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	495143	A. BUILDING _____ B. WING _____	04/21/2016

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GOLDEN LIVINGCENTER- MARTINSVLLE	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/19/16 through 4/21/16. 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 142 certified bed facility was 120 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Resident #1 through Resident #21) and 3 closed record reviews (Resident #22, Resident #24 and Resident #24).	F 000	Disclaimer: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws.	
F 151 SS=E	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL 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. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, it was determined the facility staff failed to facilitate voting rights for facility residents. Findings: On 4/20/16 at 3:30 PM a member of the survey team met with seven alert and oriented members of the facility resident council. During this meeting the residents discussed their voting rights.	F 151	1. Resident #13 is registered to vote and have consented to vote in the November 2016 election. 2. All residents registered to vote have the potential to be affected. 100% audit of all residents registered to vote will be completed by Activities Director/ Designee. Consent forms to vote to be completed with each resident that is alert and oriented and registered to vote. 3. Department Heads inserviced by Executive Director regarding resident's right to vote. Will attend Resident Council as requested monthly to ensure residents	6/2/2016

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Mayfield, LNHA, MS | TITLE: Executive Director | (X6) DATE: 5/20/16

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

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F 151	Continued From page 1 The residents said they usually went to the polls for elections, but for the recent primary held March 1st, 2016, "Super Tuesday," no accommodations were made for them to go vote. Four of the seven residents present indicated they had wanted to cast a ballot in the Super Tuesday primary--and would have gone if the facility staff had made plans to take them or provide an absentee ballot. They were identified as Resident #13, and Residents S-I, S-VI, and S-VII. On 4/21/16 at 10:30 AM the facility administrator, DON and activities director were informed of the finding. The activity director said she usually made plans for the residents to vote in general elections--but she had not facilitated voting privileges for the primary election. She said she now had a plan to do so.	F 151	have completed consent forms to vote. 4. Results of audit will be brought to monthly QAPI for review and recommendations implemented as indicated.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	1. Shower curtains placed in all shower rooms in the facility. 2. All staff inserviced on maintaining privacy for residents while showers are being given. Staff are to place a sign on the outside of the shower doors stating that the showers are in use. Staff are to ensure shower curtains are being used and pulled while giving showers. 3. Maintenance/designee to audit shower rooms weekly to ensure shower curtains are in place.	6/3/2016

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F 164	Continued From page 2 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview it was determined the facility staff failed to provide privacy for facility residents while showering on 3 of 3 units. Finding: On 4/20/16 at 3:30 PM a member of the survey team met with seven alert and oriented members of the facility resident council. During this meeting the residents discussed their privacy issues in the facility shower rooms. Resident #13 said there was no curtain in the shower room and "people keep walking in and out." The resident said she was exposed naked to the hallway and she could see people outside the door "and they can see in and see us." Resident #15 told the surveyor she had been in the shower and had people walk in on her. "One was a man, he just walked right in and stood there talking to the girl giving me a shower."	F 164	Audits to occur weekly x 4 weeks, then monthly x 3 months. DNS/designee to interview 3 residents weekly x 4 weeks, then monthly x 3 months to ensure privacy is maintained during showers. 4. Results of audit will be brought to Quality Assurance Performance Improvement (QAPI) for review and recommendations implemented as indicated.	

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F 164	Continued From page 3 Resident S-V complained the very first time she had a shower at the facility, the staff had opened the door two times to the hallway. The surveyor checked the three shower units and did not observe any curtains at all to provide privacy to residents while using the facility. All the stalls could be viewed from the hallway when the doors were opened. On 4/21/16 at 10:30 AM the facility administrator, and DON were informed of the finding. The administrator said they had put shower curtains in all the shower rooms.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and clinical record review, facility staff failed to assess a resident for safe medication self-administration for 1 of 24 residents in the survey sample (Resident #16). Resident#16 was admitted to the facility on 3/14/13 with diagnoses including respiratory failure, lichen sclerosis atrophius, peripheral neuropathy, and paranoid schizophrenia. The resident was assessed without signs of delirium, psychosis, or behavior issues and scored 15/15	F 176	1. Resident #16 had self administration 6/2/2016 medication assessment completed and filed in resident's medical record. Resident #16's care plan updated. 2. 100% audit of all rooms conducted on 4/20/2016 to ensure no other residents have medications present in their room without an MD order and a self-administration assessment completed. 100% audit of all residents with the ability to self administer medications completed and care plans updated accordingly.	

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F 176	Continued From page 4 on the Brief Interview for Mental Status on the Quarterly Minimum Data Set assessment dated 2/5/16. During medication pass observation on 4/20/16 at 9:15 AM, the surveyor observed the medication nurse enter Resident #16's room to administer morning medication. One of the medications ordered was DuoNeb solution 0.5-2.5 mg/3 ML 1 application inhale orally every 4 hours related to respiratory failure, give every 4 hours while awake. When the surveyor entered the room with the medication nurse, the resident was using the nebulizer to self-administer a nebulizer treatment. She stated that she didn't feel she could wait for the regularly scheduled treatment, so she used one of the treatments she kept in her room. The surveyor asked if she told nursing staff when she used one of those treatments. She said she did not. The medication nurse said she was unaware that the resident had nebulizer treatments available for self-administration. The resident's comprehensive care plan included Self medication administration- combivent inhaler (date initiated 4/1/15). The resident had not been care planned for self administration of nebulizer treatments. The surveyor reported the concern to the director of nursing on 4/20/16 during a summary meeting. The DON reported on 4/21/16 that the resident had been assessed for self-administration of nebulizer treatments and determined that, after some education, that it was safe for the resident to self-administer the medication, but that the resident had returned her supply of DuoNebs and declined to do so at that time.	F 176	3. New admissions will be assessed for the ability to self administer medications. DNS/designee will audit 10 rooms a week x 4 weeks, then monthly x 3 months to ensure medications are not left at beside without orders and self-administration assessment. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	

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F 176	Continued From page 5 The DON and administrator were notified that this was an ongoing concern at a summary meeting on 4/21/16.	F 176		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and resident council minutes, it was determined the facility staff failed to listen to the views and act upon the grievances and recommendations of residents in the council and respond to those grievances in a resident council meeting. Findings: On 4/20/16 at 3:30 PM a member of the survey team met with seven alert and oriented members of the facility resident council. During this meeting the residents discussed their various complaints and suggestions they had made as a resident council to the administrative staff. One recurring complaint (reviewed in the council minutes September 2015 and January, and March 2016) was the residents were not getting their nighttime snack. Further review of the council minutes indicated no one from the	F 244	1. All Resident Council Meeting Minutes pulled from the last six months to ensure resident's concerns were addressed and resolved. All residents are now being offered HS snacks. 2. 100% Audit of the Resident Council Meeting minutes completed to ensure resident's concerns were addressed and resolved. Resident Council Department Form initiated to ensure that Department Heads respond to concerns in a timely manner. Department Heads inserviced on resident council concerns and addressing the concerns in a timely manner. All staff inserviced on ensuring all residents are offered HS snacks. 3. Executive Director or designee to audit resident council concerns/minutes monthly x 6 months, then quarterly x 6 months assuring that all concerns are being addressed timely. ED to sign off on all Resident Council Minutes. DNS or designee to audit 5 residents from each unit each week x 4 weeks, then monthly x 3 months.	6/2/2016

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F 244	Continued From page 6 administrative staff had ever responded to the residents within the council venue. Residents #13, 15, S-I, S-5, S-6 and S-7 all complained that only the diabetic residents were offered snacks and half the time--they didn't get them either. S-3 told the surveyor, "I might get one, but might not. If I do, it's because I asked for it." S-I said the last two weeks--it was sketchy if the diabetics got one. "I am a very brittle diabetic and they sometimes just hand me animal crackers! That's not enough to keep me from bottoming out in the middle of the night--I need a solid snack with some good protein in it." All attendees indicated the administrative staff had not addressed or discussed the issue with them at any of their meetings. On 4/20/16 the surveyor remained in the facility to observe the nightly snack run. At 8:00 PM the diabetic snacks were delivered to the resident pantry and left on a tray. At 8:10 PM the facility CNAs picked up the diabetic snacks and delivered them to their respective destinations named on the wrapper. The two CNAs followed never stopped and asked anyone else if they would like something. Several diabetic snacks were delivered to rooms with two residents. The diabetic resident got a snack--but the other resident was not asked if he, or she would like anything. On 4/20/16 at 8:20 PM CNA III was asked if every resident got a nightly snack. She stated, "No, we	F 244	DNS or designee to audit 5 residents from each unit each week x 4 weeks, then monthly x 3 months inquiring about resident's HS snacks being offered. 4. Results of audit will be brought to Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations.	

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F 244	Continued From page 7 just pass out the snacks they (kitchen) put in there for us. Everybody don't get a snack at night." At 8:20 PM the facility DON and administrator were informed the residents that were not diabetic did not get a snack. Every unit was observed to have a full (unopened) loaf of bread and a large (unopened) jar of peanut butter, animal crackers and some ice cream. On 4/21/16 at 10:30 AM the DON and administrator were further informed that they had failed to address the concerns of the resident council and had failed to respond to the council's concerns during a council meeting. The administrator told the survey team she did know they were supposed to respond to council concerns--but thought the dietary department had handled that. She said she did not realize the snacks had to be offered.	F 244		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and staff interview, the facility staff failed to maintain a clean, comfortable, sanitary, and homelike environment on 3 of 3 units and for 3 of 24	F 252	1. North, South and Patio shower rooms all cleaned immediately. No odor noted in shower rooms or facility. Resident #7 privacy curtain cleaned. Resident #6 room deep cleaned and floor in room was stripped and waxed. Resident # 8 room deep cleaned and rug in room cleaned. Shower curtains put up in each shower room. Odor Digester removed from the beauty shop.	6/2/2016

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F 252	Continued From page 8 Residents (Residents #7, #6, and #8). The findings included. 1. On 04/19/16 at approximately 1:30 p.m. the surveyors entered the facility. During the initial tour the surveyors were able to smell a pervasive odor throughout the facility. The odors were more prevalent on the North and South units. On 04/19/16 at approximately 2:50 p.m. the surveyor entered the shower room on the South unit. When entering this shower room the surveyor observed a large amount of dirty linen in the room. The shower room had a very strong odor of feces and urine. The surveyor also observed a cigarette butt in the floor and a brown substance approximately the size of quarter in the shower floor. This brown substance resembled feces. When exiting this shower room the surveyor observed the housekeeping account manager in the hallway and asked them to step into the shower room with the surveyor. The concerns were shared with the housekeeping account manager. The surveyor then checked the shower room on the North unit. The surveyor observed several wet wash cloths in the floor and a pervasive odor throughout. On 04/20/16 at approximately 2:10 p.m. two surveyors entered the shower room on the North unit. During this observation the surveyors observed a bathing stretcher that had been pushed into a shower stall. On top of this stretcher the surveyors observed a sheet, towel, and an empty medication cup. Someone had placed a pair of socks on top of the towel	F 252	2. Housekeeping to clean shower rooms daily. Nursing staff inserviced on ensuring shower rooms are kept clean and picked up after every shower. Housekeeping staff inserviced on leaving chemicals in the shower room/beauty shop or anywhere else in the facility unattended and taking out the trash when the trash can is overflowing. 3. Audits to be performed on all shower rooms each week x 1 month, then monthly x 3 months to ensure shower rooms are being cleaned, resident rooms are being cleaned, non-skid mats in rooms are being cleaned, no chemicals are left unattended, and shower curtains are in place. 4. Results of audit will be brought to monthly QAPI for review and recommendations implemented as indicated.	

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dispenser, there was a glove in the floor, as well as several empty medication cups, debris was scattered throughout and the trashcan was observed to be overflowing.

On 04/20/16 at approximately 2:25 p.m. the housekeeping account manager was shown the North unit shower room. When asked about housekeeping services he stated there was a manager here until 5:00 p.m. and the housekeepers worked until 3:00 p.m.

On 04/20/16 at approximately 3:05 p.m. CNA (certified nursing assistant) #1 was asked about the odor in the South unit shower room and verbalized to the surveyor that yes it did smell in the shower room and it always seemed to have an odor of some type.

A group interview was held on 04/20/16 at approximately 3:30 p.m. Seven alert and orientated Residents of the facility attended this meting. Five of seven Residents in group stated the facility was odorous.

None of the shower rooms in the facility included shower curtains.

The administrative staff were notified of the above findings in a meeting with the survey team on 04/20/16 at approximately 5:05 p.m.

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

2. For Resident #7 the facility staff failed to ensure a clean, comfortable and homelike environment. Resident #7 ' s privacy was dirty

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and soiled in two (2) areas with a brownish debris.

Resident #7 was a 67 year old female who was originally admitted on 9/22/15 and readmitted on 12/11/15. Admitting diagnoses included, but were not limited to: dementia without behaviors, hypokalemia, Bipolar, affective mood disorder, anxiety, hypertension and pain.

