17

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F 425	Continued From page 78 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure physician ordered meds were available for administration for 2 of 20 Residents, Resident #19 and Resident #15. The findings included: 1. For Resident #19 the facility staff failed to ensure the medication Vitamin B Complex was available for administration. Resident #19 was admitted to the facility on 11/102/16. Diagnoses included but not limited to bradycardia, hypotension, hyponatremia, dementia, atrial fibrillation congestive heart failure anemia and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/09/16 coded the Resident as 5 out of 15 in section C, cognitive patterns. This is an admission MDS. During a medication pass and pour observation on12 /07/16 at approximately 0800, the surveyor observed LPN (licensed practical nurse) #8 administer 1 vitamin B-12 500 mcg tablet and 1 folic acid 400 mcg tablet. Resident #19's medications were reconciled with the clinical record on 12/07/16 at approximately	F 425	Clarification order from MD for Vitamin B12 and Folic Acid received on 12/5/2016. Clinical record updated with clarification order on 12/7/2016. An audit will be conducted by the DON/Designee to ensure all residents have physician□ ordered medications available. Licensed nurses will be educated regarding the process of reordering medications and ordering medications on a timely basis to ensure they are available for administration. DON/Designee will audit a sample of medications available against Physician orders weekly x 4 weeks to ensure medications are available. DON/Designee will report to the QA Committee quarterly x 12 months.	

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0930. Resident #19's clinical record contained a signed POS (physician's order summary) dated 12/05/16 which read in part "vitamin B12-folic acid [OTC (over the counter)] tablet; 500-400 mcg; amt: 1 tab; oral Special instructions: 1 tab PO (by mouth) QD (everyday)". The POS also contained an order which read in part "Pharmacy may act as an agent for the physician to obtain medications for the Resident".

Resident #19's clinical record also contained a discharge summary from the hospital which read in part "Medications at discharge: Current discharge medication list: Continue taking these meds which have not changed: Vitamin B complex (B complex PO) take by mouth every day."

The surveyor spoke with pharmacist #10 on 12/08/16 at approximately 1420. Surveyor asked pharmacist #10 why the medication was in two tablets vs one tablet per the physician's order and pharmacist stated that the medication was not available in a combination tablet, therefore the pharmacy had sent the equivalent dosage in two tablets. The surveyor asked the pharmacist if there was any difference in Vitamin B12-folic acid and Vitamin B complex and the pharmacist stated that B complex had other things in it i.e.: B12, B5, B6, B2 and B1. The surveyor then asked the pharmacist why the medication had been filled with B12-folic acid rather than the B complex and pharmacist stated the pharmacy had received an electronic prescription from the facility for Vitamin B12-folic acid.

The surveyor spoke with the administrator on 12/08/16 at approximately 1430 regarding Resident #19's physician's orders. Surveyor

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requested a copy of the order for Vitamin B12-folic acid and the administrator stated that the orders had come from the hospital discharge summary. Administrator also stated that these were the orders sent to the pharmacy unless the physician requested changes. The administrator could not locate an order for Vitamin B12-folic acid.

The concern of not having the correct medication available for administration was discussed during a meeting with the administrative staff on 12/08/16 at approximately 1630.

No further information was provided prior to exit.

2. For Resident #15 the facility staff failed to ensure that physician ordered Bumetanide was available for administration.

Resident #15 was an 89 year old female who was originally admitted on 3/17/16 and readmitted on 6/30/16. Resident #15 was discharged on 11/2/16. Admitting diagnoses included, but were not limited to: congestive heart failure, acute respiratory failure, pneumonia, hypertension, depression and a pressure ulcer.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 11/11/16. The facility staff coded that Resident #15 had a Cognitive Summary Score of 13. The facility also coded that Resident #15 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On December 8, 2016 at 10:25 a.m. the surveyor reviewed Resident #15's closed clinical record. Review of the closed clinical record produced signed physician orders dated 11/1/16.

