STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE ON THE MOUNTAIN	417 MOUNTAIN TRACE ROAD SYLVA, NC 28779

(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 152 SS=D	483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on medical record review, family interview and staff interview the facility failed to obtain consent of the Power of Attorney prior to sending a resident to a health care specialist and failed to honor the Power of Attorney specified request on the Medical Orders for Scope of Treatment (MOST) form prior to transfer to the hospital for 1 of 1 sampled resident. (Resident #4) The findings included: Resident #4 was admitted to the facility on 06/08/13 with diagnoses that included: malnutrition, pressure ulcer, fractured femur, osteoarthrosis, anxiety, kidney disease, pain, altered mental status, depression, hypertension, Hodgkin disease and a history of colon cancer. A significant change Minimum Data Set dated 05/26/15 noted Resident #4 was assessed with severe cognitive impairment.	F 152	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 152 With regards to the surveyors' concerns, Res #4 has a signed Medical Orders for Scope of Treatment (MOST) on the resident's medical record. The MOST form instructions are being followed and the legal representative is notified of any physician orders for consults or appointments. The facility has determined that all residents are at risk for this alleged deficit practice. The facility provides an ongoing education program to licensed nurses by 8/10/15 by the ADON, during orientation, and throughout the year by the Director of Nursing and/or ADON regarding Honoring Code Status, MOST form instructions, and Advanced Directives. Education is provided to licensed nurses on 8/10/15 by the ADON regarding Notification to residents' legal	8.11.15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Morrow — TITLE: Administrator — (X6) DATE: 8.5.15

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.

DHSR NC Black Mountain MDO Received AUG 11 2015 by: SKH

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F 152	Continued From page 1 a. Within the medical record of Resident #4 was a Medical Orders for Scope of Treatment (MOST) form originally completed 06/27/11 by the Power of Attorney (POA) of Resident #4 with specifics under "Comfort Measures" which noted "Do not transfer to hospital unless comfort needs cannot be met in current location. Only transfer patient if confirmed fracture with uncontrolled pain. X-ray to be done in facility first." Review of the medical record of Resident #4 noted a Situation Background Assessment Recommendation (SBAR) note dated 12/23/14 by Nurse #5 which indicated that on 12/23/14 Resident #4 had a fever of 103.1. Nurse #5 documented on the SBAR there were "no signs/symptoms of distress noted" and "respirations clear and even." A guideline on the SBAR form indicated a checklist of 5 items for the nurse to do "before calling physician" which included: 1. Evaluate the resident 2. Check vital signs 3. Review record 4. Review and interact care path or acute change in condition file card 5. Have relevant information available when reporting (medical record, vital signs, advance directives such as Do Not Resuscitate and other care limiting orders, allergies, medication list). The first four items on the checklist were checked off on the SBAR and the last items was not checked off by Nurse #5. A Nursing Home to Hospital Transfer Form completed 12/23/14 for Resident #4 noted a voice mail was left for the POA of Resident #4 regarding the transfer to the hospital.	F 152	representatives regarding consults and appointments. The Social Services Director has audited all residents in the facility concerning MOST forms, Advanced Directives, and Code Status of the residents. This updated report is presented to the members of the Interdisciplinary team and Administrator by the 10th of each month. The Director of Nursing, ADON, or Unit Manager audit 5 residents weekly times 4 weeks to ensure that consults and appointments have been communicated to the residents' legal representatives. The Social Worker keeps the appointment book updated and coordinates transportation of facility made appointments. The Social Services Director reports to the monthly QA meeting regarding this plan of correction and the monthly audits to ensure consistent substantial compliance. These measures are in place by August 11, 2015.	

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F 152	Continued From page 2 An Acute Care Transfer Document Checklist included a checklist of the following items to be sent with the resident when transferred to the hospital: 1. Resident transfer form 2. Face sheet 3. Current medication list 4. SBAR and/or other change in condition progress note 5. Advance directives (durable power of attorney for health care, living will) 6. Advance care orders (POLST, MOLST, POST, others) This checklist had all areas except #6 checked off as included with the hospital transfer. Review of physician orders and the December Medication Administration Record (MAR) for Resident #4 noted medication to attempt to reduce the fever had not been administered to Resident #4 prior to the transfer to the hospital on 12/23/14. A physician's order on 12/23/14 read, Send to emergency room related to fever of 103.1. Resident #4 went to the hospital on 12/23/14 and returned later that day with diagnosis of influenza. On 07/09/15 at 11:30 AM the POA of Resident #4 stated she had been out of the country on 12/23/14 but had very specific instructions in the MOST form regarding hospital transfer for Resident #4. The POA stated these instructions had not been followed on 12/23/14 when Resident #4 was transferred to the hospital. The POA stated she would have thought the nurse would have asked the physician about giving medication to attempt to reduce the fever in lieu of transfer to the hospital.	F 152		

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F 152	Continued From page 3	F 152		

On 07/10/15 at 12:35 PM Nurse #6 (who had been the Director of Nursing on 12/23/14) stated that mid December residents in the facility started to show flu like symptoms and Resident #4 was transferred to the hospital for that reason. Nurse #6 noted the POA of Resident #4 was out of the country on 12/23/14 and a voicemail was left for the POA by Nurse #5 regarding the hospital transfer. Nurse #6 stated that, at the time, Nurse #5 was a new nurse and did not report the MOST information to the physician of Resident #4 prior to the decision to transfer to the hospital. Nurse #6 noted that nurses should always review MOST forms prior to sending a resident out of the facility to ensure any advance directives were honored.

An interview with Nurse #5 was not able to be done because Nurse #5 no longer worked at the facility and facility staff reported they did not have contact information for Nurse #5.

b. Review of the medical record of Resident #4 noted a physician's progress note dated 5/17/14 which indicated "please observe on back, skin tag very large with bleeding at times" and a note for "dermatology consult if okay with family." Written on the physician's note was a notation a copy of the physician's note was sent to the facility social worker on 05/19/14.

A social worker note in the medical record of Resident #4 dated 05/27/14 indicated the POA of Resident #4 was called about bathing preferences but did not mention the dermatology appointment.

A nurses note on 06/10/14 indicated Resident #4 was out of the facility for a dermatology

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F 152	Continued From page 4 appointment and returned with no new orders. A progress note from the dermatologist noted an examination was done with no treatment. On 07/10/15 at 4:00 PM the POA of Resident #4 reported she had recently found out Resident #4 had been sent to the dermatologist in June of 2014 when reviewing billing information. The POA stated she was not contacted to approve the dermatology appointment and would not have agreed to the appointment had she been contacted. Attempts were made to contact the former social worker on 07/10/15 (that was working in the facility 05/27/14) but the attempts were unsuccessful. On 07/10/15 at 5:00 PM Nurse #1 reported there had been many changes at the facility since May 2014 that she could not remember which staff member made appointments at that time. Nurse #1 stated the physician note from 05/17/14 was from a former physician who no longer worked at the facility. Nurse #1 stated since the note was sent to the former social worker that was probably the staff member that made the appointment. Nurse #1 stated she was not aware of any other staff currently working at the facility that could provide any additional information about the dermatology appointment for Resident #4 in June of 2014.	F 152		8.11.15
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior	F 166	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid	8.11.15