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 2/22/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #7 required set up (0/1) to limited assistance (2/2) with Activities of Daily Living (ADL).

On April 19, 2016 at 3:10 p.m. the surveyor observed Resident #7's room. The surveyor observed that Resident #7's privacy curtain was dirty and soiled in two (2) areas with a brownish debris. One area was approximately 4 cm round. The other area was approximately 10 cm's long and 4 cm's wide.

On April 20, 2016 at 8 a.m. the surveyor observed Resident #7 lying in bed and sleeping. The surveyor observed that Resident #7's privacy curtain remained dirty and soiled with a brownish debris in two (2) areas.

On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that Resident #7's privacy curtain was dirty and soiled with a brownish debris.

No additional information was provided prior to exiting the facility as to why the facility staff

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failed to ensure a clean, comfortable and homelike environment for Resident #7.
3. For Resident #6, facility staff failed to provide a clean, comfortable, homelike environment.

Resident #6 was admitted to the facility on 7/9/15 with diagnoses including coronary artery disease, heart failure, hypertension, diabetes mellitus, stroke, seizure disorder, asthma, and chronic pain. The resident scored 15/15 on the brief interview for mental status on the quarterly minimum data set assessment (MDS) dated 3/9/16 and was assessed without symptoms of delirium, psychosis, or behavior issues.

While interviewing the resident on 4/29/16, the surveyor observed what appeared to be dried rose petals on the floor under the resident's bed. The resident stated that the dried roses at the bedside had been her Valentine's day flowers. The dried rose petals were still under the bed at 10:45 AM on 4/21/16, and there was a sticky substance on teh floor between the beds.

The director of nursing and administrator were notified of the concern during a summary meeting on 4/20/16.

4. For Resident #8, facility maintenance staff failed to provide a comfortable, homelike interior.

Resident #8 was admitted to the facility on 10/24/05 with diagnoses including diabetes mellitus, heart failure, hypertension, peripheral vascular disease, dementia, anxiety, depression, and bipolar disorder.
The resident scored 12/15 on the brief interview for mental status and was assessed without

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F 252	Continued From page 12 symptoms of delirium, psychosis, or behavior disorder on the minimum data set assessment dated 1/29/16. On 4/19/16 at approximately 3 PM, the surveyor observed the resident in the room. The resident's bedside rug was stained and covered with loose brown material. On 4:21 PM at approximately 11 AM, the resident's rug was observed to be stained and covered with loose debris. There was a sticky spot on the floor near the sink and a floor mop pad was lying on the floor near the sticky substance. The resident stated that the rug "could use a good vacuum". The administrator and director of nursing were notified of the concern during a summary meeting on 4/21/16.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and facility document review, the facility staff failed to provide maintenance services on 3 of 3 units and for 3 of 24 Residents, Residents #6, #8, and #11. The findings included.	F 253	1. Missing/broken tiles on the North, South, and Patio shower rooms were repaired. Capital Request completed and approved for vinyl rub rails for 3 shower rooms and 1 downstairs closet. Resident #6, #8, and #11's sinks all repaired. 2. Executive Director inserviced Department Head staff on putting all broken, rusty, dripping sinks in to Building Engines for repairs to be completed. 100% Audit completed on all sinks in the building.	6/2/2016

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F 253	Continued From page 13 1. The shower rooms on the North, South, and Patio units were observed to have cracked and/or missing tiles. On 04/19/16 at approximately 1:30 p.m. the surveyor entered the shower room/beauty shop on the South unit. When entering this shower room the surveyor observed 1 cracked tile. On 04/19/16 at approximately 1:45 p.m. the surveyor entered the shower room on the patio unit. Upon entering this shower room the surveyor observed that the wall next to the commode had 4 damaged tiles that were pushed inward. On 04/19/16 at approximately 2:50 p.m. the surveyor entered the shower room on the South unit the surveyor was able to observe a large amount of tile missing in front of the tub and missing tile on the wall underneath a hanging cabinet. After exiting the South unit shower room the surveyor walked to the North unit shower room and upon entering the North unit shower room the surveyor observed missing tile in the first shower stall and broken tile in the second shower stall. The administrative staff were notified of the missing/broken tiles during a meeting with the survey team on 04/20/16 at approximately 5:05 p.m. Prior to the exit conference the facility staff provided the surveyor with a copy of a letter dated 04/19/16 for a bid for vinyl rub rails for 3 shower rooms and 1 downstairs closet.	F 253	All sinks that were identified were repaired by Maintenance Staff. 3. Maintenance Director/ Designee to audit all sinks and shower rooms in the facility once a week x 4 weeks, then monthly x 3 months to ensure there are no cracked tiles or rusted, leaking sinks. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	

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The maintenance director was shown all of the missing and broken tiles during a walkthrough of the facility with the surveyor on 04/21/16 at approximately 9:05 a.m. The maintenance director stated they were going to replace the missing tiles with a rubber base board.

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

2. For Resident #6, facility maintenance staff failed to provide a comfortable, homelike interior.

Resident #6 was admitted to the facility on 7/9/15 with diagnoses including coronary artery disease, heart failure, hypertension, diabetes mellitus, stroke, seizure disorder, asthma, and chronic pain. The resident scored 15/15 on the brief interview for mental status on the quarterly minimum data set assessment (MDS) dated 3/9/16 and was assessed without symptoms of delirium, psychosis, or behavior issues.

While interviewing the resident on 4/29/16, the surveyor observed that the sink in the resident's room dripped water. There was a steady stream of water at 10:45 AM on 4/21/16, and the surveyor was unable to turn off the water or reduce the flow to a drip.

The director of nursing and administrator were notified of the concern during a summary meeting on 4/20/16.

3. For Resident #8, facility maintenance staff failed to provide a comfortable, homelike interior .

Resident #8 was admitted to the facility on

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10/24/05 with diagnoses including diabetes mellitus, heart failure, hypertension facility maintenance staff failed to provide a comfortable, homelike interior, peripheral vascular disease, dementia, anxiety, depression, and bipolar disorder.
The resident scored 12/15 on the brief interview for mental status and was assessed without symptoms of delirium, psychosis, or behavior disorder on the minimum data set assessment dated 1/29/16.

On 4:21 PM at approximately 11 AM, the resident's faucet was observed to be dripping water. The surveyor was unable to turn off the water.

The administrator and director of nursing were notified of the concern during a summary meeting on 4/21/16.

4. For Resident #11, facility maintenance staff failed to provide a comfortable, homelike interior.

Resident #11 was admitted to the facility on 12/30/15 with diagnoses including peripheral vascular disease, gastroesophageal reflux disease, anxiety, hip fracture, and sarcoidosis of the lung. The resident scored 15/15 on the brief interview for mental status on the quarterly minimum data set assessment (MDS) dated 3/9/16 and was assessed without symptoms of delirium, psychosis, or behavior issues.

On 4:21 PM at approximately 11 AM, the resident's faucet was observed to be rusty and dripping water. The surveyor was unable to turn off the water.

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F 253	Continued From page 16 The director of nursing and administrator were notified of the concern during a summary meeting on 4/20/16.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	1. CAA's for all residents indicated were reviewed and any identified concerns were addressed. 2. All residents had the potential to be affected by deficient practice. 3. Re-education was provided by the Clinical Assessment and Reimbursement Specialist on 4/29/2016 regarding completion of CAA's and the CAA worksheet. An audit of 10% of comprehensive assessments will be completed by the DNS/designee monthly x 3 months to ensure compliance. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	6/2/2016

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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 complete and accurate Care Area Assessment Summary (CAA ' S) for 12 of 24 Residents in the sample survey, Resident #7, #12, #3, #4, #6, #11, #1, #2, #14, #5, #9 and #10.
The Findings Included:
1. For Resident #7 the facility staff failed to ensure complete and accurate Care Area Assessment Summary (CAA'S) on an Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/28/15. Resident #7 was a 67 year old female who was originally admitted on 9/22/15 and readmitted on 12/11/15. Admitting diagnoses included, but were not limited to: dementia without behaviors, hypokalemia, Bipolar, affective mood disorder, anxiety, hypertension and pain.
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 2/22/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #7 required set up (0/1) to limited assistance (2/2) with Activities of Daily Living (ADL).
On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced an Admission MDS assessment with an ARD of 9/28/16. The facility

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staff coded that Resident #7 had a Cognitive Summary Score of 10. The facility staff also coded that Resident #7 required set up assistance (1/1) to limited assistance (2/2) with ADL's. In Section V. Care Area Assessment Summary (CAA'S) Resident #7 triggered for Cognitive Loss, ADL Functional/Rehabilitation Potential, Falls, Nutritional Status and Psychotropic Drug use. In the column titled, "Location and Date of CAA documentation," the facility staff documented "CAA WS (worksheet) dated 10/2/15." (sic) The instructions documented in Section V that the facility staff were to document where pertinent information related to the CAA could be found regarding the care plan decision making. The instructions also documented that the CAA documentation should include information on the complicating factors, risks, and any referrals for the resident for the care area.

On April 20, 2016 at 8:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #7's CAA's on the Admission MDS assessment with the ARD of 9/28/15 were incomplete and inaccurate. The surveyor reviewed the Admission MDS assessment with the UM. The surveyor notified the UM that the specific location of supporting documentation regarding the care plan decision making had to be documented in the column titled, Location and Date of CAA documentation. The surveyor notified the UM that the CAA'S were incomplete and inaccurate.

On April 20, 2016 at 11:20 a.m. the surveyor notified the MDS Nurse, who was a RN, that Resident #7's CAA's associated with the Admission MDS with the ARD of 9/28/15 were incomplete and inaccurate. The surveyor notified the MDS Nurse that the facility staff had

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documented that the CAA worksheet was completed on 10/2/15. The surveyor notified the MDS Nurse that the specific location of supporting documentation in the care plan decision making process had to be documented. The MDS Nurse stated that another surveyor had already told her that the specific location of supporting documentation had to be documented and that she could not document that the CAA worksheet was completed.

On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that Resident #7's CAA's on the Admission MDS assessment dated 9/28/15 were incomplete and inaccurate.

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 #7.

2. For Resident #12 the facility staff failed to ensure complete and accurate Care Area Assessment Summary (CAA'S) on an Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/2/15. Resident #12 was a 66 year old female who was originally admitted on 10/15/14 and readmitted on 11/24/15. Admitting diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, paralysis agitans, hypertension, pneumonia, dyspnea, hypothyroidism, mood disorder, anxiety and depression.

The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date

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(ARD) of 3/22/15. The facility staff coded that Resident #12 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #12 required limited (2/2) to total nursing care with Activities of Daily Living (ADL's).
On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #12's clinical record. Review of the clinical record produced an Annual MDS assessment with an ARD of 10/2/15. The facility staff coded that Resident #12 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #12 was independent after set up (0/1) to requiring total nursing care (4/2) with ADL's. In Section V. Care Area Assessment Summary (CAA'S) Resident #12 triggered for ADL Functional/Rehabilitation Potential, Urinary Incontinence, Mood State, Falls, Nutritional Status and Psychotropic Drug Use. In the column titled, "Location and Date of CAA documentation," the facility staff documented "CAA WS (worksheet) dated 10/7/15." (sic) The instructions documented in Section V that the facility staff were to document where pertinent information related to the CAA could be found regarding the care plan decision making. The instructions also documented that the CAA documentation should include information on the complicating factors, risks, and any referrals for the resident for the care area.
On April 20, 2016 at 10:25 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #12's CAA's on the Annual MDS assessment with the ARD of 10/2/15 were incomplete and inaccurate. The surveyor reviewed the Annual MDS assessment with the UM. The surveyor notified the UM that the specific location of supporting documentation regarding the care plan decision making had to be documented in the column titled, Location and

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Date of CAA documentation. The surveyor notified the UM that the CAA'S were incomplete and inaccurate.
On April 20, 2016 at 11:20 a.m. the surveyor notified the MDS Nurse, who was a RN, that Resident #12's CAA's associated with the Annual MDS with the ARD of 10/2/15 were incomplete and inaccurate. The surveyor notified the MDS Nurse that the facility staff had documented that the CAA worksheet was completed on 10/7/15. The surveyor notified the MDS Nurse that the specific location of supporting documentation in the care plan decision making process had to be documented. The MDS Nurse stated that another surveyor had already told her that the specific location of supporting documentation had to be documented and that she could not document that the CAA worksheet was completed.
On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that Resident #12's CAA's on the Annual MDS assessment dated 10/2/15 were incomplete and inaccurate.
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 #12.
3. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident #3. The resident's clinical record was reviewed on 4/20/16 at 9:30 AM.

Resident # 3 was admitted to the facility on 12/16/14. The diagnoses included Schizophrenia, anxiety, depression, and seizure disorder.

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The resident's significant change MDS (minimum data set) assessment dated 6/25/15 coded the resident with severely impaired cognitive function. Resident #3 required staff assistance for all ADL (activities of daily living.)