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Signed physician orders included, but were not limited to: "bumetanide tablet; 1 mg; amt (amount); 1 tablet; oral Special Instructions: one tablet PO (by mouth) BID (twice a day DX (diagnoses) CHF (congestive heart failure) Twice a Day 06:00 AM, 02:00 PM." (sic)

Continued review of the closed clinical record produced the November 2016 Medication Administration Records (MAR's). Review of the November 2016 MAR's produced documentation that the physician ordered Bumetanide 1 mg was not available for administration on November 9, 2016 at 6 a.m. The nurse documented "Not Administered: Drug/Item unavailable." (sic)

On December 8, 2016 at 10:35 a.m. the surveyor notified a Licensed Practical Nurse (LPN (#1), who was an MDS Nurse, that Resident #15 did not have physician ordered Bumetadine available on 11/9/16. The surveyor reviewed the closed clinical record with the MDS Nurse (LPN #1). The surveyor pointed out the specific physician order for the Bumetadine. The surveyor then reviewed the November 2016 MAR's with the MDS Nurse (LPN #1). The surveyor pointed out that the facility staff had documented that the Bumetadine was not available for administration on November 9, 2016. The surveyor asked if the facility staff had a back-up pharmacy and the MDS Nurse (LPN #1) named a local pharmacy. The surveyor requested the facility policy and procedure for obtaining medications.

On December 8, 2016 at 11 a.m. the Ward Clerk hand delivered the facility policy and procedure titled, "Administration of Medications." The policy and procedure read in part ...

"12. Medication fills and refills shall be timely to avoid missed dosages. Medications should be reordered according to the pharmacy procedures

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F 425	Continued From page 82 or electric record vendor procedure. 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 delivery or follow electronic record policy for checking status." On December 8, 2016 at 4:30 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #15 did not have her physician ordered Bumetadine available for administration on November 9, 2016. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that physician ordered medication, Bumetadine, was available for Resident #15.	F 425		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 428		1/19/17

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F 428	Continued From page 83 (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to identify and report medication irregularities for 1 of 20 Residents,	F 428	Clarification order written for medication discrepancy on 12/8/2016.	

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F 428	Continued From page 84 Resident #19. The findings included: For Resident #19 the facility staff failed to identify a discrepancy in the physician's order for the medication digoxin. Resident #19 was admitted to the facility on 11/102/16. Diagnoses included but not limited to bradycardia, hypotension, hyponatremia, dementia, atrial fibrillation congestive heart failure anemia and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/09/16 coded the Resident as 5 out of 15 in section C, cognitive patterns. This is an admission MDS. Resident #19's clinical record contained a signed POS (physician's order summary) dated 12/05/16 which read in part "Lanoxin (digoxin) tablet; 125mcg; amt: 125mg; oral Dx (diagnosis) cardiac Once A day; 09:00 AM". Resident #19's clinical record contained a "Medication Regimen Review" form for the months of November and December 2016. The pharmacist had initialed and dated the form for both months and checked the box labeled "NI*." The asterisk (*) was defined at the bottom of the form as "Based on the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the Resident's medication regimen contained no new irregularities (as defined in SOM Appendix PP 483.60(c)). For purpose of the foregoing statement, the term "irregularity" means an event	F 428	An audit will be conducted by the DON/Designee to ensure all residents have physician□ ordered medications available. Licensed nurses will be educated regarding the process of reordering medications and ordering medications on a timely basis to ensure they are available for administration. DON/Designee will audit a sample of medications available against Physician orders weekly x 4 weeks to ensure medications are available. DON/Designee will report to the QA Committee quarterly x 12 months.	

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F 428	Continued From page 85 or circumstance that is substantially inconsistent with customary, accepted clinical approaches to providing pharmaceutical product and services, or that could reasonably be expected to impede or interfere with the achievement of intended or reasonably expected outcomes." The surveyor spoke with pharmacist #10 on 12/08/16 at approximately 1420. The surveyor asked the pharmacist about Resident #19's digoxin order. The pharmacist stated that 125mg on the physician's order was a typo and that the pharmacy had sent 125mcg as the ordered dose. Pharmacist stated that she would correct the typo immediately. The concern of the discrepancy in the physician's order for digoxin was discussed during a meeting with administrative staff on 12/08/16 at approximately 1630. No further information was provided prior to exit.	F 428		
F 431 SS=F	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 431		1/12/17