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F 166	Continued From page 5 of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to resolve concerns about a resident's care for 1 of 13 residents reviewed for grievances (Resident # 18). The findings included: Resident # 18 was admitted to the facility on 10/05/09 with diagnoses including Alzheimer's disease, hypertension and end stage renal disease. The most recent assessment was an annual Minimum Data Set (MDS) completed on 04/12/15. The MDS indicated Resident # 18 had severe cognitive impairment for daily decision making and was dependent on staff for provision of all activities of daily living (ADL). The MDS also indicated Resident # 18 was always incontinent of bowel and bladder. Review of a facility form titled "Concern Form" revealed instructions to use the form to provide written documentation of any concern expressed by a patient or patient representative and to record the follow-up action taken and results thereof. A Concern Form dated 05/07/14 indicated a family member of Resident # 18 had expressed concern that the resident wasn't being checked by staff for as long as 4 hours and staff wasn't providing the care the resident needed. A note on the form dated 05/08/14 indicated staff were educated on the care needs of Resident #18. The signature on the entry was unreadable	F 166	programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 166 In regards to the surveyors' concerns, the family member of Resident #18 was interviewed to ensure there were no issues or concerns about the care of Resident #18. Any issues or concerns were reported to the Administrator and an investigation initiated. The facility has determined that all residents are at risk for this alleged deficit practice. Residents and/or their Responsible Party were interviewed by the Social Worker on 8/7/15 to ensure there were no current issues, concerns, or grievances. Residents and/or their Responsible Parties were educated by the Social Worker regarding their rights to file a grievance and to have prompt efforts by the facility to resolve their grievance. Grievances, the investigation, and the follow-up resolution are documented on the green grievance form by the Social Worker, with signed oversight by the Administrator. The Administrator monitors the investigation and resolution of all grievances to ensure accurate and timely grievance investigations and resolution.	

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F 166	Continued From page 6 and current staff were not able to state who made the entry on the document. A second note on the form, which was signed by the former Social Worker, under "Resolution of Concern" indicated the Social Worker spoke with the family member on 05/29/14 at 10:20 AM and the family member stated there had been no change in the areas of concern. An interview on 07/10/15 at 5:08 PM with the Administrator revealed the concerns expressed by the family member of Resident # 18 were received in a care plan meeting and she didn't have any additional information about the grievance or the resolution. An interview on 07/10/15 at 5:44 PM with the current Social Worker, who was the Activity Director at the time the grievance was filed, revealed she didn't recall the grievance being discussed with department managers. An interview on 07/10/15 at 5:53 PM with the MDS Nurse revealed she didn't recall the concerns from 05/07/14. The MDS Nurse stated the family member of Resident # 18 often brought up similar concerns at care plan meetings including the most recent care plan meeting. The MDS Nurse stated she asked the former Administrator to meet with the family member and she didn't know if the family member's concerns were resolved as she had not had any further contact with him.	F 166	The facility provided an in-service program to all facility staff by the Director of Nursing and/or ADON by 8/10/15 regarding resident rights to file a grievance, the staff's responsibility to report the grievance, and the facility's responsibility to investigate the grievance and make efforts to provide a prompt resolution. All new or unresolved grievances are brought to the morning meeting by the Social Worker and discussed in the Morning Meeting with the Administrator and the Interdisciplinary Team until the grievance is resolved. The Administrator signs off once resolution is made and documentation is in place. The Social Worker will conduct weekly random audits with 5 different residents and/or Responsible Parties times 4 weeks, then monthly times three, to ensure resident issues are identified, investigated, and reported to the Administrator according to facility policies and procedures. All grievances, for the previous month, will be discussed at the monthly QA committee meeting to ensure consistent substantial compliance These measures are in place by August 11, 2015.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to	8.11.15

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F 225	Continued From page 7 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 225	participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 225 In regards to the surveyors' concerns, resident #35 was interviewed by the Social Worker and states that she has no concerns, that she has not been treated roughly and that no one has injured her or been abusive to her. All residents are at risk for the alleged deficient practice. Alert and Oriented residents in the facility were interviewed by the Social Worker by 8/7/15 regarding their concerns with rough or rude treatment, abuse, neglect, or misappropriation of their property. Alert and Oriented residents of this facility were educated by 8/7/15 by the Social Worker regarding their right to file a grievance or to report any instance of rough or rude treatment, abuse, neglect, or misappropriation of their property. All new or unresolved grievances are discussed daily in the morning meeting by the Administrator and the Interdisciplinary Team and a decision is made to implement remedies to correct any issues. All allegations of abuse, neglect, misappropriation, and/or injuries of unknown origin are reported immediately	

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F 225	Continued From page 8 facility failed to report a complaint of staff being rough with care within 24 hours to the State's Health Care Personnel Registry (HCPR), failed to complete a 5 day report on the same incident to the State's HCPR, failed to report an allegation of misappropriation and verbal abuse within 24 hours to the State's HCPR and failed to submit a 5 day report on the same incident to the State's HCPR for 2 of 3 reviewed abuse investigations involving one resident (Resident # 35). The findings included: 1. Resident # 35 was admitted to the facility on 08/12/14 with diagnoses including cerebrovascular disease, hypertension and diabetes mellitus. The most recent assessment for Resident # 35 was a quarterly Minimum Data Set (MDS) which was completed on 06/24/15. The MDS indicated Resident # 35 had no cognitive impairment and required extensive assistance from staff for all activities of daily living (ADL) except eating. The MDS also specified the resident did not refuse care or have any behavioral symptoms such as being verbally or physically abusive towards staff. A care plan which was last updated on 07/03/15 addressed Resident # 35's need for assistance with ADL and the interventions were appropriate to address her needs. A. Review of the facility's grievances revealed Resident # 35 made a report on 12/07/14 in which she alleged that Nurse Aide (NA) # 4, who gave her shower on 12/06/14, was rough with transferring her and caused her to hit her head on a shelf in the bathroom. Review of the facility's abuse investigations revealed no record that a 24 hour or 5 day report	F 225	to the Administrator. Reports to local law enforcement, state and federal agencies are reported to the appropriate agencies in accordance with State law through established procedures. All allegations of abuse, neglect, misappropriation, and/or injuries of unknown origin have a complete and thorough investigation initiated at the time discovered. If an allegation is made towards an employee, that employee is immediately suspended, pending investigation results. The 24 hour and 5 day reports are filed to the state by the Administrator and/or the Director of Nursing. An In-service education program was conducted for all facility employees by 8/10/15 by the Director of Nursing and/or ADON addressing Identifying, Prevention, and Reporting of any abuse, neglect, misappropriation, and/or injuries of unknown origin. Ongoing education is provided at orientation and periodically throughout the year by the ADON. All grievances are discussed at morning meeting ,by the Administrator and the Interdisciplinary team, to ensure compliance with established reporting procedures. All allegations of abuse, neglect, misappropriation, or injuries of unknown origin are reported to the Administrator immediately. The ADON and/or Unit Manager conducts random audits, weekly, times 4 weeks, then monthly times 4, of 5 residents to ensure that any injuries or allegations are identified, properly investigated, and reported to the appropriate people or agencies. This plan of correction and audits is brought by the Social Worker and is discussed at the monthly QA committee meeting, to ensure that consistent substantial compliance has been met.	

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F 225	Continued From page 9 was made to the State's HCPR or that any investigation was conducted. During an interview on 07/07/15 at 1:10 PM with Resident # 35 when she was asked if anyone had abused her, she stated a NA "jerked her back in the shower chair causing her to hit her head on a shelf in the shower because she didn't sit down fast enough to suit the NA." Resident # 35 stated she reported it to the nurse. An interview on 07/10/15 at 1:33 PM with the former Director of Nursing (DON), who was the DON at the time of the allegation, revealed it was the facility policy to send a 24 hour report and a 5 day report to the State's HCPR for all allegations of abuse, neglect or exploitation, to investigate the allegation and to suspend the accused staff member. She was unable to recall if she filed a 24 hour or 5 day report to the State's HCPR. The former DON stated she thought the Social Worker interviewed other residents who reported that NA # 4 provided good care. An interview on 07/10/15 at 3:55 PM with the Social Worker (SW) revealed she recalled interviewing other residents who were provided care by NA # 4 during the time of the alleged incident on 12/06/14. The SW stated none of the residents reported any problem with the care provided by NA # 4. The SW stated she gave documentation of the interviews to the former DON and didn't know why they weren't attached to the grievance. An interview on 07/10/15 at 5:10 PM with the Administrator revealed she didn't recall knowing about the allegation made by Resident # 35 on 12/07/14 and thought it might have been during	F 225	These measures are in place by August 11, 2015.	