The MDS contained CAAs signed and dated 6/30/15. The location and date section (Section V) of the CAA documentation was observed to be incomplete for location and dates of the summarized material.

This information was shared with the DON and administrator on 4/21/16 at 10:30 AM. No additional info was provided.

4. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident #4. The resident's clinical record was reviewed on 4/20/16 at 9:30 AM.

Resident # 4 was admitted to the facility on 12/16/14. The diagnoses included Schizophrenia, dementia, hypertension, anxiety and depression.

The resident's annual MDS (minimum data set) assessment dated 12/10/15 coded the resident with unimpaired cognitive function. Resident #4 required staff assistance for all ADL (activities of daily living.)

The MDS contained CAAs signed and dated 12/10/15. The location and date section (Section V) of the CAA documentation was observed to be incomplete for location and dates of the summarized material.

This information was shared with the DON and

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administrator on 4/21/16 at 10:30 AM. No additional info was provided.

5. For Resident #6, facility staff failed to document the source of information in the care area assessment (CAA) summary.

Resident #6 was admitted to the facility on 7/9/15 with diagnoses including coronary artery disease, heart failure, hypertension, diabetes mellitus, stroke, seizure disorder, asthma, and chronic pain. The resident scored 15/15 on the brief interview for mental status on the quarterly minimum data set assessment (MDS) dated 3/9/16 and was assessed without symptoms of delirium, psychosis, or behavior issues.

During clinical record review on 4/20/16, the surveyor noted that the CAA summary on the admission assessment dated 7/16/15 did not document the source of the information used in the CAA. The CAA summary documents under "Location and Date of CAA documentation" CAA WS (worksheet) dated 7/21/15. The CAA worksheets contain a summary of information pertaining to the triggered areas, but do not document the sources of that information.

In an interview on 4/19/16, the MDS nurse stated she had not been taught to list the sources of individual items of information.

The director of nursing and administrator were notified of the concern during a summary meeting on 4/20/16.

6. For Resident #11, facility staff failed to document the source of information in the care area assessment (CAA) summary.

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Resident #11 was admitted to the facility on 12/30/15 with diagnoses including peripheral vascular disease, gastroesophageal reflux disease, anxiety, hip fracture, and sarcoidosis of the lung. The resident scored 15/15 on the brief interview for mental status on the quarterly minimum data set assessment (MDS) dated 3/9/16 and was assessed without symptoms of delirium, psychosis, or behavior issues.

During clinical record review on 4/20/16, the surveyor noted that the CAA summary on the admission assessment dated 1/6/15 did not document the source of the information used in the CAA. The CAA summary documents under "Location and Date of CAA documentation" CAA WS (worksheet) dated 1/13/16. The CAA worksheets contain a summary of information pertaining to the triggered areas, but do not document the sources of that information.

In an interview on 4/19/16, the MDS nurse stated she had not been taught to list the sources of individual items of information.

The director of nursing and administrator were notified of the concern during a summary meeting on 4/20/16.

7. For Resident #1, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/22/15.

Resident #1 was admitted to the facility 10/19/13. Diagnoses included, but were not limited to, history of urinary tract infections, hyperkalemia,

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chronic pain, osteoarthritis, cerebrovascular disease, and anxiety disorder.

Section C (cognitive patterns) of the Resident significant change in status MDS assessment with an ARD of 06/22/15 scored the Resident 12 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented CAA WS (worksheet) and had documented the dates of 06/25/15 and 06/29/15. The actual location(s) regarding the documentation had not been documented.

On 04/20/16 at approximately 10:15 a.m. RN (registered nurse) #2 (MDS coordinator) was asked about the missing documentation. After reviewing section V RN #2 verbalized to surveyor that the required information was missing.

This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m.

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

8. For Resident #2, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/14/16.

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Resident #2 was admitted to the facility 03/08/16. Diagnoses included, but were not limited to, hypertension, dementia, hypokalemia, insomnia, and depressive disorder.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD of 03/14/16 scored the Resident 15 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented CAA WS (worksheet) and had documented the dates of 03/14/16 and 03/22/16. The actual location(s) regarding the documentation had not been documented.

On 04/20/16 at approximately 10:15 a.m. RN (registered nurse) #2 (MDS coordinator) was asked about the missing documentation. After reviewing section V RN #2 verbalized to surveyor that the required information was missing.

This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m.

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

9. For Resident #14, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with

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an ARD (assessment reference date) of 09/15/15.

Resident #14 was admitted to the facility 11/30/12. Diagnoses included, but were not limited to, Alzheimer's disease, generalized pain, anemia, hypothyroidism, and glaucoma.

Section C (cognitive patterns) of the Residents significant change in status MDS assessment with an ARD of 09/15/15 scored the Resident 0 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented CAA WS (worksheet) and had documented the dates of 09/17/15 and 09/18/15. The actual location(s) regarding the documentation had not been documented.

On 04/20/16 at approximately 10:15 a.m. RN (registered nurse) #2 (MDS coordinator) was asked about the missing documentation. After reviewing section V RN #2 verbalized to surveyor that the required information was missing.

This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m.

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

10. For Resident #5 the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) assessment.

Resident #5 was admitted to the facility on

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09/07/12. Diagnoses included but not limited to atrial fibrillation, hypertension, gastroesophageal reflux disease, hyperlipidemia, arthritis, fracture, dementia, anxiety, depression, cataracts, delirium and anorexia.
The most recent comprehensive MDS (minimum data set) with and ARD (assessment reference date) of 03/04/16 coded the Resident as 6 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 plan. The only documentation was " CAA WS (worksheet) dated 03/10/16 " .
The MDS coordinator was interviewed on 04/20/16 at approximately 1020. She stated " That ' s just how I do them " .
The administrative staff was informed of the findings during a meeting on 04/20/16 at approximately 1710.
No further information was provided prior to exit.
11. For Resident #9 the facility staff failed to ensure an accurate comprehensive MDS assessment.
Resident #9 was admitted to the facility on 07/28/10 and readmitted on 12/12/15. Diagnoses included but not limited to congestive heart failure, hypertension, dementia, anxiety, depression, psychotic disorder, schizophrenia, atrial fibrillation, gastroesophageal reflux disease, arthritis and cataracts.
The most recent comprehensive MDS with an ARD of 04/09/15 coded the Resident as 15 out 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 plan. The only documentation was " CAA WS dated 04/15/15 " .

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F 272	Continued From page 29 The MDS coordinator was interviewed on 04/20/16 at approximately 1020. She stated " That ' s just how I do them " . The administrative staff was informed of the findings during a meeting on 04/20/16 at approximately 1710. No further information was provided prior to exit. 12. For Resident #10 the facility staff failed to ensure an accurate comprehensive MDS assessment. Resident #10 was admitted to the facility on 11/03/14. Diagnoses included but not limited to anemia, hypertension, hypotension, hyperkalemia, malnutrition, anxiety, depression, bipolar disorder, chronic obstructive pulmonary disease, respiratory failure, dysphagia, gastroesophageal reflux disorder and end stage renal disease. The most recent comprehensive MDS with an ARD of 10/19/15 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 determine the care plan. The only documentation was " CAA WS dated 10/22/15 " . The MDS coordinator was interviewed on 04/20/16 at approximately 1020. She stated " That ' s just how I do them The administrative staff was informed of the findings during a meeting on 04/20/16 at approximately 1710. No further information was provided prior to exit.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		

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F 280	Continued From page 30 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to develop a CCP (comprehensive care plan) for pressure for 1 of 24 Residents, Resident #2. The findings included. The facility staff failed to develop a CCP for pressure. Resident #2 was admitted to the facility 03/08/16. Diagnoses included, but were not limited to, hypertension, dementia, hypokalemia, insomnia, and depressive disorder. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with	F 280	1. The care plan for resident #2 reviewed and updated to reflect a care plan problem for all triggers identified with the need to proceed to care plan. 2. A 100% audit will be completed of all current residents most recent comprehensive assessment to ensure that a care plan has been generated for all triggering CAA's that have been identified with the need to proceed to care plan. 3. Re-education was provided by the Clinical Assessment and Reimbursement Specialist on 4/29/2016 regarding completion of CAA's and the CAA worksheet, including the care plan decision. An audit of 10% of Comprehensive Assessment Triggers and care plans will be completed by the DNS/designee monthly and submitted to QAPI for review x 3 months. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	6/2/2016

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F 280	Continued From page 31 an ARD (assessment reference date) of 03/14/16 scored the Resident 15 out of a possible 15 points. Section H (bladder/bowel) was coded to indicate the Resident was occasionally incontinent of urine. Section M (skin conditions) was coded to indicate the Resident did not have any pressure ulcers but had a pressure reducing device for the bed. Section V (care area assessment (CAA) summary) had triggered for the area of pressure ulcer and the facility staff had indicated that they would develop a CCP for pressure. A review of the current CCP did not include any reference to pressure. On 04/20/16 at approximately 10:15 a.m. the surveyor and RN (registered nurse) #2 reviewed the Residents MDS and CCP. After reviewing the CCP RN #2 verbalized to the surveyor that she must have missed it. This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m. No additional information regarding this issue was provided to the survey team prior to the exit conference.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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F 281	Continued From page 32 Based on resident interview, family interview, staff interview, and clinical record review, facility staff failed to 1- follow standard nursing practice for administration of controlled substances for 1 of 24 residents in the survey sample (Resident #17) and 2- failed to follow standard precautions when preparing medication for administration. 1. Resident #17 was admitted to the facility on 10/14/15 with diagnoses including coronary artery disease, hypertension, orthostatic hypotension,renal failure, metabolic encephalopathy, low back pain, and hip pain. On the admission minimum data set (MDS) assessment dated 10/21/15, the resident scored 6/15 on the brief assessment for mental status and was assessed as without signs of delirium, psychosis, or behavior disorder. The resident was assessed as having frequent pain at a level 8 on a 10 point scale. During a family interview on 4/21/16, the resident's son reported that the pharmacy appeared to be billing for pain medication which the resident was not receiving. The resident stated that she frequently asked for pain medication and was told she could not have pain medication because she had medication scheduled every 4 hours. The resident's son showed the surveyor the resident's pharmacy bill for March 2016. The resident had been billed for 120 Norco 5/325. The Resident's son reported that the resident's order had been changed to Norco 7.5/325 early in the month. Clinical record review of the medication administration records for March and April 2016 revealed the resident received hydrocodone-acetaminophen 5-325 (Norco) 4	F 281	1. Resident #17 has had an up to date pain assessment and plan of care was reviewed and revised as indicated. 2. All residents on a pain management program will have an up to date pain assessment and plan of care will be reviewed and revised as indicated. All PRN Narcotic administration in the last 30 days will be reconciled to the Medication Administration record and identified concerns will be addressed as indicated. 3. DNS/Designee will provide the Licensed Nurses with education regarding the Pain Management Guidelines, Medication Administration Guidelines, and required documentation. DNS/Designee will review residents with pain management needs daily in clinical start-up and identified concerns will be addressed as indicated. DNS/Designee will do a weekly random audit of 10 narcotic administrations and the required documentation including review of the pain management program.	6/2/2016

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F 281	Continued From page 33 times per day March 1 through March 17 (17 X 4 = 68 pills), then changed to hydrocodone-acetaminophen 7.5-325 4 times per day March 18 through March 31 (14 X 4 = 56 pills). The March MAR indicated that hydrocodone -acetaminophen 5-325 as needed for pain, ordered 1/16/16 was not administered in March 2016. The April 2016 MAR indicated the resident received scheduled hydrocodone-acetaminophen 7.5-325 4 times per day as ordered until the surveyor's review on 4/21/16. The April MAR indicated the resident received hydrocodone-acetaminophen 7.5-325 on 4/12 at 5:50 AM and 4/16 at 6:20 AM. The surveyor requested the narcotic sign out logs fro the resident for March and April 2016. Facility staff provided only one sheet for hydrocodone-apap 7.5-325 and one for hydrocodone-apap 5-325. For hydrocodone-acetaminophen 7.5-325, the sheet covered 4/15/16 through 4/20/16. For those dates, the narcotic sheet indicated medication was signed out for the resident: 4/15 8:30 AM, 1 PM, 9 PM 4/16 8 AM, 12:45 PM, 5 PM, 9 PM 4/17 9 AM, 1 PM, 5 PM, 9 PM 4/18 9 AM, 1 PM, 18:30 PM 4/19 8 AM, 1 PM, 5 PM, 8 PM 4/20 8 AM, 12 PM The Controlled Substance Accountability sheet given to the surveyor ended on 4/20 at 12 PM with 10 pills remaining. The surveyor's interview notes indicated that there were 7 pills remaining on the card at 12 PM on 4/21/16 (implying that the final 2 doses on 4/20 and the first on 4/21 had been signed out). The PRN Controlled Substance Accountability Sheet for hydrocodone-acetaminophen 5-325	F 281	4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	

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indicated that the resident had received 14 unscheduled doses of pain medication between 3/18 and 4/20. The MAR documented only 2 doses. No nurse's notes documented administration of unscheduled pain medication except for the 4/12 and 4/17 doses.