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biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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F 431	Continued From page 87 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility staff failed to ensure narcotics were stored in a permanently affixed compartment and failed to discard expired medications for 2 of 2 units in the facility. The finding included: For unit 1 and unit 2 of the facility the facility staff failed to permanently affix the emergency narcotics box and failed to discard expired medications in the emergency medications box. The surveyor observed the medication room on unit 2 of the facility on 12/07/16 at approximately 1445 with LPN (licensed practical nurse) #4. The surveyor observed the emergency medication box. It contained the medication Aricept. The medication had an expiration date of 06/2016. The surveyor showed the expired medication to LPN #4. The surveyor observed a metal box sitting on the counter top in the medication room, secured by a keypad lock, a keyed lock and a plastic zip type lock. The surveyor picked the box up by the handle and moved it from the counter top. The surveyor asked LPN (licensed practical nurse) #4 what was in the box and LPN #4 replied that it was the narcotic stat box, and in order to access the medications inside, the nurse must call the pharmacy to request a code for the keypad lock. The surveyor asked if any nurse could just call and request the code, and LPN #7 stated that the pharmacy must have a valid hard script before they would issue the keypad code.	F 431	Stat box was placed in a locked cabinet in locked medication room on 12/8/2016. Stat box will continue to be placed in locked cabinet in locked medication room. Nurses will be educated on the proper storage of stat box. DON/Designee will monitor stat box weekly x 4 weeks. DON/Designee will report issues to the QA Committee quarterly x 12 months.	

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The surveyor observed the medication room on unit 1 of the facility on 12/07/16 at approximately 1500. The surveyor observed the emergency medication box. It contained the medication Solumedrol. The medication had an expiration date of 09/20/16. The surveyor showed the expired medication to LPN #7.

The surveyor observed a metal box sitting on the counter top in the medication room, secured by a keypad lock, a keyed lock and a plastic zip like lock. The surveyor picked the box up by the handle and moved it from the counter top. The surveyor asked LPN #4 what was in the box and LPN #4 replied that it was the narcotic stat box.

The surveyor requested and received a copy of the contents of the narcotics stat boxes from LPN #4 which included zolpidem (Ambien) 5mg- 5 tabs, lorazepam (Ativan) 0.5mg-5 tabs, OxyContin 10mg-4 tabs, Oxy IR 5mg-5 tabs, Oxycodone/Apap (Percocet) 5/325mg-5 tabs, alprazolam (Xanax) 0.25mg-5 tabs, hydrocodone/Apap (Vicodin) 5/325mg-5 tabs and morphine sulfate oral concentrate 20mg/ml-1 vial.

The surveyor was provided with a copy of "Administration of Medications" policy which read in part "Controlled substances (scheduled drugs) shall be double locked (i.e. in a locked medicine drawer and inside a locked medication cart). Access to these medications will be strictly limited to the person administering medications and the director of nursing or designee."

The concern of the narcotics box not being permanently affixed was discussed during a meeting with the administrative staff on 12/08/16 at approximately 1630.

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F 431	Continued From page 89 No further information was provided prior to exit.	F 431		
F 441 SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		1/19/17

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F 441	Continued From page 90 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. The facility staff failed to complete the	F 441	Infection control tracking logs are now being completed monthly. DON/Designee will observe medication administration and resident care. All staff will receive in-service training	

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F 441	Continued From page 91 infection control tracking sheet completely, the facility staff failed to don appropriate PPE (personal protective equipment) and utilize infection control practices for 1 of 20 residents (Resident #1), and failed to maintain infection control practices during a medication pass and pour observation for 2 of 20 residents (Resident #10 and Resident #12). The findings included. 1. The facility staff failed to ensure the infection control logs were complete. During the entrance conference, the administrator was asked who tracked the infections in the facility. The administrator stated the director of nursing tracked the infections in the facility but the surveyor could interview licensed practical nurse #4. The surveyor interviewed licensed practical nurse #4 on 12/8/16 at 10:35 a.m. L.P.N. #4 stated up until three weeks she tracked the infections. L.P.N. #4 stated she would write down any resident who had an infection on the infection control log. She stated she didn ' t track but each month gave the form to the director of nursing. L.P.N. #4 stated a committee met weekly to review infections. L.P.N. #4 stated "We try to figure out what the course is for each resident. I keep the logs but I don ' t know what ' s done with the data." The surveyor reviewed the infection control logs from March 2016 through December 8, 2016. The infection control logs were incomplete. The infection control logs did not contain complete information on the onset date, site, diagnoses, if a culture was done, x-ray done, organism, antibiotic used, isolated, nosocomial, recultured or if resolved.	F 441	regarding Infection Control Practices. DON/Designee will evaluate infections monthly and update infection control logs. DON/Designee will monitor medication administrations and resident care weekly x 4 weeks. DON/designee will report findings to the QA Committee quarterly x 12 months.	