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F 225	Continued From page 10	F 225		

the transition to the previous Administrator. The Administrator stated she would have filed a 24 hour and a 5 day report to the State's HCPR if she had known about the allegation.

B. Review of the facility's grievances revealed Resident # 35 made a report on 04/21/15 that NA # 5 and NA # 6 ate her snacks without asking, told her not to ring her call bell and put the call bell out of her reach. A statement on the grievance form by the current DON indicated both NAs were counseled and their resident assignments were changed.

Review of the facility's abuse investigations revealed no record that a 24 hour or 5 day report was made to the State's HCPR or that any investigation was conducted.

An interview on 07/10/15 at 5:46 PM with the SW revealed she interviewed other residents who were provided care by NA # 5 and NA # 6 during the time of the alleged incident on 04/21/15. The SW stated none of the other residents voiced any complaints about NA # 5 and NA # 6.

An interview on 07/10/15 at 6:08 PM with the DON revealed she investigated the allegation made by Resident # 35 on 04/21/15. When the DON was asked if she filed a 24 hour or 5 day report with the State's HCPR, she stated she did not. The DON stated she didn't know she was expected to report the allegation to the State HCPR.

An interview on 07/10/15 with the Administrator, who was not the Administrator on 04/21/15, about her expectation for reporting abuse and neglect revealed she expected a 24 hour and 5 day report

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE ON THE MOUNTAIN	417 MOUNTAIN TRACE ROAD SYLVA, NC 28779

(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 225	Continued From page 11 should be submitted to the State HCPR.	F 225		8.11.15
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow their abuse policy for reporting a complaint of staff being rough with care within 24 hours to the State's Health Care Personnel Registry (HCPR), failed to complete a 5 day report on the same incident to the State's HCPR, failed to report an allegation of misappropriation and verbal abuse within 24 hours to the State's HCPR and failed to submit a 5 day report on the same incident to the State's HCPR for 2 of 3 reviewed abuse investigations involving one resident (Resident # 35). The findings include: A document titled "Policy" which was undated, read in part: "The facility will report all allegations and substantiated occurrences of abuse, neglect and misappropriation of resident property to the state agency and law enforcement officials designated by state law. The facility will report any occurrences of abuse by registered or certified staff to the State Board as required by State Law."	F 226	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 226 In regards to the surveyors' concerns, the facility has an updated Abuse/Neglect Policy. Resident#35 has been interviewed by the Social Worker and has no concerns and makes no allegations of any abuse, neglect, and/or misappropriation. The Director of Nursing and Administrator, who were staff members of this facility on 4/21/15 or before that date, are no longer staff members of the facility. The facility has determined that all residents are at risk for this alleged deficit practice. All interviewable residents and/or their legal representatives were interviewed by 8/10/15 by the Social Worker to ensure there are no allegations of abuse, neglect,	

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F 226	Continued From page 12 1. Resident # 35 was admitted to the facility on 08/12/14 with diagnoses including cerebrovascular disease, hypertension and diabetes mellitus. The most recent assessment for Resident # 35 was a quarterly Minimum Data Set (MDS) which was completed on 06/24/15. The MDS indicated Resident # 35 had no cognitive impairment and required extensive assistance from staff for all activities of daily living (ADL) except eating. The MDS also specified the resident did not refuse care or have any behavioral symptoms such as being verbally or physically abusive towards staff. A care plan which was last updated on 07/03/15 addressed Resident # 35's need for assistance with ADL and the interventions were appropriate to address her needs. A. Review of the facility's grievances revealed Resident # 35 made a report on 12/07/14 in which she alleged that Nurse Aide (NA) # 4, who gave her a shower on 12/06/14, was rough with transferring her and caused her to hit her head on a shelf in the bathroom. Review of the facility's abuse investigations revealed no record that a 24 hour or 5 day report was made to the State's HCPR or that any investigation was conducted. During an interview on 07/07/15 at 1:10 PM with Resident # 35 when she was asked if anyone had abused her, she stated a NA "jerked her back in the shower chair causing her to hit her head on a shelf in the shower because she didn't sit down fast enought to suit the NA." Resident # 35 stated she reported it to the nurse. An interview on 07/10/15 at 1:33 PM with the	F 226	and/or misappropriation, and if there are, the Administrator is notified immediately and a complete and thorough investigation is conducted. No allegations were reported. An In-service education program was conducted to all facility staff by 8/10/15 by the Director of Nursing and/or ADON regarding the facility Policy and Procedures concerning Abuse, Neglect, and Misappropriation of resident property. The policy is posted in the employee lounge and all employees are in-serviced to the policy at orientation, and periodically, throughout the year by the ADON. The Director of Nursing and/or ADON will conduct random audits, weekly times 4 weeks, then monthly times 4, of 5 residents to ensure there are no allegations of abuse, neglect, or misappropriation of resident property, and if so, the Administrator is notified immediately, and a complete and thorough investigation is conducted. If an allegation is made about an employee, the employee is suspended immediately, pending investigation results. These weekly audits and this plan of correction are discussed at the monthly QA Committee meeting until such time that consistent substantial compliance is met. The QA committee reviews the Abuse Policy, along with any Reportables for the month, to ensure that any Reportable was investigated and reported per facility policy. These measures are in place by August 11,2015.	

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F 226	Continued From page 13	F 226		

former Director of Nursing (DON), who was the DON at the time of the allegation, revealed it was the facility policy to send a 24 hour report and a 5 day report to the State's HCPR for all allegations of abuse, neglect or exploitation, to investigate the allegation and to suspend the accused staff member. The former DON stated she recalled talking to NA # 4 but couldn't recall if she suspended NA # 4 while the allegation was investigated although she knew that was the facility policy. She also was unable to recall if she filed a 24 hour or 5 day report to the State's HCPR. The former DON stated she thought the Social worker interviewed other residents who reported that NA # 4 provided good care.

An interview on 07/10/15 at 2:53 PM with the Human Resources Director (HRD) revealed NA # 4 was suspended during the investigation and was allowed to return to work when the allegation was found unsubstantiated.

An interview on 07/10/15 at 3:55 PM with the Social Worker (SW) revealed she recalled interviewing other residents who were provided care by NA # 4 during the time of the alleged incident on 12/06/14. The SW stated none of the residents reported any problem with the care provided by NA # 4. The SW stated she gave documentation of the interviews to the former DON and didn't know why they weren't attached to the grievance.