In addition to the medication cards, the facility employs a pharmaceutical single dose dispenser. During the period from 4/1/16 through 4/21/16, hydrocodone-acetaminophen 7.5-325 was withdrawn form the system on 4/3 (2 doses), 4/4 (3 doses), 4/5 (3 doses), 4/6 (3 doses), 4/7 (4 doses), 4/9 (6 doses), 4/11 (6 doses), 4/13 (4 doses), 4/14 (4 doses).

On 4/21/16 at 11:30 AM, the surveyor interviewed the resident's nursing unit manager about the resident's complaint that nurses will not give her pain medication when she asks for it. The nurse stated that the medication was ordered every 4 hours. When the doctor ordered the higher dose (hydrocodone-apap 7.5-325), she made the prior dose PRN, but said she hoped the resident wouldn't need to use it. The nurse said the resident's order was that she could have a PRN dose every 4 hours, but "we try not to give her too much".

The surveyor discussed withholding ordered pain medication with the director of nursing on 4/21/16 at approximately 12:15 PM. The narcotic sheets and Alixa machine requisition reports documenting that fewer doses of scheduled pain medication than ordered and documented were signed out for the resident and that more than documented given were signed out of the PRN supply, while the resident complained that she did not receive medication when requested. The

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pharmacy appeared to have no mechanism for reconciling medication administration records with the supply on hand.

The facility policy for medication administration states in: Administration Procedures For All Medications, section" J. After administration, return to cart, replace the medication container (if multi-dose and doses remain), and document administration in the MAR or TAR, and controlled substance sign out record, if indicated." and section "M. When administering an 'as needed' (PRN) medication, document the reason for giving, observe for medication actions/reactions and record [on the PRN effectiveness sheet/nurse's notes] (emphasis present in the facility policy).

The concern that the resident's reports of pain were not being addressed and the resident's pain medication was not properly controlled or documented were reported to the facility administrator, director of nursing, and other members of the administrative staff at a summary meeting on 4/21/16.

2. On 4/20/16 at 5:55 PM, the surveyor observed the medication nurse on the north wing at the medication cart drawing insulin into a syringe. The nurse turned to greet the surveyor and the surveyor observed the needle cap for the syringe held between the nurse's teeth. The director of nursing was not in her office, so the surveyor reported the incident to the administrator.

On 4/21/16 at 8 AM, the director of nursing reported that the registered nurse had been educated not to put needle caps in her mouth and provided an Employee Education record as

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F 281	Continued From page 36 evidence. The administrator and director of nursing were made aware of the concerns as they were discovered.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview, and clinical record review, facility staff failed to help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain for 1 of 24 residents in the survey sample (Resident #17). Resident #17 was admitted to the facility on 10/14/15 with diagnoses including coronary artery disease, hypertension, orthostatic hypotension,renal failure, metabolic encephalopathy, low back pain, and hip pain. On the admission minimum data set (MDS) assessment dated 10/21/15, the resident scored 6/15 on the brief assessment for mental status and was assessed as without signs of delirium, psychosis, or behavior disorder. The resident was assessed as having frequent pain at a level 8 on a 10 point scale.	F 309	1. Resident #17 has had an up to date pain assessment and plan of care was reviewed and revised as indicated. 2. All residents on a pain management program will have an up to date pain assessment and plan of care will be reviewed and revised as indicated. All PRN Narcotic administration in the last 30 days will be reconciled to the Medication Administration record and identified concerns will be addressed as indicated. 3. DNS/Designee will provide the Licensed Nurses with education regarding the Pain Management Guidelines, Medication Administration Guidelines, and required documentation. DNS/Designee will review residents with pain management needs daily in clinical start-up and identified concerns will be addressed as indicated. DNS/Designee will do a weekly random audit of 10 narcotic administrations and the required	6/2/2016

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F 309	Continued From page 37 During a family interview on 4/21/16, the resident's son reported that the pharmacy appeared to be billing for pain medication which the resident was not receiving. The resident stated that she frequently asked for pain medication and was told she could not have pain medication because she had medication scheduled every 4 hours. The resident's son showed the surveyor the resident's pharmacy bill for March 2016. The resident had been billed for 120 Norco 5/325. The Resident's son reported that the resident's order had been changed to Norco 7.5/325 early in the month. Clinical record review of the medication administration records for March and April 2016 revealed the resident received hydrocodone-acetaminophen 5-325 (Norco) 4 times per day March 1 through March 17 (17 X 4 = 68 pills), then changed to hydrocodone-acetaminophen 7.5-325 4 times per day March 18 through March 31 (14 X 4 = 56 pills). The March MAR indicated that hydrocodone -acetaminophen 5-325 as needed for pain, ordered 1/16/16 was not administered in March 2016. The April 2016 MAR indicated the resident received scheduled hydrocodone-acetaminophen 7.5-325 4 times per day as ordered until the surveyor's review on 4/21/16. The April MAR indicated the resident received hydrocodone-acetaminophen 7.5-325 on 4/12 at 5:50 AM and 4/16 at 6:20 AM. The surveyor requested the narcotic sign out logs fro the resident for March and April 2016. Facility staff provided only one sheet for hydrocodone-apap 7.5-325 and one for hydrocodone-apap 5-325. For hydrocodone-acetaminophen 7.5-325, the sheet	F 309	documentation including review of the pain management program. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	

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covered 4/15/16 through 4/20/16. For those dates, the narcotic sheet indicated medication was signed out for the resident:
4/15 8:30 AM, 1 PM, 9 PM
4/16 8 AM, 12:45 PM, 5 PM, 9 PM
4/17 9 AM, 1 PM, 5 PM, 9 PM
4/18 9 AM, 1 PM, 18:30 PM
4/19 8 AM, 1 PM, 5 PM, 8 PM
4/20 8 AM, 12 PM
The Controlled Substance Accountability sheet given to the surveyor ended on 4/20 at 12 PM with 10 pills remaining.
The surveyor's interview notes indicated that there were 7 pills remaining on the card at 12 PM on 4/21/16 (implying that the final 2 doses on 4/20 and the first on 4/21 had been signed out).

The PRN Controlled Substance Accountability Sheet for hydrocodone-acetaminophen 5-325 indicated that the resident had received 14 unscheduled doses of pain medication between 3/18 and 4/20. The MAR documented only 2 doses. No nurse's notes documented administration of unscheduled pain medication except for the 4/12 and 4/17 doses.

In addition to the medication cards, the facility employs a pharmaceutical single dose dispenser. During the period from 4/1/16 through 4/21/16, hydrocodone-acetaminophen 7.5-325 was withdrawn form the system on 4/3 (2 doses), 4/4 (3 doses), 4/5 (3 doses), 4/6 (3 doses), 4/7 (4 doses), 4/9 (6 doses), 4/11 (6 doses), 4/13 (4 doses), 4/14 (4 doses).

On 4/21/16 at 11:30 AM, the surveyor interviewed the resident's nursing unit manager about the resident's complaint that nurses will not give her pain medication when she asks for it. The nurse

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F 309	Continued From page 39 stated that the medication was ordered every 4 hours. When the doctor ordered the higher dose (hydrocodone-apap 7.5-325), she made the prior dose PRN, but said she hoped the resident wouldn't need to use it. The nurse said the resident's order was that she could have a PRN dose every 4 hours, but "we try not to give her too much". The surveyor discussed withholding ordered pain medication with the director of nursing on 4/21/16 at approximately 12:15 PM. The narcotic sheets and Alixa machine requisition reports documenting that fewer doses of scheduled pain medication than ordered and documented were signed out for the resident and that more than documented given were signed out of the PRN supply, while the resident complained that she did not receive medication when requested. The pharmacy appeared to have no mechanism for reconciling medication administration records with the supply on hand. The concern that the resident's reports of pain were not being addressed and the resident's pain medication was not properly controlled or documented were reported to the facility administrator, director of nursing, and other members of the administrative staff at a summary meeting on 4/21/16.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		6/2/2016

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F 312	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to provide Activities of Daily Living (ADL) care to a dependent resident for 1 of 24 Residents in the sample survey, Resident #12. For Resident #12 the facility staff failed to provide nail care. The Findings Included: Resident #12 was a 66 year old female who was originally admitted on 10/15/14 and readmitted on 11/24/15. Admitting diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, paralysis agitans, hypertension, pneumonia, dyspnea, hypothyroidism, mood disorder, anxiety and depression. The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/22/15. The facility staff coded that Resident #12 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #12 required limited (2/2) to total nursing care with Activities of Daily Living (ADL ' s). On April 19, 2016 at 3:15 p.m. the surveyor observed Resident #12 sitting in her wheelchair in her room. Resident #12 was dressed in street clothes. The surveyor observed that Resident #12 ' s finger nails were painted a greenish color and the fingers and finger nails were dirty with a brownish debris. On April 20, 2016 at 10:05 a.m. the surveyor observed Resident #12 sitting at the nurses ' station in her wheelchair. Resident #12 was dressed in street clothing. The surveyor	F 312	1. Resident #12 had fingernails trimmed and cleaned 4/20/2016. 2. 100% audit to be completed of all resident's fingernails by 5/27/2016. Nursing staff inserviced to ensure nails are cleaned and trimmed on residents designated shower days. 3. DNS or designee to audit 10 resident's nails each week x 4 weeks, then monthly x 3 months. 4. Results of Audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	6/2/2016

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F 312	Continued From page 41 observed that Resident #12 ' s finger nails were painted a greenish color. The surveyor also observed that Resident #12 ' s finger nails and fingers were dirty with a brownish debris. The surveyor observed that the Unit Manager, who was a Registered Nurse (RN), at the nurses ' station. The surveyor informed the UM that Resident #12 ' s finger nails and were dirty. The UM stated that Resident #12 refused care sometimes, but that she would see if Resident #12 would allow the staff to provide nail care. The UM asked Resident #12 if the facility staff could provide nail care and Resident #12 stated, " Yes. " On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that Resident #12 ' s fingers and finger nails were dirty with a brownish debris. The surveyor notified the AT that the facility staff failed to provide nail care to Resident #12. No additional information was provided prior to exiting the facility as to why the facility staff failed to provide nail care to a dependent Resident, Resident #12.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		6/2/2016

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F 323	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to maintain a hazard free environment on 1 of 3 units. The South unit. The findings included. During initial tour of the facility on 04/19/16 at approximately 1:30 p.m. the surveyor entered the shower room/beauty shop on the South unit. The door was unlocked. Upon entering this room the surveyor found a partially used spray bottle of odor digester. The label on this bottle read "Keep out of reach of children." The surveyor gave this spray bottle of odor digester to LPN # 10. The surveyor requested from the facility the MSDS (material safety data sheet) related to the odor digester. The MSDS sheet included the following information. Hazard Identification-may cause skin and eye irritation avoid contact with eyes and skin. This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m. During a walkthrough of the facility with the maintenance director on 04/21/16 at approximately 9:05 a.m. the maintenance director stated they had put a lock on the door. No additional information regarding this issue was provided to the survey team prior to the exit conference.	F 323	1. Bottle of odor digester immediately removed from shower room/beauty shop on South Wing. Shower room/ beauty shop immediately shut and locked. 2. 100% audit of all rooms in the facility completed to ensure that there were no chemicals left unattended in facility. 100% of shower room/beauty shop doors to ensure doors are locked. 3. Housekeeping/maintenance/designee to check shower rooms and beauty shop once a week x 4 weeks, then once a month x 3 months to ensure the doors are locked and there are no chemicals left unattended. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	6/2/2016

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F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 9 of 24 Residents in the sample survey were free of unnecessary medications, Resident #7, #12, #15,#22, #2, #14, #18, #9 and #10. For the residents identified the facility staff failed to monitor psychotropic drug use. The Findings Included:	F 329	1. Resident #7, #12, #15, #22, #2, #14, #18, #9, and #10 behavior logs were reviewed and placed in Point Click Care. 2. All residents on psychotropic medications reviewed and behavior monitoring logs placed in Point Click Care for licensed nursing staff to address each shift along with monitoring side effects each shift. Inserviced licensed nursing staff on behavior monitoring for side effects. Order by order reports to be reviewed each day in clinical start up to check for psychotropic medication so that behavior logs can be initiated. New admissions and readmissions to be checked in daily clinical start up and behavior logs to be initiated if indicated. 3. DNS/designee to audit behavior logs weekly x 4 weeks,and then monthly x 3 months on 15 residents to ensure behavior logs are present for each drug class and that there are no omissions from the logs.	6/2/2016

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F 329	Continued From page 44 1. For Resident #7 the facility staff failed to monitor psychotropic drug use to include: specific behavior, interventions, side effects and effectiveness. Resident #7 was receiving Quetiapine Fumarate (Seroquel) 50mg, a psychotropic medication, every evening at bedtime. Resident #7 was a 67 year old female who was originally admitted on 9/22/15 and readmitted on 12/11/15. Admitting diagnoses included, but were not limited to: dementia without behaviors, hypokalemia, Bipolar, affective mood disorder, anxiety, hypertension and pain. 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 2/22/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #7 required set up (0/1) to limited assistance (2/2) with Activities of Daily Living (ADL). On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced physician orders for "QUEtiapine Fumarate Tablet (Seroquel) 50mg Give 1 tablet by mouth at bedtime related to UNSPECIFIED MOOD [AFFECTIVE] DISORDER (F39)." (sic) The order originated on 12/11/15. Continued review of the clinical record produced the April Medication Administration Record (MAR's). The April MAR's documented that the facility staff were administering the Seroquel every evening as ordered by the physician. Continued review of the clinical record produced the Behavioral Monitoring Sheet for April 2016. Review of the April 2016 Behavioral Monitoring Sheet failed to document specific behavior, interventions, side effects and effectiveness on	F 329	4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	

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the 7-3 shift on 4/1/16, 4/2/16, 4/3/16, 4/5/16, 4/6/16, 4/7/16, 4/10/16, 4/11/16, 4/12/16, 4/13/16, 4/14/16, 4/15/16, 4/16/16 and on the 3/11 shift on 4/7/16, 4/8/16, 4/11/16, 4/12/16, 4/13/16, 4/15/16, 4/16/16, 4/17/16, and on the 11-7 shift on 4/18/16.