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The surveyor requested the facility infection control policy from the administrator on 12/6/16 at 3:25 p.m.
The surveyor reviewed the facility policy titled "Infection Control Program" on 12/7/16. The policy read "The community shall maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. Procedure:
1. The infection control program shall include all staff, services, physical plant, and grounds.
2. The Director of Nursing shall be responsible for implementing and maintaining the infection control program under the supervision of the Administrator.

3. Surveillance, prevention, and control of infections shall include: a. Procedures to isolate the infecting organism; b. easy access to handwashing equipment for all staff and volunteers; c. Training for and supervisory monitoring of all staff and volunteers in proper handwashing techniques to prevent cross contamination; d. Training for all staff and volunteers in appropriate implementation of standard precautions; e. prohibiting staff and volunteers with communicable diseases or infections from direct contact with residents or their food, if direct contact may transmit disease; f. Monitoring performance of infection control practices by staff and volunteers; g. Handling, storing, processing and transporting medical waste in accordance with applicable regulations; h. Maintaining an effective pest control program; i. Providing staff and volunteer education regarding infection risk-reduction behavior.

4. The methods used for infection control shall

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be described in a written document that shall be available to all staff.

The surveyor interviewed the regional director of quality assurance on 12/8/16 at 10:40 a.m. She acknowledged the incompleteness of the infection control logs provided. The regional RN stated that the facility did track infections and submitted their findings to her monthly. The regional RN stated she reviewed the infection control logs and if she had concerns, then she would call the director of nursing directly. The regional RN provided the surveyor with the quarterly QA for 6/17/16 which identified the problem of urinary tract infections. The regional RN provided the surveyor with the QA for 10/10/16 which identified the urinary tract infections and upper respiratory infections.

The regional RN stated she was unable to locate any data that the DON had sent to her.

The surveyor informed the administrator, the assistant administrator and the regional director of quality assurance of the above concern in the end of the day meeting on 12/8/16 at 4:35 p.m.

2. The facility staff failed to follow infection control practices for Resident #1. Resident #1 was on contact precautions due to Clostridium difficile.

The clinical record of Resident #1 was reviewed 12/6/16 and 12/7/16. Resident #1 was admitted to the facility 10/15/16 and readmitted 12/1/16 with diagnoses that included but not limited to Clostridium difficle colitis, type 2 diabetes mellitus, hypertension, gastroparesis, coronary artery disease, aortic stenosis, left carotid

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stenosis, Vitamin B12 deficiency, obstructive uropathy, acute renal failure superimposed on stage 3 chronic kidney disease, bladder cancer, weight loss of 10%-severe protein-calorie malnutrition, severe sepsis with acute organ dysfunction, nephrostomy, urinary tract infection E. Coli (Escherichia coli), ESBL (Extended spectrum beta-lactamase), hydronephrosis, paroxysmal atrial fibrillation, and scabbed area on lateral malleolus of the left ankle.

Resident #1's admission minimum data set (MDS) was not completed.

Resident #1's admission physician orders dated 12/1/16 through 12/31/16 were signed 12/2/16. The orders included "Contact Isolation for C-Diff."

The interim care plan initiated 12/2/16 read "Resident is on abx (antibiotic) for C Diff. Interventions: Antibiotics as ordered, resident is on contact isolation."

The surveyor observed Resident #1 on 12/6/16 at 2:40 p.m. At the entrance to Resident #1's room, there was a 3 drawer cart that contained gloves and disposable gowns. The surveyor entered the resident ' s room and observed other #1 (licensed physical therapy assistant) providing therapy to resident and working with his lower legs. Other #1 was wearing disposable gloves. Other #1 was not wearing any other PPE (personal protective equipment). Resident #1's wife was sitting in a chair. She had no type of PPE.

On 12/7/16 at 8:25 a.m., the surveyor observed Resident #1. As the surveyor entered the resident's room, other #9 (a speech therapist) was observed donning a disposable gown and

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gloves after entering the room. One certified nursing assistant (C.N.A. #1) was observed setting up Resident #1 ' s food tray. C.N. A. #1 wore disposable gloves only. The maintenance technician was also observed standing in Resident #1 ' s room. He wore no type of PPE.