An interview on 07/10/15 at 5:10 PM with the Administrator revealed she didn't recall knowing about the allegation made by Resident # 35 on 12/07/14 and thought it might have been during the transition to the previous Administrator. The Administrator stated she would have filed a 24

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F 226	Continued From page 14 hour and a 5 day report to the State's HCPR if she had known about the allegation. B. Review of the facility's grievances revealed Resident # 35 made a report on 04/21/15 that NA # 5 and NA # 6 ate her snacks without asking, told her not to ring her call bell and put the call bell out of her reach. A statement on the grievance form by the current DON indicated both NAs were counseled and their resident assignments were changed. Review of the facility's abuse investigations revealed no record that a 24 hour or 5 day report was made to the State's HCPR or that any investigation was conducted. An interview on 07/10/15 at 5:46 PM with the SW revealed she interviewed other residents who were provided care by NA # 5 and NA # 6 during the time of the alleged incident on 04/21/15. The SW stated none of the other residents voiced any complaints about NA # 5 and NA # 6. An interview on 07/10/15 at 6:08 PM with the DON revealed she investigated the allegation made by Resident # 35 on 04/21/15. The DON stated she thought Resident # 35 made the accusations in an attempt to get her family to take her home. When the DON was asked if she filed a 24 hour or 5 day report with the State's HCPR, she stated she did not. When the DON was asked about the facility policy for reporting allegations of abuse and neglect, she stated the policy specified that she report it to the Administrator, which she did. The DON stated she didn't know she was expected to report the allegation to the State's HCPR.	F 226		

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F 226	Continued From page 15 An interview on 07/10/15 with the Administrator, who was not the Administrator on 04/21/15, about her expectation for reporting abuse and neglect revealed she expected the accused staff to be suspended while an investigation was conducted and a 24 hour and 5 day report should be submitted to the State's HCPR.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to honor a resident's choice about being given psychotropic medication for 1 of 3 residents reviewed for choices (Resident # 103). The findings included: Resident # 103 was admitted on 03/18/14 with diagnoses including traumatic fracture of lower leg, closed fracture of upper end of tibia (the front bone in the lower leg), muscle weakness and anxiety. An admission Minimum Data Set (MDS) assessment dated 03/25/14 indicated the resident was cognitively intact for daily decision making. Review of a care plan dated 03/28/14 which addressed the resident's mood and anxiety	F 242	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 242 In regards to the surveyors' concerns, Resident # 103 was discharged from this facility, prior to the date of the annual survey. The facility has determined that all residents are at risk for this alleged deficit practice. An audit was conducted by 8/09/15 on all residents' medical records to determine which residents are on psychotropic	8.11.15

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F 242	Continued From page 16 included the following interventions: "explain care in advance to resident; provide services if desired by the resident and ordered by the physician." Review of a Hospital Discharge summary for Resident # 103 dated 03/18/14 revealed the discharge medications included a multivitamin daily and Vistaril (a medication used to treat anxiety) 25 milligrams (mg) every 8 hours as needed for anxiety. Review of the facility's admission orders for Resident # 103 dated 03/18/14 revealed they included a multivitamin daily and Vistaril 25 mg every 8 hours as needed. A physician's order dated 03/28/14 prescribed Seroquel (an anti-psychotic medication) 25 mg twice daily for diagnosis of mood disorder. A physician's order dated 04/01/14 read: "discontinue Seroquel 25 mg twice daily; discontinue multivitamin daily per resident's request." A note by the psychiatric nurse practitioner dated 03/28/14 indicated Resident # 103 was referred for psychiatric evaluation and medication management. The note indicated the resident had tangential thoughts (easily switched topics of conversation and had trouble staying on track) and initially expressed sad feelings, hopelessness and difficulty with sleep and energy but later denied. Review of the March 2015 Medication Administration Record (MAR) revealed documentation that Resident # 103 was given a multivitamin daily from March 19 - March 26, 2015. Seroquel 25 mg twice daily was entered on	F 242	medications and which residents had signed consents for those psychotropic medications in their medical records. Signed or verbal consents were obtained from the residents and/or their legal representatives. Refusals for psychotropic medications were communicated to the resident's physician. Signed consents are placed in the medical records and verbal consents are noted in the medical record. The facility provided In-services to all facility staff by 8/09/15 by the ADON/MDS, and/or Unit Manager regarding Resident Rights. Inservice was provided to licensed nurses by the DON/ADON, or Unit Manager by 8/10/15 regarding notifying residents and/or their legal representatives of new psychotropic medications prescribed, obtaining a signed consent to go in the medical record, or communicating to the physician regarding refusals. New psychotropic drug orders are discussed, at morning clinical meeting. New orders for psychotropic medications are communicated to the resident and/or their legal representative by the Unit Manager and a signed consent is obtained. Refusals are communicated to the physician. The MDS Coordinator conducts random audits, weekly of 5 residents, times 4 weeks, then monthly times 4 months for consent forms to be on medical records for those resident receiving psychotropic drugs. The Director of Nursing and/or ADON report to QA monthly on new psychotropic orders that were received and whether the signed consent was obtained and placed on the chart or if a refusal was communicated to the physician. This QA process remains in place on a ongoing basis. These measures are put in place by August 11,2015.	

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F 242	Continued From page 17 the MAR on 03/28/15 but all doses were circled. Documentation on the back of the MAR revealed Resident # 103 refused the Seroquel. Review of the April 2015 MAR revealed Resident # 103 was given Seroquel 25 mg at 8:00 AM on 04/01/15. The MAR indicated the multivitamin and Seroquel were discontinued on 04/01/15. Review of the nurses notes revealed an entry dated 03/29/14 at 11:00 AM which indicated Resident # 103 refused Seroquel and stated she didn't know it had been prescribed. A 03/31/14 nurses note indicated Resident # 103 refused all her morning medications except medications for pain and stated she didn't need them any more. An interview on 07/10/15 at 4:42 PM with Nurse # 1 revealed she remembered Resident # 103 and Nurse # 1 stated the resident was able to make her own health care decisions. Nurse # 1 was asked about the facility policy for notifying residents, who were their own responsible party, of new medication orders especially psychotropic medications. Nurse # 1 stated the facility used a specific form that the resident signed as a consent. Nurse # 1 stated the medication nurses usually discussed new orders with residents. Nurse # 1 reviewed Resident # 103's medical record and confirmed there was no documentation in the nurses notes or physician progress notes that resident was informed about the Seroquel. Nurse # 1 was unable to locate a consent form that was signed by the resident	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to	8.11.15

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F 281	Continued From page 18 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to transcribe and implement the physician's order for lab work for 1 of 7 residents reviewed for unnecessary medications (Resident #34). The findings included: Resident #34 was admitted to the facility on 09/04/14 with diagnoses that included low potassium, high blood pressure, dementia, and anxiety. A review of Resident #34's medical record indicated she had pharmacy reviews of her medication regimen on a monthly basis. On 10/20/14 during a review of Resident #34's medications, the pharmacist made a recommendation to the physician for a basic chemistry panel to be drawn. Further review of the medical record indicated the physician initialed the pharmacy recommendation for the lab to be drawn. Review of the physician orders for the October to November 2014 time period indicated the physician order was not transcribed in the medical record. Review of Resident #34's lab results revealed the chemistry panel ordered on 10/20/14 was not completed. On 07/08/15 at 4:30 PM an interview was conducted with the Director of Nursing (DON). She indicated when a pharmacist wrote a recommendation for labs, the recommendation was to be faxed to the physician for his review. The DON acknowledged the physician had initialed the pharmacy request for labs, indicating his agreement with the recommendation. On 07/08/15 at 4:40 PM Nurse #1 called the lab	F 281	participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 281 In regards to the surveyors' concerns, the medical record for Resident #34 was reviewed and all labs are current, results filed in the medical record, and the physician notified of the results. The facility has determined that all residents are at risk for this alleged deficit practice. An audit was conducted by the ADON of all current residents' medical records to ensure that labs are being drawn per physician orders, transcribed correctly, and a lab requisition is written for the lab to be drawn, and that labs are drawn. When an order is received for a lab to be drawn, the nurse notes the order, and makes a notation in the lab book for the date the lab is to be drawn. The night nurse fills out the lab requisition form on the date the lab is to be drawn. After the lab is drawn, there is daily follow-up by the ADON or Unit Manager to ensure the results are returned to the facility, results communicated to the physician, and the results filed in the medical record. All pharmacy recommendations are communicated to the	