On April 20, 2016 at 8:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #7 was receiving Seroquel, a psychotropic medication, every evening. The surveyor notified the UM that the facility staff had not monitored Resident #7 for specific behavior, interventions, side effects and effectiveness of the Seroquel drug use. The surveyor reviewed Resident #7's clinical record with the UM. The surveyor pointed out the specific physician order for the Seroquel. The surveyor then reviewed the April MAR's and April Behavioral Monitoring Sheet with the UM. The surveyor pointed out that the facility staff failed to monitor the psychotropic drug use.

On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that the facility staff failed to monitor Resident #7 for psychotropic drug use, Seroquel, to include specific behavior, interventions, side effects and effectiveness.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #7 was free of unnecessary medications. The facility staff failed to monitor for specific behavior, interventions, side effects and effectiveness of the Seroquel use.

2. For Resident #12 the facility staff failed to

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monitor psychotropic drug use to include: specific behavior, interventions, side effects and effectiveness. Resident #12 was receiving RisperDal 1 mg, a psychotropic medication, every evening at bedtime.
Resident #12 was a 66 year old female who was originally admitted on 10/15/14 and readmitted on 11/24/15. Admitting diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, paralysis agitans, hypertension, pneumonia, dyspnea, hypothyroidism, mood disorder, anxiety and depression.
The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/22/15. The facility staff coded that Resident #12 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #12 required limited (2/2) to total nursing care with Activities of Daily Living (ADL's).
On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #12's clinical record. Review of the clinical record produced signed physician orders dated 12/1/15. Physician orders included, but were not limited to: "RisperDal Tablet (Risperidone) Give 1 mg by mouth one time a day related to UNSPECIFIED Psychosis NOT DUE TO A SUBSTANCE FOR PSYCHOLOGICAL CONDITION (F29) Give 1 MG by mouth." (sic) The order originated on 11/15/15.
Continued review of the clinical record produced the April Medication Administration Records (MAR's). The April MAR's documented that the facility staff were administering the Risperdal as ordered by the physician.
Further review of the clinical record produced the April 2016 Behavioral Monthly Flow Sheet. Review of the Behavioral Monitoring Flow failed

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to document specific behavior, interventions, side effects and effectiveness for the Risperdal drug use on the 7-3 shift on 4/3/16, 4/5/16, 4/6/16, 4/7/16, 4/10/16, 4/11/16, and 4/12/16, 4/13/16, 4/15/16, 4/16/16, 4/17/16, 4/18/16, 4/19/16 and on the 3-11 shift on 4/7/16, 4/8/16, 4/11/16, 4/12/16, 4/13/16, 4/15/16, 4/16/16, 4/17/16 and on the 11-7 shift on 4/4/16 and 4/18/16.
On April 20, 2016 at 10:25 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #12 was receiving Risperdal, a psychotropic medication, every evening. The surveyor notified the UM that the facility staff had not monitored Resident #12 for specific behavior, interventions, side effects and effectiveness of the Risperdal drug use. The surveyor reviewed Resident #12's clinical record with the UM. The surveyor pointed out the specific physician order for the Risperdal. The surveyor then reviewed the April MAR's and April Behavioral Monitoring Sheet with the UM. The surveyor pointed out that the facility staff failed to monitor the psychotropic drug use.
On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that the facility staff failed to monitor Resident #12 for psychotropic drug use, Risperdal, to include specific behavior, interventions, side effects and effectiveness.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #12 was free of unnecessary medications. The facility staff failed to monitor for specific behavior, interventions, side effects and effectiveness of the Risperdal

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use.
3. For Resident #15 the facility staff failed to monitor psychotropic drug use to include: specific behavior, interventions, side effects and effectiveness. Resident #15 was receiving Abilify, a psychotropic medication, every evening at bedtime.
Resident #15 was a 72 year old female who was admitted on 7/24/14. Admitting diagnoses included, but were not limited to: pneumonia, chronic pain, edema, cataract vitreous degeneration, heart failure, Bipolar, hypertension, hypothyroidism, morbid obesity, kidney failure and Schizophrenia.
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 3/18/16. The facility staff coded that Resident #15 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #15 required extensive assistance (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL).
On April 21, 2016 at 9:10 a.m. the surveyor reviewed Resident #15's clinical record. Review of the clinical record produced Physician Order Sheets (POS's). Physician orders included but were not limited to: " Abilify Tablet 10 MG (ARIPiprazole) Give 1 tablet by mouth at bedtime related to BOPLOAR DISORDER, UNSPECIFIED (F31.9)." (sic) The order originated on 3/23/16.
Continued review of the clinical record produced the April 2016 Medication Administration Records (MAR's). Review of the April 2016 MAR's documented that the facility staff were administering the Abilify as ordered by the physician. Continued review of the clinical record produced the April 2016 Behavioral Monthly Flow

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Sheets. Review of the Behavioral Monitoring flowsheets failed to document specific behavior, interventions, side effects and effectiveness for the Abilify drug use. The Behavioral Monitoring flowsheet failed to document specific behavior, interventions, side effects and effectiveness on the 7-3 shift on 4/4/16 and on the 3-11 shift on 4/2/16 and on the 11-7 shift on 4/2/16, 4/4/16 and 4/19/16.

On April 21, 2016 at 9:50 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse (RN), that Resident #15 was receiving Abilify, a psychotropic medication every evening. The surveyor notified the UM that the facility staff had not monitored Resident #15 for specific behavior, interventions, side effects and effectiveness of the Abilify drug use. The surveyor reviewed Resident #15's clinical record with the UM. The surveyor pointed out the specific physician order for the Abilify. The surveyor then reviewed the April MAR's and April Behavioral Monitoring Sheet with the UM. The surveyor pointed out that the facility staff failed to monitor the psychotropic drug use.

On April 22, 2016 at 11:45 a.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that the facility staff failed to monitor Resident #15 for psychotropic drug use, Abilify, to include specific behavior, interventions, side effects and effectiveness. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #15 was free of unnecessary medications. The facility staff failed to monitor for specific behavior, interventions, side effects and effectiveness of the Abilify use.

4. For Resident #22 the facility staff failed to monitor psychotropic drug use to include: specific

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behavior, interventions, side effects and effectiveness. Resident #22 was receiving Seroquel, a psychotropic medication, every evening at bedtime.
Resident #22 was a 63 year old male who was admitted on 2/19/16 and was discharged on 3/9/16. Admitting diagnoses included, but were not limited to: pneumonia, obesity, Bipolar, chronic obstructive pulmonary disease and respiratory failure.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 3/3/16. The facility staff coded that Resident #22 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #22 was independent after set up (0/1) for Activities of Daily Living.
On April 21, 2016 at 8:10 a.m. the surveyor reviewed Resident #22's closed clinical record. Review of the closed clinical record produced Physician Order Sheets (POS's). Physician orders included but were not limited to: "QUEtiapine Fumarate Tablet 100mg (Seroquel) Give 1 tablet by mouth at bedtime related to BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MODERATE (F31.21)." (sic)
Continued review of the closed clinical record produced the March 2016 Medication Administration Records (MAR's). Review of the March 2016 MAR's documented that the facility staff were administering the Seroquel as ordered by the physician. Continued review of the closed clinical record failed to produce any behavioral monitoring to include specific behavior, interventions, side effects and effectiveness for the Seroquel drug use.
On April 21, 2016 at 9:50 a.m. the surveyor notified the Unit Manager (UM), who was a

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Registered Nurse (RN), that Resident #22 had received Seroquel during his stay at the facility. The surveyor notified the UM that review of the closed clinical record failed to produce any behavioral monitoring for the Seroquel drug use. The surveyor reviewed Resident #22's closed clinical record with the UM. The UM was unable to locate any behavioral monitoring for March 2016 related to the Seroquel drug use.
On April 22, 2016 at 11:45 a.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that the facility staff failed to monitor Resident #22 for psychotropic drug use, Seroquel, to include specific behavior, interventions, side effects and effectiveness. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #22 was free of unnecessary medications. The facility staff failed to monitor for specific behavior, interventions, side effects and effectiveness of the Seroquel use.
5. For Resident #2, the facility staff failed to provide evidence of adequate monitoring. The Resident was currently receiving paxil for depression, lorazepam for anxiety, and trazodone for insomnia. .

Resident #2 was admitted to the facility 03/08/16. Diagnoses included, but were not limited to, hypertension, dementia, hypokalemia, insomnia, and depressive disorder.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/14/16 scored the Resident 15 out of a possible 15 points. Indicating the Resident was cognitively

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intact. Section E (behaviors) was coded to indicate the Resident did not have any behaviors.

Resident #2's CCP (comprehensive care plan) included the focus area "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Anxiety medication, Anti-Depressant medication." Interventions included, but were not limited to, monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications...Monitor for side effects and report to physician: Antidepressant-Sedation...Provide Medications as ordered by physician and evaluate for effectiveness..."

The Residents current orders included lorazepam 0.5 mg give 1 tablet by mouth three times a day related to anxiety disorder, paxil 40 mg give 1 tablet by mouth one time a day related to major depressive disorder, single episode, and trazodone give 75 mg by mouth at bedtime related to insomnia. The start date for all three of these medications had been documented on the POS (physician order summary) as 03/08/16 (date of admit).

A review of the Residents MAR's (medication administration records) for April 2016 indicated the medications had been administered per orders.

The "BEHAVIOR MONTHLY FLOW SHEET" used by the facility and dated April 2016 contained no data from April 1-April 8 and was incomplete for April 15, 16, 19, and 20. Someone had documented a 0 for April 3 on the night shift. However, this had been crossed out with an X.

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This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m.

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

6. For Resident #14, the facility staff failed to provide evidence of adequate monitoring. The Resident was currently receiving escitalopram oxalate (lexapro) for depression and xanax for anxiety.

Resident #14 was admitted to the facility 11/30/12. Diagnoses included, but were not limited to, Alzheimer's disease, generalized pain, anemia, schizoeffective disorder, hypothyroidism, and glaucoma.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/15/15 scored the Resident 0 out of a possible 15 points. Section E (behaviors) was coded to indicate the Resident did not have any behaviors.

Resident 14's CCP (comprehensive care plan) included the focus area "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Anxiety medication, Anti-Depressant." Interventions included, but were not limited to, monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications...Monitor for side effects and report to physician: Antidepressant-Sedation...Provide Medications as ordered by physician and evaluate for effectiveness..."

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The Residents current orders included escitalopram oxalate 20 mg give 1 tablet by mouth one time a day related to depressive disorder and xanax tablet 0.5 mg by mouth two times a day for anxiety and 1 tablet by mouth every 4 hours as needed for anxiety.

A review of the Residents MAR's (medication administration records) for April 2016 indicated the medications had been administered per orders. The as needed xanax had been documented as being administered on April 8 at 1723 (5:23 p.m.). The staff had documented an "E" for effective.

The "BEHAVIOR MONTHLY FLOW SHEET" used by the facility and dated April 2016 contained incomplete monitoring data for April 1, 4, 15, 19, and 20.

This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m.

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

7. For Resident #18, the facility staff failed to provide evidence of adequate monitoring. The Resident was currently receiving valium for anxiety and citalopram (celexa) for depression.

Resident #18 was most recently admitted to the facility 12/11/12. Diagnoses included, but were not limited to, chronic lymphoid leukemia, shortness of breath, pain, and constipation.

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Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/18/15 scored the Resident 15 out of a possible 15 points. Section E (behaviors) was coded to indicate the Resident did not have any behaviors.