The surveyor interviewed licensed practical nurse #1 on 12/7/16 at 8:45 a.m. regarding infection control and staff responsibilities. L.P.N. #1 stated for isolation, there should be a sign posted that says "See Nurse." There should be a cart by the door for PPE. L.P.N. #1 stated visitors need to glove and gown as well as staff when entering the resident's room.

The surveyor informed the administrator, the assistant administrator, and the regional director of quality assurance of the above concern on 12/7/16 at 3:35 p.m. and requested the facility policy on infection control/isolation precautions. The policy titled "Isolation Precautions" read "Clostridium Difficile (C-Diff) To prevent the spread of infection, standard precautions are used when caring for a resident with C-Diff. 1. c. For residents who are infected with C-Diff 1. Wear clean, non-sterile gloves when providing care. Gloves shall be changed after contact with material that may contain C-Diff (stool, etc.) 2. A clean, non-sterile gown may be worn for direct care with the resident, environmental surfaces in the room (bed, over bed table, etc.) or if the resident is incontinent, has diarrhea, or has an ileostomy, colostomy, or a wound. Gowns are removed and discarded in a plastic bag before leaving the resident's room." Resident #1 had wounds on the left lateral ankle and sacrum. Resident #1 also had a neprhostomy.

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The policy titled "Infection Control Program" was reviewed 12/7/16. "Policy The facility will utilize a TWO-TIER Transmission Based Precautions as approved by the Centers for Disease Control and Prevention (CDC). First Tier: Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. Second Tier: Transmission-based Precautions include Contact, Droplet, and Airborne precautions. These are designed for the resident with a suspicion of highly transmissible pathogens for which additional precautions may be needed."

Resident #1 was on contact isolation. "Second Tier: Transmission Based Precautions: Contact Precautions are used in addition to Standard precautions for specified residents known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact or indirect contact.
1. Resident placement: refer to specific policies for MRSA, VRE, and C-Diff.
2. Gloves and Handwashing-Wear gloves when entering room, change gloves during the course of providing care, after having contact with infective material that may contain high concentrations of microorganisms, remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or waterless antiseptic agent.
3. Gowns-Wear a gown when entering the room if you anticipate that your clothing will have substantial contact with the resident, with environmental services or items in the room, with residents who are incontinent, have diarrhea, an ileostomy or colostomy, and with wound drainage

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not contained by a dressing.
6. Visitors-Place a sign on the door of the resident ' s room and instruct visitors to report to the Nurses' station prior to entering."

The surveyor informed the administrator, the assistant administrator, and the regional director of quality assurance of the above concern with infection control on 12/8/16 at 4:35 p.m.

No further information was provided prior to the exit conference on 12/8/16.

3. The facility staff failed to perform hand hygiene during a medication pass and pour observation.

The surveyor observed a medication pass and pour with LPN (licensed practical nurse) #6 on 12/07/16 at approximately 1700. LPN #6 set up Resident #12's medications, which included three medications. LPN# 6 retrieved Resident's glucometer from the medication cart, and then prepared to check the Resident's blood sugar. LPN #6 carried Resident #12's medications and glucometer into Resident's room, placed it on the Resident's over bed table, and then assisted Resident with folding his walker and moving it aside. LPN #6 then retrieved a pair of non-sterile gloves, and holding them in her left hand, reached behind her with her left hand, scratched her back and pulled her top down, with gloves in hand. She then administered Resident's medications, donned the gloves and checked Resident's blood sugar. LPN #6 returned the glucometer to the medication cart without cleaning it, and then returned to Resident's room to perform hand hygiene. She did not perform hand hygiene prior to setting up meds, after handling Resident's walker or after scratching her

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back and pulling at her top.

Resident #12 was admitted to the facility on 11/29/16. Diagnoses included but not limited to pancreatic cancer, diabetes mellitus, gastroesophageal reflux disease and neuropathy. The admission MDS (minimum data set) had not been completed at this time. Surveyor spoke with the Resident, who was alert and oriented.

Surveyor observed a medication pass and pour with LPN #7 on 12/08/16 at approximately 1525. LPN #7 performed hand hygiene, then set up Resident #10's medications, which included an inhaler. After administering Resident #10's medications, LPN #7 did not perform hand hygiene.

Resident #10 was admitted to the facility on 02/13/16. Diagnoses included but not limited to dementia, major depression, cardiopulmonary disease, hypertension, atrial fibrillation, and congestive heart failure. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/28/16 coded the Resident as 7 of 15 in section C, cognitive pattern.