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F 281	Continued From page 19 company that provided lab services for the facility. She revealed the lab company did not receive an order for the lab work and it was not completed. On 07/08/15 at 4:45 PM an interview was conducted with the DON. She revealed the order for the lab should have been written and a lab requisition filled out by the nurse on duty when the order was received. She stated it appeared the lab request was filed and the order was not written. The DON stated it was her expectation when a physician reviewed and initialed a pharmacy request, that the order be written by the nurse that received the request and the lab should be completed.	F 281	physician for review and orders transcribed correctly and requisitions written, and the labs drawn and results received. The facility provided an In-service program to licensed nursing staff by 8/10/15 by the ADON and/or MDS Coordinator regarding Following Physician Orders, transcribing correctly, writing lab requisitions, and follow-up with lab results and physician notification. The Director of Nursing, ADON, or Unit Manager audits the lab book 5 times a week to ensure compliance with scheduled lab draws. The Director of Nursing, ADON, or Unit Manager conducts weekly random audits on 5 residents times 4 weeks, then monthly times 4 months to ensure labs are current, results are in the medical record, and the physician was notified.	
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 observations, staff interviews and record reviews the facility failed to provide follow up assessment after initial treatment related to an eye injury, medications as ordered by the physician, and pain medication before a dressing change for 3 of 8 residents reviewed for wellbeing. (Residents #4, #64 and #74). Findings Included:	F 309	The Assistant Director of Nursing, or Unit Manager, reports in morning meeting which labs were drawn for the day. The Assistant Director of Nursing, or Unit Manager, audits lab draws, for that day, before the end of the day, to ensure results have been obtained and that follow-up has been done. The Plan of Correction and random audits are monitored by the monthly QA committee and recommendations made, to ensure compliance. These measures are in place by August 11, 2015. This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency	8.11.15

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F 309	Continued From page 20 1. Resident #64 was admitted to the facility on 07/14/14. Diagnoses included chronic kidney disease, muscle weakness and depressive disorder. Quarterly Minimum Data Set (MDS) dated 01/13/15 recorded Resident #64 was moderately cognitively impaired and indicated he required extensive assistance with transfers, toileting and personal hygiene. Resident #64's care plan dated 07/03/15 listed a problem of OS (left eye) corneal abrasion and subconjuntival hemorrhage. The care plan goal was for the resident to have no complications by next review period. Approaches included treatment as ordered and follow up with a specialist as needed. Hospital discharge instructions dated 07/03/15 directed Resident #64 to receive a follow up assessment at an eye clinic in 3 days. The hospital discharge instructions directed Resident #64 to have a follow up appointment at an eye clinic on Monday 07/06/15 even if the eye was healed. Resident #64's medical record was reviewed on 07/10/15. The review of records revealed a nursing progress note written by Nurse #1 dated 07/03/15 at 3:00 PM. The note indicated Resident #64 had been sent to the emergency room (ER) to be evaluated related to an injury to his left eye and had returned to the facility with new orders and a diagnosis. The review of records also revealed a nurse progress note dated 07/03/15 at 5:00 PM written by the Director of Nursing (DON). This note specified Resident #64 had returned from the hospital with a diagnosis of OS corneal abrasion and subconjunctional hemorrhage. Further review of	F 309	exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 309 With regards to the surveyors' concerns, Resident #74 has been discharged from the facility. Resident #64 had an eye consult on 7/10/15 with Asheville Eye Associates that noted the corneal abrasion was well-healed. He was seen on 7/14/15 at Family Medical Center regarding his eye and had an eye exam on 7/22/15 where no corneal abrasion was noted. Resident #4 is receiving her medications, per physician orders, in a timely manner. No adverse outcome was noted from missed medications. If a medication is not available, the pharmacy is notified immediately. If unable to administer the medication, the physician and legal representative are notified. The facility has determined that all residents are at risk for this alleged deficit practice. Audits were done by 8/10/15 by the DON, ADON, and/or MDS Coordinator to ensure that all appointments are current for the residents and that follow up appointments were made. All prescribed medications were available. New medications that are unavailable have the pharmacy and physician notified immediately. Efforts are made to obtain the medication from the	

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F 309	Continued From page 21 Resident #64's medical record conducted on 07/10/15 did not contain any record of a follow up assessment being performed by a physician or other qualified medical provider related to Resident #64's left eye injury which occurred on 07/03/15. A staff interview was conducted with Nurse #2 on 07/10/15 at 2:16 PM. Nurse #2 verbalized she did not reference the order from the hospital discharge instructions for Resident #64 to receive a follow up assessment at an eye clinic within 3 days when she spoke with the facility's on call physician via telephone upon Resident #64's return to the facility from the hospital on 07/03/15. Nurse #2 reported she did not take any other action to notify the facility provider of Resident #64's order for a follow up assessment at an eye clinic. Nurse #2 verbalized the facility transporter was supposed to put a copy of discharge instructions on the DON's door so follow up appointments may be scheduled. Nurse #2 added she knew a facility provider would be in to see residents prior to the date the follow up was ordered and thought a facility provider would assess Resident #64 then. A staff interview was conducted with Nursing Assistant (NA) #1 on 07/10/15 at 4:15 PM. NA #1 reported he transported Resident #64 back to the facility from the ER on 07/03/15. NA #1 verbalized he did not recall placing a copy of the discharge instructions on the DON's door when he returned to the facility from the ER. A staff interview was conducted with the DON on 07/10/15 at 3:12 PM. The DON reported she was present in the facility on 07/03/15 when Resident #64 was transported to the hospital. The DON	F 309	back-up pharmacy during off-hours. Consulting physician orders or follow-up appointments are audited to ensure orders were noted and follow up appointments scheduled. The facility provided education programs to licensed nurses by the ADON and/or MDS Coordinator by 8/10/15 regarding following physician orders for consults, making appointments, and scheduling transportation to the appointments. The facility also provided In-service programs to the licensed nurses by the ADON and/or MDS Coordinator by 8/10/15 regarding Following Physician Orders for Medication Administration in a timely manner and Notifying the pharmacy, and physician when a medication is not available. Nurses make an effort to obtain the medication through the back-up pharmacy during off-hours. The Director of Nursing, ADON, and/or Unit manager review new orders, consulting physician orders, and appointments at the morning clinical meeting to ensure compliance. The Unit Manager reviews papers from consulting physicians for orders or follow-up appointments. The Director of Nursing, ADON, and/or Unit Manager conducts random audits of 5 residents per week, times 4 weeks, then monthly ongoing, to ensure consulting physician orders and appointments are followed. The Director of Nursing reports to the monthly QA Committee meeting, ongoing, regarding this plan of correction and the random audits to ensure consistent substantial compliance. These measures are in place by August 11, 2015.	

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F 309	Continued From page 22 added she was also present upon Resident #64's return from the hospital on 07/03/15. The DON verbalized it was her expectation when a resident returned from the hospital, the nurse receiving the resident back into the facility review the discharge instructions completely with the facility provider. The DON added it was her expectation staff who transport residents place a copy of hospital discharge instructions and any other information concerning resident care on her door when they return residents from receiving medical treatment outside the facility. The DON verbalized she reviewed hospital discharge instructions and other information concerning resident care she found on her door. She added she ensured orders have been reviewed by the facility provider and follow up appointments were properly scheduled. 2a. Resident #4 was admitted to the facility on 06/08/13 with diagnoses that included: malnutrition, pressure ulcer, fractured femur, osteoarthrosis, anxiety, kidney disease, pain, altered mental status, depression, hypertension, Hodgkin disease and a history of colon cancer. A significant change Minimum Data Set dated 05/26/15 noted Resident #4 was assessed with severe cognitive impairment.	F 309		

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Review of the medical record revealed a physician's order on 12/23/14 to transfer Resident #4 to the hospital due to a fever of 103. Hospital medical records noted Resident #4 was diagnosed at the hospital with influenza, administered Tamiflu (a medication to treat influenza), and returned to the facility later that day with orders to take Tamiflu twice a day, for five days.