Resident 18's CCP (comprehensive care plan) included the focus area "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Anxiety medication, antidepressant medication." Interventions included, but were not limited to, monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications...Monitor for side effects and report to physician: Antidepressant-Sedation...Provide Medications as ordered by physician and evaluate for effectiveness..."

The Residents current orders included citalopram 20 mg by mouth one time a day related to depressive disorder and valium 2.5 mg by mouth three times a day for anxiety and every 6 hours as needed.

The "BEHAVIOR MONTHLY FLOW SHEET" used by the facility and dated April 2016 contained incomplete monitoring data for April 1, 4, 6, 15, 19, 20, and 21.

This information was shared with the administrator and DON (director of nursing) on 04/21/16.

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

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8. For Resident #9 the facility staff failed to provide evidence of adequate of monitoring of the antipsychotic medication fluphenazine.

Resident #9 was admitted to the facility on 07/28/10 and readmitted on 12/12/15. Diagnoses included but not limited to congestive heart failure, hypertension, dementia, anxiety, depression, psychotic disorder, schizophrenia, atrial fibrillation, gastroesophageal reflux disease, arthritis and cataracts.
The most recent MDS with an ARD of 03/09/16 coded the Resident as 9 out of 15 in Section C, cognitive patterns. This is a quarterly MDS. The Resident's CCP (comprehensive care plan) was reviewed and contained care plans which read in part "I sometimes have behaviors which include yelling, cursing, hitting, throwing items, refusing care and resisting care. She also believes the food is poisoned at times" and "Potential for drug related complications associated with the use of psychotropic medications related to:
Anti-psychotic medication". Interventions listed for these care plans included "Monitor for target behaviors/symptoms of delusion, false beliefs, yelling, refusal of care/meds and document. Report behavior changes to physician".

Resident #9's clinical record was reviewed on 04/20/16. It contained a physician ' s order summary for April 2016 which read in part "fluphenazine 2.5mg Give 2.5mg by mouth two times a day related to schizoaffective disorder, unspecified".

The Resident ' s " Behavior Monthly Flow Sheet" for April 2016 was reviewed on 04/20/16. The flow sheet was coded for the monitoring of "false beliefs" and "hallucinations/paranoia/delusion".

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There were multiple blank spaces on the flow sheet. Surveyor spoke with the unit manager regarding the incomplete flow sheet on 04/20/16 at approximately 1530 and she could offer no explanation as to why it was not complete.

The concern of the incomplete flow sheets was brought to the attention of the administrative staff during a meeting on 04/20/16 at approximately 1705.

No further information was provided prior to exit.

9. For Resident #10 the facility staff failed to provide evidence of adequate of monitoring of the antipsychotic medication Seroquel.

Resident #10 was admitted to the facility on 11/03/14. Diagnoses included but not limited to anemia, hypertension, hypotension, hyperkalemia, malnutrition, anxiety, depression, bipolar disorder, chronic obstructive pulmonary disease, respiratory failure, dysphagia, gastroesophageal reflux disorder and end stage renal disease.
The most recent MDS with an ARD of 10/19/15 coded the Resident as 15 of 15 in Section C, cognitive patterns. The Resident's CCP was reviewed and contained care plans which read in part "I sometimes have behaviors which include: not asking for assistance when needed form staff. Often saying no one is helping me even Hough I never ask for any help" and ""Potential for drug related complications associated with use of psychotropic medications related to: Anti-psychotic medication". Interventions for this care plan are listed as "Provide medications as ordered by physician and evaluate for

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F 329	Continued From page 58 effectiveness". Resident #10's clinical record was reviewed on 04/20/16. It contained a physician's order summary for April 2016 which read in part "Seroquel tablet 25mg give 50mg by mouth two times a day related to bipolar disorder...". The Resident ' s " Behavior Monthly Flow Sheet" for April 2016 was reviewed on 04/20/16. The flow sheet was coded for the monitoring of "anxiety, compulsive, and multiple med complaints". There were multiple blank spaces on the flow sheet. Surveyor spoke with the unit manager regarding the incomplete flow sheet on 04/20/16 at approximately 1530 and she could offer no explanation as to why it was not complete. The concern of the incomplete flow sheets was brought to the attention of the administrative staff during a meeting on 04/20/16 at approximately 1705. No further information was provided prior to exit.	F 329		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical	F 363	1. Resident #4 interviewed. Request to have prune juice discontinued. Care plan and tray card updated. Resident #3 meal plan updated to provide oatmeal and/or cold cereal. Menus updated by Registered Dietician for correct portion for all diets.	5/27/2016

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F 363	Continued From page 59 record review and facility document review, it was determined the facility staff failed to ensure dietitian approved menus were complete per individual tray card for 2 of 24 residents. (Residents #3 and 4.) Findings: 1. Facility staff failed to provide Resident #4 with her dietitian approved food, as stated on the tray card. The clinical record was reviewed on 4/20/16 at 10:00 AM. Resident #4 was admitted to the facility on 6/28/11. The diagnoses included dementia, constipation, chronic pain, insomnia and neuralgia. The latest MDS (minimum data set) assessment, dated 3/2/16 coded the resident with unimpaired cognitive function. She required the assistance of facility staff for all the ADLs (activities of daily living)--with a set-up only to eat. The latest CCP (comprehensive care plan) updated 4/14/16 included the problem, "Inadequate oral/food intake due to dementia." The interventions to nursing staff included, "Diet as ordered....Obtain and update food/beverage preferences.....Provide food substitutes. Resident #4's physician ordered weekly weights on 2/26/16 to monitor the resident for weight loss. The resident was on an unrestricted, regular diet. On 4/20/16 at 8:45 AM CNA I set up Resident #4's breakfast tray in her bedroom. Once set-up was complete--the surveyor reviewed the tray card for the contents of the meal.	F 363	2. 100% audit completed of residents preferences. 3. Inservice to be completed by DSM with all dining staff regarding resident preferences. Weekly audits to be conducted 5 x a week x 4 weeks to ensure compliance. 4. Results of Audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	

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The resident was supposed to receive 4 oz of prune juice on her tray and 6 oz of water. The tray did not contain these items. Resident #4 stated, "I never get my prune juice, it's for constipation. I have a problem with that."

On 4/21/16 at 8:30 AM, the DM (dietary manager) was interviewed about the diets and tray card selections. She said the corporate menu was approved by a dietitian and all food selections on the tray cards should be served to the resident. "No, they're not getting what they're supposed to get."

On 4/21/16 at 10:30 AM the facility DON and administrator were informed of these findings.

2. Facility staff failed to provide Resident #3 with the menu selections listed on his tray card. Resident #3's clinical record was reviewed on 4/20/16 at 9:30 AM.

Resident #3 was admitted on 12/16/11. His diagnoses included anxiety, depression, blindness seizure disorder, schizophrenia, and chronic obstructive pulmonary disease.

The resident's latest MDS, dated 1/29/16 coded the resident with severe cognitive impairment. The resident was completely dependent on nursing staff for all the ADLs.

The resident's CCP, updated on 2/10/16, included the following focus, "Inadequate oral food/beverage intake due to chronic pain, blindness." The staff interventions included, ""Diet as ordered...monitor meal consumption daily....provide assistance with meals."

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F 363	Continued From page 61 The physician's orders, signed and dated 4/12/16, included the diet order, "No salt packet diet. Mechanical soft texture. Patient to receive food in bowls at all meals. Large portions." On 4/20//16 at 8:15 AM the surveyor observed CNA II assisting Resident #3 with breakfast. CNA II was feeding the resident, as he was blind and couldn't feed himself. The tray card was compared to the foods on the breakfast tray. The tray card contained oatmeal, 3 waffles, coffee and water. The oatmeal, coffee and water were not on the tray. There were only two waffles served instead of three. In addition, the tray card said, "NO COLD CEREAL." The resident had a cup of Frosted Flakes with milk on the tray. He seemed to enjoy them and ate the whole bowl. At no time did CNA II stop and realize the foods on the tray did not reflect the menu on the tray ticket. On 4/21/16 at 8:30 AM, the DM was asked about the resident's tray ticket/menu discrepancies. She said the corporate menu was approved by a dietitian and all food selections on the tray cards should be served to the resident. "No, they're not getting what they're supposed to get." On 4/21/16 at 10:30 AM the facility DON and administrator were informed of these findings.	F 363		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	F 366		

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F 366	Continued From page 62 Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and clinical record review it was determined the facility staff failed to provide a food substitute of a similar nutritive value for one that was declined for 1 of 24 residents (Resident #4.) Findings: Facility staff failed to provide Resident #4 with a substitute selection for a food she said she didn't like. The clinical record was reviewed on 4/20/16 at 10:00 AM. Resident #4 was admitted to the facility on 6/28/11. The diagnoses included dementia, constipation, chronic pain, insomnia and neuralgia. The latest MDS (minimum data set) assessment, dated 3/2/16 coded the resident with unimpaired cognitive function. She required the assistance of facility staff for all the ADLs (activities of daily living)--with a set-up only to eat. The latest CCP (comprehensive care plan) updated 4/14/16 included the problem, "Inadequate oral/food intake due to dementia." The interventions to nursing staff included, "Diet as ordered....Obtain and update food/beverage preferences.....Provide food substitutes.	F 366	1. Resident #4's food preferences have been updated. 2. 100% audit to be completed on resident food preferences. 3. Dietary Manager/designee to complete inservices with staff regarding resident food preferences. Weekly audits x 4 weeks will be completed in random dining areas to determine if residents are being offered substitutes. All food preferences will be updated quarterly with resident's scheduled MDS assessments. 4. Results of Audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	5/31/2016

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F 366	Continued From page 63 Resident #4's physician ordered weekly weights on 2/26/16 to monitor the resident for weight loss. The resident was on an unrestricted, regular diet. On 4/20/16 at 8:45 AM CNA I set up Resident #4's breakfast tray in her bedroom. During the tray set-up, CNA I began to cut up a sausage patty on the resident's plate. The resident stated, "I don't eat sausage," The CNA said "OK" and left the patty whole on the plate. She did not offer to go get the resident another breakfast meat selection. (When asked, the resident told the surveyor she liked bacon.) On 4/21/16 at 8:30 AM, the DM (dietary manager) was informed that CNA I had failed to offer Resident #4 an alternate selection when the resident told her she did not like sausage. The DM agreed the CNA should have asked her what she would like instead of the sausage. On 4/21/16 at 10:30 AM the facility DON and administrator were informed of these findings.	F 366		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced	F 386	1. Obtained Physician Progress Notes resident #7. 2. 100% audit completed of each medical record performed to ensure that each medical record contained the most up to date Physician Progress Note for each resident.	6/2/2016

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by:
Based on staff interview and clinical record review, it was determine that the facility staff failed to ensure timely Physician Progress Notes for 1 of 24 Residents in the sample survey, Resident #7.
Resident #7 went from 10/2/15 until 2/18/16 without having Physician Progress Notes written.
The Findings Included:
Resident #7 was a 67 year old female who was originally admitted on 9/22/15 and readmitted on 12/11/15. Admitting diagnoses included, but were not limited to: dementia without behaviors, hypokalemia, Bipolar, affective mood disorder, anxiety, hypertension and pain.
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 2/22/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #7 required set up (0/1) to limited assistance (2/2) with Activities of Daily Living (ADL).
On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced the latest Physician Progress Notes dated 10/2/15. Additional review of the clinical record failed to produce any additional Physician Progress Notes since 10/2/15.
On April 20, 2016 at 8:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #7's clinical record did not produce and Physician Progress Notes since 10/2/15. The surveyor reviewed the clinical record with the UM. The UM was unable to locate any additional Physician Progress Notes. The UM stated she would ask Medical

3. A running log was created to effectively monitor Physician Visits by resident and date of the last physician visit. Medical records to give proper notification of upcoming required visits to the physician's office via fax, as well as upcoming scheduled need for a resident's visit by physician. An audit of 5 random charts a week to be completed by Medical Records Coordinator x 4 weeks, then once a month x 3 months to ensure physician compliance with progress notes.
4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations.