The surveyor requested the facility policy on handwashing as was provided with a policy which read in part "2. Handwashing: a. Wash hands after touching the following- (gloved or not) i. blood, ii. Body fluids, iii. Secretions, iv. Excretions, v. contaminated items. b. Wash hands immediately i. After gloves removed, ii. Between Resident to Resident contact, iii. As indicated to avoid transfer of microorganisms to others and/or the environment, iv. Between tasks and procedures on the same Resident to prevent cross-contamination of different body parts."

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F 441	Continued From page 99 The concern of the poor hand hygiene was discussed during a meeting with the administrative staff on 12/08/16 at approximately 1630. No further information was provided prior to exit.	F 441		
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered lab for 1 of 20 Residents, Resident #4. The findings included: For Resident #4 the facility staff failed to obtain a CBC (complete blood count) as ordered. Resident #4 was admitted to the facility on 08/27/16. Diagnoses included but not limited to colon cancer, anemia, atrial fibrillation, hypertension, wound infection, hypertension, hyperkalemia, hypothyroidism, and macular degeneration. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 09/03/16 coded the Resident as 15 of 15 in section C, cognitive patterns. This is an admission MDS.	F 502	MD and RP notified of labs not being obtained per order for Resident #4. DON/Designee will conduct an audit of all current resident physician orders to verify labs have been obtained per physicians order. Licensed nurses will be educated on following physician lab orders. DON/Designee will review lab orders daily x 4 weeks. DON/Designee will review labs results weekly x 4 weeks. DON/Designee will report findings to the QA committee quarterly x 12 months.	1/12/17

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F 502	Continued From page 100 Resident #4's clinical record was reviewed on 12/06/16. It contained a signed physician's order dated 08/29/16 which read in part "CBC/BMP on Wed". The surveyor could not locate the results of the CBC in the Resident's clinical record. The surveyor asked LPN #4 (licensed practical nurse) if she could locate the results of the lab test and she could not. The concern of the missing lab report was discussed with the administrative team during a meeting on 12/07/16 at approximately 1550. No further information was provided prior to exit.	F 502		
F 504 SS=D	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN CFR(s): 483.50(a)(2)(i) (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician's order prior to obtaining a lab for 1 of 20 Residents, Resident #6. The findings included:	F 504	MD and RP notified of failure to obtain order for Resident #4. DON/Designee will conduct an audit of all lab results to verify physician orders have been obtained.	1/12/17

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F 504	Continued From page 101 For Resident #6 the facility staff failed to obtain a physician's order prior to obtaining a CBC (complete blood count) and BMP (basic metabolic panel). Resident #6 was admitted to the facility on 03/12/13 and readmitted on 08/15/16. Diagnoses included but not limited to anemia atrial fibrillation, congestive heart failure, chronic kidney disease dementia and gastroesophageal reflux disease. The most recent comprehensive MDS (minimum data) set with and ARD (assessment reference date) of09/10/16 coded the Resident as 9 of 15 in section C, cognitive patterns. Resident #6's clinical record was reviewed on 12/6/16. It contained a lab report for a CBC and BMP. The surveyor could not locate a physician's order for this test. Surveyor spoke with LPN (licensed practical nurse) #1 regarding the missing order and LPN #1 stated that she would see if she could locate them. The concern of the missing physician's order was discussed during a meeting with the administrative staff during a meeting on 12/07/16 at approximately 1550. No further information was provided prior to exit.	F 504	Licensed nurses will receive education regarding obtaining labs per physicians order. DON/Designee will review lab results weekly x 4 weeks. DON/Designee will report findings to the QA committee quarterly x 12 months.	
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5)	F 514		1/12/17

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F 514	Continued From page 102 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and facility document review it was determined that the facility staff failed to ensure a complete and accurate clinical record for 4 of 20 Residents in the sample survey Resident #7, Resident #4,	F 514	Resident #7 POS reflects current MD orders as of 12/8/2016. Resident #4 chart reflects accurately as of 12/8/2016. The EMAR company was contacted to retrieve Resident #1's electronic data records for	