Physician orders on 12/23/15 included Tamiflu, 75 milligrams, every 12 hours for five days. This order was transcribed on the December 2014 Medication Administration Record of Resident #4 and the first dose of Tamiflu was documented as given to Resident #4 on 12/26/14. The Tamiflu was documented as given twice a day from 12/26/14-12/30/14. A nurses progress note in the medical record of Resident #4 noted on 12/26/14, "Patient complained of pain all over. Started Tamiflu today for fever and congestion after being sent to hospital."

On 07/08/15 at 4:00 PM the Family Nurse Practitioner (FNP) of Resident #4 stated although medication should be administered as ordered the delay in receiving the Tamiflu at the facility could have been due to the shortage of Tamiflu last December. The FNP stated the Tamiflu should have been administered after it arrived 12/24/14.

On 07/09/15 at 9:00 AM the Director of Nursing (DON) stated she reviewed the pharmacy manifest for the Tamiflu for Resident #4 and noted it arrived at the facility after midnight on 12/24/14. The DON stated she was not the DON December 2014 could not explain why Resident #4 did not receive the Tamiflu on 12/25/14. The

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F 309	Continued From page 24 DON identified Nurse #5 as the staff member that worked with Resident #4 on 12/25/14 when the Tamiflu was scheduled to be administered (per the December 2014 MAR) at 8:00 AM and 8:00 PM. The DON stated Nurse #5 no longer worked at the facility and did not have contact information available for Nurse #5. On 07/10/15 at 12:35 PM Nurse #6 (the DON December 2014) stated she remembered there was a delay in starting the Tamiflu for Resident #4 after it was ordered on 12/23/14 but could not recall the reason for the delay. b. Resident #4 was admitted to the facility on 06/08/13 with diagnoses that included: malnutrition, pressure ulcer, fractured femur, osteoarthrosis, anxiety, kidney disease, pain, altered mental status, depression, hypertension, Hodgkin disease and a history of colon cancer. A significant change Minimum Data Set dated 05/26/15 noted Resident #4 was assessed with severe cognitive impairment. Review of care plans for Resident #4 noted a care plan problem area dated 8/19/14 which included, Has chronic pain related to osteoarthritis, degenerative joint disease shoulders and knees, pressure ulcer left bunion area, history of left mastectomy, history of fractured hip. One of the approaches to this problem area was to assess pain on an ongoing basis. Review of physician orders in the medical record of Resident #4 noted an order written 07/31/14 for Hospice services. Changes were made to the medications of Resident #4 and included an order on 08/05/14 for Fentanyl (a medication for pain) 12 micrograms/hour patch, apply one patch	F 309		

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F 309	Continued From page 25 topically every 72 hours. Review of the August 2014 Medication Administration Record (MAR) for Resident #4 noted the Fentanyl was added to the MAR with administration blocked off for the Fentanyl patch to be applied 08/06/14, 08/09/14, 08/12/14 and 08/15/14. The MAR was initialled and circled (which indicated it was not administered) on 08/06/14, 08/09/14 and 08/12/14. Review of the pharmacy manifest and Controlled Drug Record of the Fentanyl for Resident #4 noted the Fentanyl (ordered 08/05/14) was first administerd 08/13/15. A progress note dated 08/13/14 by the hospice social worker in the medical record of Resident #4 noted, "Patient alert, complained of pain in chest. Bunion area left great toe joint dressed with Calcium Alginate and border dressing. Fentanyl was ordered in chart on 08/05/14, however hard script for this not written until today. Reason unknown by staff." Review of concern forms noted a concern dated 08/14/14 by Nurse #6 (the former Director Of Nursing) which addressed Fentanyl had not been administered to Resident #4 from 08/06/13-08/13/14. The concern form indicated the Fentanyl was not available to be given because the pharmacy assumed there was Fentanyl available in the facility for Resident #4. Nurse #6 indicated Resident #4 had been on Fentanyl up until 07/22/14 when there was a decline in the resident's condition and most medications (including Fentanyl) had been discontinued. Nurse #6 explained the leftover Fentanyl patches had been returned to the pharmacy on 07/23/14 and, once the issue was	F 309		

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F 309	Continued From page 26 discovered, Fentanyl was ordered and a patch applied on 08/13/14. Review of subsequent MARs and the Controlled Drug Record for Resident #4 revealed the following: Fentanyl was not administered 09/12/14, 09/15/14, 10/21/14, 01/16/15 and 01/19/15. Notation on the back of the MAR indicated the Fentanyl was not available 10/21/14 and 01/16/15. On 7/10/15 at 10:10 AM Nurse #1 stated she worked with Resident #4 on 08/06/14 and 09/15/14 and, if the Fentanyl wasn't available, she would have called the pharmacy and passed the information on to the oncoming nurse. Nurse #1 stated if a hard script was needed she would have called the doctor for that. Nurse #1 stated she could not remember the circumstances surrounding the Fentanyl patch for Resident #4 on 08/06/14 and 09/15/14 but indicated if it was circled or left blank on the MAR that indicated it was not administered as ordered. On 07/10/15 at 12:35 PM Nurse #6 (the former DON) stated she recalled there were times the Fentanyl was not available to be administered to Resident #4 as ordered but could not recall the reasons. Nurse #6 stated nurses would have known they needed a hard script when narcotic medication was re-ordered from the pharmacy. On 07/10/15 at 6:50 PM Nurse #8 stated she worked on 01/16/15 with Resident #4 and, though she could not remember the exact reason Fentanyl was not available, she supposed it was because the hard script had not been filled out. Nurse #8 stated there was ongoing problems with	F 309		

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F 309	Continued From page 27 narcotics not always being available to be administered to residents because a hard script had to be completed for each request for refill from the pharmacy. Nurse #8 stated there was poor response to requests for a hard script from the physicians office and usually staff waited until the physician was in the facility to write the hard script. Attempts were made to contact nursing staff that worked with Resident #4 on 08/09/14, 08/12/14, 09/12/14 and 01/19/15 but were unsuccessful. 3. Resident #74 was admitted to the facility 03/19/15 with diagnoses which included history of stroke with left sided paralysis, failure to thrive, and pressure ulcer to right heel. a. An admission Minimum Data Set (MDS) dated 03/26/15 indicated the resident's cognition was intact. The MDS specified the resident required extensive staff assistance with activities of daily living and had an unstageable pressure ulcer on admission. A Care Area Assessment (CAA) dated 04/01/15 specified Resident #74 was admitted with an unstageable pressure ulcer to the left heel. The area was being treated and monitored. The resident was at risk for developing further pressure ulcers related to issues that included impaired mobility from a stroke with left sided paralysis and variable nutrition. The CAA also contained good nutritional intake was encouraged. A review of Resident # 74's medical record	F 309		

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F 309	Continued From page 28 revealed a blood analysis completed 06/17/15 specified the resident's albumin level (a measure of a resident's protein status) was 2.7 deciliters (G/DL). The normal albumin reference range was noted on the blood analysis report as 3.5 - 5.0 G/DL. A quarterly MDS dated 06/22/15 assessed Resident #74 at risk for development of pressure ulcers. The MDS further specified no pressure ulcer was present at this time. Further review of Resident #74's medical record revealed a physician's order dated 06/30/15 for a wound consult for an opened pressure ulcer on the resident's heel. An additional physician's order dated 06/30/15 was noted for a liquid protein supplement (used to promote improved albumin levels and tissue healing) 30 centimeters daily to promote wound healing. A review of the Medication Administrator Record (MAR) dated 07/01/15 through 07/31/15 revealed no documentation for the ordered supplement and no indication it had been initiated or administered. An interview was conducted with the Director of Nursing (DON) on 07/08/15 at 3:44 PM. She stated the supplement order was written on 06/30/15 and the last check of the MAR for the new month was done 06/26/15 as designated by signatures on the MAR. The DON stated the night nurse that placed the MARs into the medication administration book for the next month should do a final check on orders written the last days of the previous month. The DON pointed out the order was noted at 10:30 PM on 06/30/15. The DON added she expected all medications/supplements were on the MAR when the new monthly MARs went into use. An interview with Nurse #3 on 07/08/15 at 4:30 PM confirmed she noted the supplement order at	F 309		