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F 386	Continued From page 65 Records if she had any Physician Progress Notes that needed to be filed or that had been thinned from the record. On April 20, 2016 at 9 a.m. the Medical Records clerk approached the surveyor and stated that she did not have any additional Physician Progress Notes. On April 20, 2016 at 9:05 a.m. the Corporate Compliance Nurse (CCN) approached the surveyor and informed the surveyor that the facility's electronic system was not capturing the Physician Progress Notes that were being done electronically. The CCN stated that they had contacted the vendor that supplied the electronic system and that they were working to correct the problem. On April 20, 2016 at 11 a.m. the UM hand delivered two (2) Physician Progress Notes. The Physician Progress Notes were dated 2/18/16 and 3/22/16. The surveyor pointed out to the UM that Resident #7's did not have any Physician Progress Notes for over 4 months from 10/2/15 through 2/18/16. On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that Resident #7 did not have timely physician progress notes. The surveyor notified the AT that Resident #7's Physician Progress Notes were dated 10/2/15 and 2/18/16. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure timely Physician Progress Notes for Resident #7.	F 386		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		

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F 425 SS=E	Continued From page 66 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) 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 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview, and clinical record review, pharmacy and facility staff failed to account for medications ordered and supplied to the facility to prevent or manage pain for 1 of 24 residents in the survey sample (Resident #17). Resident #17 was admitted to the facility on 10/14/15 with diagnoses including coronary artery disease, hypertension, orthostatic hypotension,renal failure, metabolic encephalopathy, low back pain, and hip pain. On the admission minimum data set (MDS)	F 425	1. Resident #17 has had an up to date pain assessment and plan of care was reviewed and revised as indicated. 2. All residents on a pain management program will have an up to date pain assessment and plan of care will be reviewed and revised as indicated. All PRN Narcotic administration in the last 30 days will be reconciled to the Medication Administration record and identified concerns will be addressed as indicated. 3. DNS/Designee will provide the Licensed Nurses with education regarding the Pain Management Guidelines, Medication Administration Guidelines, and required documentation. DNS/Designee will review residents with pain management needs daily in clinical start-up and identified concerns will be addressed as indicated. DNS/Designee will do a weekly random audit of 10 narcotic administrations and the required documentation including review of the pain management program.	6/2/2016

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F 425	Continued From page 67 assessment dated 10/21/15, the resident scored 6/15 on the brief assessment for mental status and was assessed as without signs of delirium, psychosis, or behavior disorder. The resident was assessed as having frequent pain at a level 8 on a 10 point scale. During a family interview on 4/21/16, the resident's son reported that the pharmacy appeared to be billing for pain medication which the resident was not receiving. The resident stated that she frequently asked for pain medication and was told she could not have pain medication because she had medication scheduled every 4 hours. The resident's son showed the surveyor the resident's pharmacy bill for March 2016. The resident had been billed for 120 Norco 5/325. The Resident's son reported that the resident's order had been changed to Norco 7.5/325 early in the month. Clinical record review of the medication administration records for March and April 2016 revealed the resident received hydrocodone-acetaminophen 5-325 (Norco) 4 times per day March 1 through March 17 (17 X 4 = 68 pills), then changed to hydrocodone-acetaminophen 7.5-325 4 times per day March 18 through March 31 (14 X 4 = 56 pills). The March MAR indicated that hydrocodone -acetaminophen 5-325 as needed for pain, ordered 1/16/16 was not administered in March 2016. The April 2016 MAR indicated the resident received scheduled hydrocodone-acetaminophen 7.5-325 4 times per day as ordered until the surveyor's review on 4/21/16. The April MAR indicated the resident received hydrocodone-acetaminophen 7.5-325 on 4/12 at 5:50 AM and 4/16 at 6:20 AM. The	F 425	4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	

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surveyor requested the narcotic sign out logs fro the resident for March and April 2016. Facility staff provided only one sheet for hydrocodone-apap 7.5-325 and one for hydrocodone-apap 5-325. For hydrocodone-acetaminophen 7.5-325, the sheet covered 4/15/16 through 4/20/16. For those dates, the narcotic sheet indicated medication was signed out for the resident:

4/15 8:30 AM, 1 PM, 9 PM
4/16 8 AM, 12:45 PM, 5 PM, 9 PM
4/17 9 AM, 1 PM, 5 PM, 9 PM
4/18 9 AM, 1 PM, 18:30 PM
4/19 8 AM, 1 PM, 5 PM, 8 PM
4/20 8 AM, 12 PM

The Controlled Substance Accountability sheet given to the surveyor ended on 4/20 at 12 PM with 10 pills remaining.
The surveyor's interview notes indicated that there were 7 pills remaining on the card at 12 PM on 4/21/16 (implying that the final 2 doses on 4/20 and the first on 4/21 had been signed out).

The PRN Controlled Substance Accountability Sheet for hydrocodone-acetaminophen 5-325 indicated that the resident had received 14 unscheduled doses of pain medication between 3/18 and 4/20. The MAR documented only 2 doses. No nurse's notes documented administration of unscheduled pain medication except for the 4/12 and 4/17 doses.

In addition to the medication cards, the facility employs a pharmaceutical single dose dispenser. During the period from 4/1/16 through 4/21/16, hydrocodone-acetaminophen 7.5-325 was withdrawn form the system on 4/3 (2 doses), 4/4 (3 doses), 4/5 (3 doses), 4/6 (3 doses), 4/7 (4 doses), 4/9 (6 doses), 4/11 (6 doses), 4/13 (4

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F 425	Continued From page 69 doses), 4/14 (4 doses). On 4/21/16 at 11:30 AM, the surveyor interviewed the resident's nursing unit manager about the resident's complaint that nurses will not give her pain medication when she asks for it. The nurse stated that the medication was ordered every 4 hours. When the doctor ordered the higher dose (hydrocodone-apap 7.5-325), she made the prior dose PRN, but said she hoped the resident wouldn't need to use it. The nurse said the resident's order was that she could have a PRN dose every 4 hours, but "we try not to give her too much". The surveyor discussed withholding ordered pain medication with the director of nursing on 4/21/16 at approximately 12:15 PM. The narcotic sheets and Alixa machine requisition reports documenting that fewer doses of scheduled pain medication than ordered and documented were signed out for the resident and that more than documented given were signed out of the PRN supply, while the resident complained that she did not receive medication when requested. The pharmacy appeared to have no mechanism for reconciling medication administration records with the supply on hand. The concern that the resident's reports of pain were not being addressed and the resident's pain medication was not properly controlled or documented were reported to the facility administrator, director of nursing, and other members of the administrative staff at a summary meeting on 4/21/16.	F 425		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS	F 468		

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F 468	Continued From page 70 The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure handrails were firmly secured on 1 of 3 units (South unit). The findings included. On 04/20/16 at approximately 3:05 p.m. the surveyor observed that the handrail beside the elevator on the South unit was loose and cracked and the handrail outside of room 136 was loose. This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m. During a walkthrough of the facility with the maintenance director on 04/21/16 at approximately 9:05 a.m. the loose and cracked handrails were reviewed. No additional information regarding this issue was provided to the survey team prior to the exit conference.	F 468	1. Handrail beside the elevator on the South unit and handrail outside of room 136 repaired. 2. 100% Audit of all handrails in the facility checked to ensure there were no loose or cracked handrails. 3. Maintenance Director and Maintenance Assistant educated on repairing loose or cracked handrails in the facility. Maintenance Director/Designee to audit handrails once a week x 4 weeks, then monthly x 3 months to ensure there are no loose or broken handrails in the facility. Any broken or loose handrails will be repaired at that time. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	6/2/2016
F 502 SS=D	483.75(j)(1) ADMINISTRATION 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.	F 502		6/2/2016

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F 502	Continued From page 71 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 2 of 24 Residents, Resident's # 9 and #1. The findings included: 1. For Resident #9 the facility staff failed to obtain a physician's order urinalysis. Resident #9 was admitted to the facility on 07/28/10 and readmitted on 12/12/15. Diagnoses included but not limited to congestive heart failure, hypertension, dementia, anxiety, depression, psychotic disorder, schizophrenia, atrial fibrillation, gastroesophageal reflux disease, arthritis and cataracts. The most recent MDS with an ARD of 03/09/16 coded the Resident as 9 out of 15 in Section C, cognitive patterns. This is a quarterly MDS. Resident #9's clinical record was reviewed on 04/20/16. It contained a signed physician's ordered dated 03/02/16 which read in part "U/A c C/S (urinalysis with culture and sensitivity)". The surveyor could not locate the results of this lab test in the clinical record. Surveyor asked the unit manager if she could locate the results of the test and she could not. The concern of the missing lab results was brought to the attention of the administrative staff during a meeting on 04/20/16 at approximately 1705. No further information was provided prior to exit. 2. For Resident #1, the facility staff failed to obtain the lab tests CBC (complete blood count),	F 502	1. Resident #9's urine was not collected as ordered. Resident's MD made aware of missed lab. There were no new orders. 2. 100% audit resident's lab orders for the last 3 months conducted. 100% audit of all residents labs for the last 3 months completed to ensure labs were collected as ordered. Licensed Nurses educated on ensuring labs ordered by the physician are placed on the the lab requisitions to be drawn. 3. Lab audits to be conducted by DNS or designee once a week x 4 weeks, then monthly x 3. 4. Results of audit will be brought to Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	6/2/2016

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CMP (comprehensive metabolic panel), and ESR (erythrocyte sedimentation rate).

Resident #1 was admitted to the facility 10/19/13. Diagnoses included, but were not limited to, history of urinary tract infections, hyperkalemia, chronic pain, osteoarthritis, cerebrovascular disease, and anxiety disorder.

Section C (cognitive patterns) of the Resident significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/22/15 scored the Resident 12 out of a possible 15 points indicating the Resident was cognitively intact.

The clinical record included a physicians order dated 03/22/16 for a CBC, CMP, and ESR on 03/23/2016. During the clinical record review the surveyor was unable to locate any results for these lab tests.

On 04/20/16 at 10:10 a.m. the surveyor asked RN (registered nurse) #1 about the missing lab results.

On 04/20/16 at 10:55 a.m. RN #1 verbalized to the surveyor that the lab tests had not been completed, the physician had been notified, and the labs would be obtained today.

This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m.

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

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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 508 SS=D	Continued From page 73 483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic 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, it was determine that the facility staff failed to obtain a physician ordered radiology test for 1 of 24 Residents in the sample survey, Resident #7. The Findings Included: For Resident #7 the facility staff failed to obtain a physician ordered CT of the head ordered on 2/22/16. Resident #7 was a 67 year old female who was originally admitted on 9/22/15 and readmitted on 12/11/15. Admitting diagnoses included, but were not limited to: dementia without behaviors, hypokalemia, Bipolar, affective mood disorder, anxiety, hypertension and pain. 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 2/22/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #7 required set up (0/1) to limited assistance (2/2) with Activities of Daily Living (ADL). On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #7 ' s clinical record. Review of the clinical record produced a physician order to obtain a CT of the head dated 2/22/16.	F 508	1. Resident #7 CT failed to be conducted timely. Copy placed in medical record. Resident's MD made aware of delay in getting CT scan ordered timely. Resident received CT scan, no concerns identified. 2. 100% audit of residents in the last 3 months completed to ensure diagnostics ordered by MD were completed and placed in the medical chart. Scheduler educated to notify ED/DNS when delays in scheduling of diagnostics occur. 3. Audit to be conducted by DNS or designee weekly x 4 weeks, then monthly x 3 months to ensure diagnostics ordered were completed and placed in the medical record. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	6/2/2016

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	495143	A. BUILDING _____ B. WING _____	04/21/2016

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F 508	Continued From page 74 Continued review of the clinical record failed to produce the results of the physician ordered CT of the head. On April 20, 2016 at 8:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #7 had a physician order for a CT of the head dated 2/22/16. The surveyor reviewed the clinical record with the UM. The surveyor pointed out the specific order for the CT of the head. The surveyor and UM reviewed the clinical record in an attempt to find the results of the CT of the head. The UM was unable to locate the results of the physician ordered head CT. The UM stated that she would check with the facility Scheduler to see if the CT of the head had been done as ordered by the physician. Within a few minutes the UM and facility Scheduler approached the surveyor. The Scheduler hand delivered several documents and stated that she had faxed to the radiology vender the physician order to obtain a CT of the head. The Scheduler stated that she never heard back from the radiology vender. On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that Resident #7 had a physician order to obtain a CT of the head on 2/22/16. The surveyor notified the AT that the CT of the head was not obtained as ordered by the physician. No additional information was provided prior to exiting the facility as to why the facility staff failed to obtain the physician ordered CT of the head for Resident #7.	F 508		

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F 513	Continued From page 75	F 513	F 513 This deficiency has been corrected.	6/2/2016
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED	F 513	1. Resident #7's CT scan obtained and placed in resident's medical record. MD made aware of the delay in obtaining the CT scan ordered timely.	
	The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.		2. 100% audit of the past 3 months completed of current residents to ensure diagnostics ordered were completed and placed in the medical chart.	
	This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determine that the facility staff failed to ensure that the results of a physician ordered radiology test was contained in the clinical record for 1 of 24 Residents in the sample survey, Resident #7. The Findings Included: For Resident #7 the facility staff failed to ensure that the results of a physician ordered CT scan of the head obtained on 4/11/16 was contained in the clinical record. Resident #7 was a 67 year old female who was originally admitted on 9/22/15 and readmitted on 12/11/15. Admitting diagnoses included, but were not limited to: dementia without behaviors, hypokalemia, Bipolar, affective mood disorder, anxiety, hypertension and pain. 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 2/22/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #7 required set up (0/1) to limited assistance (2/2) with Activities of Daily Living (ADL). On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #7 ' s clinical record. Review of the clinical record produced a physician order		3. Audit to be conducted by DNS/ designee to occur weekly x 4 weeks, then monthly x 3 months to ensure diagnostics ordered were completed and placed in the medical records timely. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	

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F 513	Continued From page 76	F 513		

to obtain a CT of the head on 4/11/16.
Continued review of the clinical record failed to produce the results of the physician ordered CT of the head.
On April 20, 2016 at 8:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #7 had a physician order to obtain a CT of the head dated on 4/11/16. The surveyor notified the UM that the results of the physician ordered CT scan of the head could not be located in the clinical record. The surveyor reviewed the clinical record with the UM. The surveyor pointed out the specific order to obtain the CT of the head dated 4/11/16. The surveyor and UM continued to review of the clinical record. The UM was unable to locate the results of the physician ordered Ct of the head for 4/11/16. The UM stated that she knew the CT of the head had been done. The UM stated she would see what she could find.
Within a few minutes the UM approached the surveyor and hand delivered the results of the physician ordered CT of the head obtained on 4/11/16. The surveyor asked were the UM had found the results. The UM stated the radiology vender had faxed the results over to her.
On April 20, 2016 at 5:05 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Compliance Nurse (CCN) and Area Vice President (AVP). The surveyor notified the Administrative Team (AT) that Resident #7 had a physician order to obtain a CT of the head on 4/11/16. The surveyor notified the AT that the results of the physician ordered CT of the head were not contained in the clinical record. The surveyor notified the AT that the UM had contacted the radiology vender and the vender had faxed the results over to her.