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F 514	Continued From page 103 Resident #1 and Resident #8. The Findings included: 1. For Resident #7 the facility staff failed to ensure complete and accurate Physician Order Sheets (POS's). Resident #7 was an 84 year old female who was admitted on 7/27/16. Admitting diagnoses included, but were not limited to: fractured radius, cognitive deficit, hypertension, major depression, anxiety, trans-ischemic attacks (TIA's) and a Vitamin D deficiency. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 10/26/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #7 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). On December 7, 2016 at 9:55 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced a "Nursing Communication Form" that was faxed back to the facility from the physician on 11/1/16. The facility staff had documented ... "Res (resident) daughter would like to know if we can change Miralax to qod (every other day). " (sic) The physician had documented "Yes as above." (sic) Continued review of the clinical record produced the most current signed Physician Order Sheets (POS's) dated and signed on 11/7/16. Signed physician orders included, but were not limited to: "Miralax (polyethylene glycol 3350) (OTC) (over the counter) powder; 17 gram/dose; amt (amount): 17 grams/dose; oral Special Instructions: Give 17grams daily in 4-8 oz (ounces) liquid of choice. DX (diagnoses)-bowel regulation. Once a Day; 08:00 AM." (sic) The surveyor noted that the POS's were signed by the	F 514	12/1/2016-12/2/2016. The data was not able to be retrieved. MDS was completed for Resident #1 as of 12/8/2016. MD and RP notified of medication discrepancy for Resident #8 on 1/5/2017. DON/Designee will review current resident physician orders, resident records, MDS schedule, and residents receiving sliding scale insulin to ensure accuracy. Licensed nurses will be educated regarding updating POS with each new order,filing labs in correct resident records, completing MDS□ in a timely manner, and documenting blood sugars and sliding scale usage properly. Medical records staff will also be educated on filing labs in correct resident records. DON/Designee will review Facility Activity Report, resident records, MDS, and EMAR weekly x 4 weeks to ensure accuracy. DON/Designee will report findings to the QA committee quarterly x 12 months.	

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physician on 11/7/16 and had not been updated with the physician faxed order on 11/1/16 to administer the Miralax every other day.
On December 7, 2016 at 11 a.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN #2), that Resident #7 had a physician order on 11/1/16 to administer Miralax 17 grams every other day. The surveyor notified the MDS Nurse (RN #2) that Resident #7 had been receiving Miralax 17 grams every day and that the daughter had requested for the Miralax to be administered every other day. The surveyor notified the MDS Nurse (RN #2) that the facility staff had notified the physician and the physician had approved for the Miralax to be administered every other day on 11/1/16. The surveyor notified the MDS Nurse (RN #2) that the POS's had not been revised to include the order for Miralax every other day and that the physician had come in on 11/7/16. The surveyor reviewed the clinical record with the MDS Nurse (RN #2) and pointed out that the current signed POS's read to give the Miralax 17 grams every day. The surveyor then reviewed the Nursing Communication Fax that documented that the physician approved for the Miralax to be administered every other day. The surveyor notified the MDS Nurse (RN #2) that the facility staff had not transcribed the new order to the POS's that had been signed on 11/7/16.
On December 7, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff had not transcribed an order on 11/1/16 to the new POS's to administer Miralax 17 grams every other day. The surveyor notified the AT that the physician had signed the POS ' s on 11/7/16.
No additional information was provided prior to

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exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record, POS's, for Resident #7.
For additional information regarding Resident #7 refer to F Tag 329.

2. For Resident #4 the facility staff filed laboratory reports from another Resident in Resident #4's clinical record.
Resident #4 was admitted to the facility on 08/27/16. Diagnoses included but not limited to colon cancer, anemia, atrial fibrillation, hypertension, wound infection, hypertension, hyperkalemia, hypothyroidism, and macular degeneration.
The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/03/16 coded the Resident as 15 of 15 in section C, cognitive patterns.
Resident #4's clinical record was reviewed on 12/06/16. It contained a laboratory report which belonged to another Resident of the facility.
The concern of the misfiled lab report was discussed with the administrative staff during a meeting on 12/07/16 at approximately 1550.
No further information was provided prior to exit.