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F 309	Continued From page 29 10:30 PM on 06/30/15. She stated she should have written the new order on the July MAR. Nurse #3 added the night nurse that relieved her should have checked to see that she did add the supplement. An interview with Nurse #4 on 07/09/15 at 8:28 AM revealed she was the night nurse that relieved Nurse #3 on 06/30/15. Nurse #4 stated it was her job to check the orders that were written the last days of the month to assure they were on the following month's MAR. She stated she just missed the supplement order. An interview was conducted via phone with the Registered Dietician (RD) on 07/10/15 at 3:29 PM. The RD stated the protein supplement was ordered in an attempt to improve Resident #74's albumin level to promote wound healing and felt the missed dose of the supplement for 8 days would not harm the resident. b. A quarterly Minimum Data Set (MDS) dated 06/22/15 indicated Resident #74's cognition was intact. The MDS assessed the resident required extensive staff assistance to total dependence on staff for all activities of daily living. The MDS specified the resident experienced frequent pain and received pain medication on an as needed basis. During the assessment the resident was assessed with pain at an intensity of 5 on a scale of 0 to 10. A review was conducted of Resident #74's Physician's Monthly Orders dated 07/01/15 through 07/31/15. The orders were signed by the facility's Medical Director. Instructions were provided to monitor for signs and symptoms of pain on a scale from 0 to 10. The Physician's Monthly Orders also contained instructions for Oxycodone 10 milligrams by mouth every 4 hours as needed (for pain). An observation was conducted on 07/08/15 at	F 309		

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F 309	Continued From page 30 3:17 PM of Unit Manager (UM) performing a dressing change to the wound on Resident #74's left heel. UM was observed explaining to Resident #74 the procedure of changing the dressing. The wound appeared to be approximately the size of a penny with an opening extendending down into the heel . During the wound care, the resident complained frequently of pain when the wound was touched or the left lower extremity was moved. Following the procedure the UM stated she would see about getting the resident a pain pill. Resident #74 stated he needed a pain pill. An interview was conducted with UM on 07/08/15 at 3:37 PM. The UM stated it was her usual practice to ask the resident if pain medication was needed before the dressing change. She stated she forgot to ask today and should have done so. An interview was conducted with Nurse #3 on 07/08/15 at 3:39 PM. Nurse #3 was Resident #74's medication nurse. She confirmed the last time Resident #74 received pain medication for breakthrough pain was 10:30 AM on 07/08/15.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and	8.11.15

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F 315	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to utilize an authorized cleansing agent while providing care for an indwelling urinary catheter for 1 of 1 resident observed for catheter care. (Resident #74). The findings included: A review of a facility policy dated October 2010 related to perineal care revealed the purpose of the policy included to provide cleanliness and comfort to the resident and to prevent infections. The policy specified to use a wet washcloth and apply soap or a skin cleansing agent. The policy further specified if the resident had an indwelling urinary catheter, gently wash the catheter tubing from the urethra (opening leading to the urinary bladder) down the catheter about 3 inches. Gently rinse and dry the area. Resident #74 was admitted to the facility 03/19/15 with diagnoses which included history of stroke, urinary retention, and a history of urinary tract infections. A care plan dated 04/08/15 identified Resident #74 with an indwelling urinary catheter due to urinary retention. The care plan goal specified the resident would be free from further complications and would be clean and dry through the next 90 day review. Interventions included catheter care as ordered. A quarterly Minimum Data Set (MDS) dated 06/22/15 indicated Resident #74's cognition was intact. The MDS specified the resident required extensive assistance of 2 staff for personal hygiene and toileting. The MDS coded the resident as having an indwelling urinary catheter. A review of Resident #74's medical record	F 315	submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 315 In regards to the surveyors' concerns, Resident # 74 has been discharged from the facility. Until discharge, the resident had catheter care completed per policy using soap and water and proper procedure. The Nurses' Aide was inserviced regarding proper catheter care using soap and water. The facility has determined that all residents with indwelling catheters are at risk for this alleged deficit practice. Observations of all residents with indwelling catheters were conducted by the ADON by 8/10/15 to ensure that catheter care is completed per facility policy and procedures. The Nursing Aides have proper supplies in place to perform catheter care per policy. The facility provided In-service program to Nurses' Aides by 8/10/15 by the ADON and/or MDS Coordinator regarding proper catheter care and proper incontinence care, per facility policy and procedures. The Director of Nursing, ADON, or Unit Manager conduct weekly random audits on 5 Nurses' Aides for catheter care and/or incontinence care to ensure consistent substantial compliance. These audits continue 5 times per week until all current Nurses Aides have proven competency. The Nurses' Aide Catheter Care audits are recorded on a competency form and monitored by the Director of Nursing. Nurses Aides not performing Catheter care or Incontinence care properly, during	

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F 315	Continued From page 32 revealed physician's monthly orders dated 07/01/15 through 07/31/15. The orders contained directions for indwelling urinary catheter care every shift. The physician's monthly order was signed by the facility's Medical Director. An observation of catheter care was conducted on 07/08/15 at 2:35 PM. Nurse Aides (NA) #2 and #3 provided the care. NA #2 was observed using a peri wipe (a disposable antiseptic wipe) to provide perineal care. During the procedure she switched to a washcloth which she moistened with water. She followed the proper procedure of wiping the catheter starting at the urethra and moving toward the catheter bag but was not observed using soap or a skin cleansing agent. An interview was conducted with NA #2 on 07/08/15 at 2:51 PM. NA #2 stated she used a washcloth wet with water for Resident #74's catheter care. She stated it was her usual practice to use soap on the washcloth when she provided catheter care. She added she was unable to find soap in Resident #74's bathroom. NA #2 explained soap was kept in the residents' bathrooms but it had been removed. She was unable to provide a reason it was moved and the location of the soap at present. An interview was conducted with the Director of Nursing (DON) on 07/08/15 at 5:10 PM. She stated soap and other toiletries used by each resident had been removed from bathrooms and placed in a plastic bag. She added the bag was stored in each resident's bedside table in the resident's room. The DON stated facility staff had been informed of this change. An additional interview with the DON on 07/10/15 at 3:54 PM revealed the DON expected staff to use peri wipes or soap for catheter care.	F 315	auditing, have an immediate 1:1 In-service and are monitored while doing catheter care until proving competency. The Director of Nursing, ADON, or Unit Manager reports to the monthly QA Committee the results of audits, the current number of residents with indwelling catheters, and the plan of correction to ensure consistent substantial compliance. These measures are in place by August 11, 2015.	8.11.15
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by	

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F 334 SS=D	Continued From page 33 IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 334	the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 334 With regards to the surveyors' concerns, Resident #4's legal representative has been sent Vaccination Information material and a consent form for the 2015 Influenza season. Education is also provided for the Pneumococcal vaccination to the residents' legal representative. The facility has determined that all residents are at risk for this alleged deficit practice. Vaccination Information has been provided to the residents and/or their legal representatives by registered letter sent by the Administrator on 8/7/15 regarding the 2015 Influenza season and the need for a Pneumococcal vaccination. Consent forms are also provided to be returned signed in order for the resident to receive needed vaccinations which are to be available when the October Influenza season begins. The facility provided education to licensed nursing staff by 8/10/15 by The ADON and/or the MDS Coordinator regarding Influenza and Pneumococcal vaccinations	