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F 513	Continued From page 77 No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that the results of the physician ordered CT of the head obtained on 4/11/16 was contained in the clinical record for Resident #7.	F 513		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. 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 a complete and accurate clinical record for 4 of 24 Residents in the sample survey, Resident #15, Resident #16, Resident #17 and Resident #18. The Findings Included: 1. For Resident #15 the facility staff had co-mingled another residents Physician Order Sheet ' s in the record. Resident #15 was a 72 year old female who was admitted on 7/24/14. Admitting diagnoses included, but were not limited to: pneumonia,	F 514	F 514 This deficiency has been corrected. 1. Resident #15's medical record corrected. Resident #16 had self administration assessment completed 4/20/2016. Resident #17 has had an up to date pain assessment and plan of care was reviewed and revised as indicated. 2. All nursing staff educated on putting the correct resident's information in resident's medical records. All residents on a pain management program will have an up to date pain assessment and plan of care will be reviewed and revised as indicated. All PRN Narcotic administration in the last 30 days will be reconciled to the Medication Administration record and identified concerns will be addressed as indicated.	6/2/2016

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F 514	Continued From page 78	F 514		

chronic pain, edema, cataract vitreous degeneration, heart failure, Bipolar, hypertension, hypothyroidism, morbid obesity, kidney failure and Schizophrenia.
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 3/18/16. The facility staff coded that Resident #15 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #15 required extensive assistance (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL).
On April 21, 2016 at 9:10 a.m. the surveyor reviewed Resident #15's clinical record. Review of the clinical record produced the Physician Order Sheets (POS ' s) of a 57 year old male who was admitted on 12/17/15. Admitting diagnoses included, but were not limited to: leg pain, enlarged prostate, major depressive disorder, diabetes mellitus and hypertension.
On April 21, 2016 at 9:50 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse (RN), that another residents POS's were co-mingled in Resident #15's clinical record. The surveyor reviewed the clinical record with the UM. The surveyor pointed out the male residents POS's in Resident #15s clinical record.
On April 22, 2016 at 11:45 a.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that a male residents POS's were located in Resident #15's clinical record.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #15.
2. For Resident #16, facility staff failed to

100% audit of all rooms conducted on 4/20/2016 to ensure no other residents have medications present in their room without an MD order and a self-administration assessment completed. 100% audit of all residents with the ability to self administer medications completed and care plans updated accordingly. 100% audit of each medical record in the facility completed to ensure there was no co-mingled information in any resident's medical record.

3. Medical records completed inservice with Nursing Staff, Therapy Department, and Department Heads regarding the proper filing order in Medical records. DNS/Designee will provide the Licensed Nurses with education regarding the Pain Management Guidelines, Medication Administration Guidelines, and required documentation. DNS/Designee will review residents with pain management needs daily in clinical start-up and identified concerns will be addressed as indicated. DNS/Designee will do a weekly random audit of 10 narcotic administrations and the required documentation including review of the pain management

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F 514	Continued From page 79 document resident self-administration of medication. Resident#16 was admitted to the facility on 3/14/13 with diagnoses including respiratory failure, lichen sclerosis atrophius, peripheral neuropathy, and paranoid schizophrenia. The resident was assessed without signs of delirium, psychosis, or behavior issues and scored 15/15 on the Brief Interview for Mental Status on the Quarterly Minimum Data Set assessment dated 2/5/16. During medication pass observation on 4/20/16 at 9:15 AM, the surveyor observed the medication nurse enter Resident #16's room to administer morning medication. One of the medications ordered was DuoNeb solution 0.5-2.5 mg/3 ML 1 application inhale orally every 4 hours related to respiratory failure, give every 4 hours while awake. When the surveyor entered the room with the medication nurse, the resident was using the nebulizer to self-administer a nebulizer treatment. She stated that she didn't feel she could wait for the regularly scheduled treatment, so she used one of the treatments she kept in her room. The surveyor asked if she told nursing staff when she used one of those treatments. She said she did not. The medication nurse said she was unaware that the resident had nebulizer treatments available for self-administration. The resident's comprehensive care plan included Self medication administration- combivent inhaler (date initiated 4/1/15). The resident had not been care planned for self administration of nebulizer treatments. The surveyor reported the concern to the director	F 514	program. New admissions will be assessed for the ability to self administer medications. DNS/designee will audit 10 rooms a week x 4 weeks, then monthly x 3 months to ensure medications are not left at beside without orders and self-administration assessment. Each morning in clinical start up, DNS or designee to review orders for self-administration and care plan will be initiated. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	

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of nursing on 4/20/16 during a summary meeting. The DON reported on 4/21/16 that the resident had been assessed for self-administration of nebulizer treatments and determined that, after some education, that it was safe for the resident to self-administer the medication, but that the resident had returned her supply of DuoNebs and declined to do so at that time.

The DON and administrator were notified that this was an ongoing concern at a summary meeting on 4/21/16.

3. For Resident #17, staff failed to document the disposition of medications ordered to prevent or manage pain.

Resident #17 was admitted to the facility on 10/14/15 with diagnoses including coronary artery disease, hypertension, orthostatic hypotension,renal failure, metabolic encephalopathy, low back pain, and hip pain. On the admission minimum data set (MDS) assessment dated 10/21/15, the resident scored 6/15 on the brief assessment for mental status and was assessed as without signs of delirium, psychosis, or behavior disorder. The resident was assessed as having frequent pain at a level 8 on a 10 point scale.

During a family interview on 4/21/16, the resident's son reported that the pharmacy appeared to be billing for pain medication which the resident was not receiving. The resident stated that she frequently asked for pain medication and was told she could not have pain medication because she had medication scheduled every 4 hours. The resident's son showed the surveyor the resident's pharmacy bill

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for March 2016. The resident had been billed for 120 Norco 5/325. The Resident's son reported that the resident's order had been changed to Norco 7.5/325 early in the month.

Clinical record review of the medication administration records for March and April 2016 revealed the resident received hydrocodone-acetaminophen 5-325 (Norco) 4 times per day March 1 through March 17 (17 X 4 = 68 pills), then changed to hydrocodone-acetaminophen 7.5-325 4 times per day March 18 through March 31 (14 X 4 = 56 pills). The March MAR indicated that hydrocodone -acetaminophen 5-325 as needed for pain, ordered 1/16/16 was not administered in March 2016. The April 2016 MAR indicated the resident received scheduled hydrocodone-acetaminophen 7.5-325 4 times per day as ordered until the surveyor's review on 4/21/16. The April MAR indicated the resident received hydrocodone-acetaminophen 7.5-325 on 4/12 at 5:50 AM and 4/16 at 6:20 AM. The surveyor requested the narcotic sign out logs fro the resident for March and April 2016. Facility staff provided only one sheet for hydrocodone-apap 7.5-325 and one for hydrocodone-apap 5-325. For hydrocodone-acetaminophen 7.5-325, the sheet covered 4/15/16 through 4/20/16. For those dates, the narcotic sheet indicated medication was signed out for the resident:

4/15 8:30 AM, 1 PM, 9 PM
4/16 8 AM, 12:45 PM, 5 PM, 9 PM
4/17 9 AM, 1 PM, 5 PM, 9 PM
4/18 9 AM, 1 PM, 18:30 PM
4/19 8 AM, 1 PM, 5 PM, 8 PM
4/20 8 AM, 12 PM

The Controlled Substance Accountability sheet

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medication with the director of nursing on 4/21/16 at approximately 12:15 PM. The narcotic sheets and Alixa machine requisition reports documenting that fewer doses of scheduled pain medication than ordered and documented were signed out for the resident and that more than documented given were signed out of the PRN supply, while the resident complained that she did not receive medication when requested. The pharmacy appeared to have no mechanism for reconciling medication administration records with the supply on hand.

The concern that the resident's reports of pain were not being addressed and the resident's pain medication was not properly controlled or documented were reported to the facility administrator, director of nursing, and other members of the administrative staff at a summary meeting on 4/21/16.

4. For Resident #18, the clinical record included an allergy to eggs and the flu vaccine. However, the POS (physician order summary) included an order for the flu vaccine.

Resident #18 was most recently admitted to the facility 12/11/12. Diagnoses included, but were not limited to, chronic lymphoid leukemia, shortness of breath, pain, and constipation.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/18/15 scored the Resident 15 out of a possible 15 points. Section O (special treatments, procedures, and programs) was coded to indicate the Resident did not receive the flu vaccine in the facility as they were not eligible-medical contraindication.

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The front cover of Resident #18's clinical record included the Resident allergies. These included the flu vaccine and eggs.

The face sheet in the clinical record also included the allergies eggs and influenza vaccine.

The current physician orders included the order "Annual Influenza vaccine q. (every) October... " The order date was documented as 10/06/15. The surveyor was unable to find evidence in the clinical record that the Resident had actually received the flu vaccine.

The administrator and DON (director of nursing) were notified of the conflicting information regarding the Residents allergy status on 04/21/16 at 11:55 a.m. the DON verbalized to the survey team that she would take care of it.

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

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F 000	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and a Biennial State Licensure Inspection was conducted 4/19/16 through 4/21/16. 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 142 certified bed facility was 120 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Resident #1 through Resident #21) and 3 closed record reviews (Resident #22, Resident #24 and Resident #24).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12 VAC 5-371-220. Nursing Services.
12 VAC 5-371-150-(A)- Cross reference to F-151

12 VAC 5-371-150. Resident Rights.
12VAC 5-371-150 (B, I) Cross Reference to F-164

12 VAC 5-371-250. Resident Rights.
12 VAC 5-371-250 (A.13,G): Cross reference to F-176.

12 VAC 5-371-150. Quality of Life.
12 VAC 5-371-150 (A, B.1-3): Cross reference to F-244.

12 VAC 5-371-370. Quality of Life.
12 VAC 5-371-370 (A, B,C,D,E,G,H,I): Cross reference to F-252 & 253.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- MARTINSVLLE	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(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) COMPLETE DATE
F 001	Continued From Page 1	F 001		

12 VAC 5-371-250. Resident assessment and care planning.
12 VAC 5-371-250 (A.1 THRU A.14) Cross Reference to F-272

12 VAC 5-371-200. Resident assessment and care planning.
12 VAC 5-371-200 (B-1) Cross Reference to F-281

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (A THRU G) Cross reference to F-309.

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (A THRU G) Cross reference to F-312.

12 VAC 5-371-370. Physical Environment.
12 VAC 5-371-370 (B) Cross reference to F-323.
12VAC 5-371-370 (B) Cross Reference to F Tag-468

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (B) Cross reference to F-329.

12 VAC 5-371-340 Dietary and Food Service Program
12 VAC-5-371-340 Cross Reference to F Tag-363 and 366

12 VAC 5-371-240. Physician Services.
12 VAC 5-371-240 (E) Cross reference to F-386.

12 VAC 5-371-300. Pharmacy Services.
12 VAC 5-371-300 (A,C,G) Cross reference to F-425.

12 VAC 5-371-310. Administration.
12 VAC 5-371-310 (A) Cross reference to F-502

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- MARTINSVLLE	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(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) COMPLETE DATE
F 001	Continued From Page 2	F 001		

12 VAC 5-371-310. Administration.
12 VAC 5-371-310 (A) Cross reference to F-508.

12 VAC 5-371-360. Clinical Records
12 VAC 5-371-360 (E) Cross reference to F513

12 VAC 5-371-360. Clinical Records
12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514