3. The facility staff failed to maintain a complete and accurate clinical record for Resident #1.

The clinical record of Resident #1 was reviewed 12/6/16 and 12/7/16. Resident #1 was admitted to the facility 10/15/16 and readmitted 12/1/16 with diagnoses that included but not limited to Clostridium difficile colitis, type 2 diabetes mellitus, hypertension, gastroparesis, coronary

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artery disease, aortic stenosis, left carotid stenosis, Vitamin B12 deficiency, obstructive uropathy, acute renal failure superimposed on stage 3 chronic kidney disease, bladder cancer, weight loss of 10%-severe protein-calorie malnutrition, severe sepsis with acute organ dysfunction, nephrostomy, urinary tract infection E. Coli (Escherichia coli), ESBL (Extended spectrum beta-lactamase), hydronephrosis, paroxysmal atrial fibrillation, and scabbed area on lateral malleolus of the left ankle.

Resident #1's admission minimum data set (MDS) was not completed.

During the clinical record review of Resident #1's December 2016 medication administration record, the surveyor noted that there was no documentation that medications had been administered and treatments completed from admission on 12/1/16 and on 12/2/16. On 12/2/16, the medications and treatments before 3:00 p.m. were not documented.

The surveyor interviewed minimum data set (MDS) coordinator/licensed practical nurse #1 on 12/7/16 at 8:20 a.m. MDS/LPN #1 reviewed the medication administration records and stated it looks like Resident #1's admission was put into their system wrong. L.P.N. #1 stated she would have the business office manager speak with the surveyor.

The surveyor interviewed the business office manager on 12/7/16 at 8:50 a.m. The business office manager stated Resident #1 was entered into the system as an admission but the resident was a readmission. The business office manager stated she would research the issue with the

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corporation.

The regional director of quality assurance discussed the incomplete documentation on Resident #1's clinical record with the surveyor on 12/7/16 at 9:45 a.m. The regional RN stated that the discontinued orders and the medication administration orders couldn't be pulled up. The regional RN stated "The information is lost."

The surveyor informed the administrator, the assistant administrator, and the regional director of quality assurance of the above concern during the end of the day meeting on 12/7/16 at 3:55 p.m.

No further information was provided prior to the exit conference on 12/8/16.

4. The facility staff failed to maintain a complete and accurate clinical record for Resident #8. The facility staff failed to document the accurate amount of sliding scale insulin Resident #8 received on the November 2016 medication administration records.
The clinical record of Resident #8 was reviewed 12/7/16. Resident #8 was admitted to the facility on 4/12/10 with diagnoses that included, but not limited to diabetes mellitus, cerebral infarction, depression, osteoarthritis, hypertension, hyperlipidemia, pain, gastroesophageal reflux disease, constipation, dysuria, and candida stomatitis.
Resident #8's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/26/16 coded the resident with a cognitive summary score of 14 out of 15 in Section C0500.

The current comprehensive care plan dated

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6/6/16 identified a problem with diabetes mellitus (DM). Approaches: Do accuchecks as ordered by the physician. Give medications as ordered.

The physician orders included the following: Accuchecks two times per day 11:30 a.m. and hs (bedtime) and orders for sliding scale insulin twice a day with Humulin R. Sliding scale as follows:
If blood sugar is 201 to 250, give 2 units.
If blood sugar is 251 to 300, give 4 units.
If blood sugar is 301 to 350, give 6 units.
If blood sugar is 351 to 400, give 8 units.
If blood sugar is greater than 400, give 10 units.
If blood sugar is greater than 400, call MD (medical doctor).

The surveyor reviewed the November 2016 and December 2016 medication administration records (MARs). On 11/16/16 at 9:00 p.m., Resident #8 ' s blood sugar was documented as 221 with 1 unit of Humulin R administered. On 11/20/16 at 11:30 a.m., the blood sugar was documented as 238 with 189 units administered. Resident #8 should have received 2 units of insulin on 11/16/16 at 9:00 p.m. Resident #8 should have received 2 units on 11/20/16 at 11:30 a.m.

The surveyor discussed the inaccurate documentation with licensed practical nurse #1 on 12/7/16 at 4:30 p.m. On 12/8/16, L.P.N. #1 informed the surveyor that the amount of insulin administered was incorrect and L.P.N. #1 provided the 24 hour report with the accurate amount of insulin administered.

The surveyor informed the administrator, the assistant administrator, and the regional director

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F 514	Continued From page 109 of quality assurance of the above documentation concern on 12/8/16 at 4:35 p.m. The surveyor reviewed the facility policy on medication administration. The policy titled "Administration of Medications" read in part "5. Before administering the drug or dietary supplement, check to see that the following are correct: b. the right dose and strength." No further information was provided prior to the exit conference on 12/8/16.	F 514		