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F 334	Continued From page 34 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on family and staff interview and medical record reviews, the facility failed to obtain consent for and administer an influenza immunization to 1 of 5 residents reviewed for immunizations (Resident #4). The findings included: Resident #4 was admitted to the facility on 06/08/13. Diagnoses included Alzheimer's Disease.	F 334	and that signed consents must be on the medical record before initiating vaccinations. Vaccinations must be given timely, after consents are signed, when vaccinations are available at the facility's pharmacological provider. Influenza season begins October 1, 2015. The Director of Nursing, ADON, or Unit Manager will receive the signed consents, place the original in the residents' medical record, and make a copy to go into a master binder. The Director of Nursing will audit progress with this plan of correction, weekly, to ensure that education has been provided, consents returned signed, and that vaccinations are given timely, per physician orders. By October 1st, the Social Worker will contact any resident and/or legal representative that have not returned a signed consent, and remind them of the need for a signed consent to be returned to the facility. The Director of Nursing reports to the monthly QA Committee meeting regarding the plan of correction, the current status of consents received, and vaccinations given until substantial compliance is met. These measures are in place by August 11, 2015.	

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F 334	Continued From page 35 A significant change Minimum Data Set (MDS) dated 05/26/15 indicated Resident #4 was moderately cognitively impaired and did not receive the influenza immunization during the most recent flu season. Review of the medical record revealed there was no influenza immunization consent form dated for the 2014 - 2015 flu season. Further review revealed an Immunization and Tuberculosis Screening Form. The form listed all of the immunizations Resident #4 had had while a resident at the facility. The form did not indicate either administration or refusal of the influenza immunization. The medical record also indicated Resident #4 was discharged to the hospital on 12/23/14, after staff discovered the resident had a fever of 103.1°F (degrees Fahrenheit). A lab report from the hospital dated 12/23/14 indicated Resident #4 tested positive for the influenza A virus. Review of the facility's influenza monitoring tools revealed a drug information insert indicating the influenza immunization used by the facility during the most recent flu season was designed to protect against both influenza A and influenza B strains. An interview was conducted on 07/10/15 at 10:41 AM with Resident #4's family member. She stated she was never asked if the facility could administer the influenza immunization to the resident. Resident #4's family member explained she had called in September 2014 and asked about the influenza immunization but was told they were not being administered at that time. An interview was conducted on 07/10/15 at 12:48 PM with the former Director of Nursing (DON). She stated she was not directly responsible for obtaining consents and was not responsible for administering the actual influenza immunization.	F 334		

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F 334	Continued From page 36 An interview was conducted on 07/10/15 at 1:04 PM with Nurse #1. She stated she was responsible for administering the influenza immunization during the most recent flu season. She explained she checked each record to see if there was a signed consent but was not responsible for obtaining consent. Nurse #1 further explained she did not remember specific information about Resident #4's influenza immunization. An interview was conducted with the Nurse Practitioner (NP) on 07/10/15 at 2:09 PM. She stated it was generally recommended for residents in a nursing facility to receive the influenza immunization unless medically contraindicated, such as an allergy. The NP explained the influenza immunization was not as effective in the most recent flu season, but she would still recommend people to have it, especially in a high-risk population like the elderly.	F 334		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by:	F 406	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	8.11.15

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F 406	Continued From page 37 Based on medical record review and staff interview the facility failed to provide rehabilitation services as ordered for 1 of 3 sampled residents. (Resident #63) The findings included: Resident #63 was originally admitted to the facility 12/08/14 with diagnoses which included abnormal gait, muscle weakness, schizophrenia, anxiety, psychosis, diabetes and was admitted after hospitalization 03/11/15-03/13/15 following a fall with repair of a right hip fracture. Resident #63 was seen by the Family Nurse Practitioner (FNP) on 03/16/15 noting, Seen at nursing request due to patient complained of new onset right shoulder and right wrist pain since getting dressed this AM. Resident reports when she got dressed this AM, she had to stretch her right shoulder higher than she is used to, and she thought she heard some popping and cracking in the joint. She knows she has had pain and has been unable to lift her arm or hand ever since. She can swing both side to side. She can make a fist but she cannot lift her hand or arm up. Limited mobility and range of motion of both right shoulder and wrist. Orders were written for an X-ray of the right shoulder and wrist and, if no fracture, to refer to therapy services. An X-ray was done 03/17/15 and did not indicate any fractures of the resident's right shoulder or wrist. Resident #63 was seen by the occupational therapist from 03/21/15-05/15/15 to work on her right upper extremity, hand and wrist due to a decline in functional status. At the end of	F 406	F 406 With regards to the surveyors' concerns, resident #63 was started on Occupational therapy services on 7/10/15, 5 times a week for 4 weeks. Resident is still a resident at the facility. Resident is reassessed for therapy services when current therapy schedule is concluded. The facility has determined that all residents are at risk for this alleged deficit practice. The facility provides educational programs to licensed nurses, therapy, nursing management, and the Interdisciplinary team by 8/11/15 by the Director of Nursing and/or ADON regarding following physician orders for therapy services and the communication of those orders to the Therapy department. When orders are written, the yellow copy goes to the Director of Nursing's box at the Nurses' Station. The yellow copies are taken to the morning clinical meeting by the ADON and/or the Unit Manager where they are discussed with the Interdisciplinary team. A member of Therapy is present at the morning clinical meeting and the yellow copy is given to the therapy department at that time. In the event the Therapy Program Director is not present, a substitute therapy member is assigned to be present. The Therapy orders are implemented by Therapy and Therapy Services started, changed, or discontinued, as per physicians' orders.	

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F 406	Continued From page 38 services the therapist noted, Patient demonstrates a decline in functional mobility of wheelchair, decreased transfer skills, increased depression and motivation, and decreased motivation/functional use of right hand/poor compliance with use of splint use. Patient to be discharged to restorative to continue passive range of motion and assistance to donn/doff splint. Resident #63 had follow-up appointments with the orthopaedic physician following the hip surgery on 03/26/15, 04/28/15 and 06/09/15. Progress notes from the orthopaedic physician in the medical record of Resident #63 included the following: 04/28/15-6 weeks after right hip surgery for fracture. Continue rehabilitation. Right wrist weakness/edema. Occupational therapy to make wrist brace. Continue rehabilitation for range of motion/edema control. Follow-up one month. 06/09/15-3 months after right hip surgery for fracture. Post op radial nerve palsy. Transfers with assistance. Occupational therapy for right upper extremity rehabilitation. Use occupational therapy splint at night. Follow-up two months. A physician's order was written on 06/9/15 for Resident #63, Per ortho orders, Follow-up in 2 months, continue occupational therapy for right upper extremity rehabilitation and use of right upper extremity occupational therapy splint bedtime. On 07/10/15 at 8:45 AM the restorative aide stated she had been doing range of motion with Resident #63's right hand though she noted the resident would often complain of pain. The restorative aide stated she would put the splint on	F 406	The Therapy Director audits 5 random residents weekly to ensure that therapy orders have been picked up and implemented by the therapy department. The Therapy Director reports to the monthly QA Committee meeting regarding the plan of correction and the random audits to ensure consistent substantial compliance. These measures are in place by August 11, 2015.	

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F 406	Continued From page 39 Resident #63's right hand but often the resident would remove the splint. On 07/10/15 at 8:50 AM the Director of Nursing (DON) stated when a resident saw a specialist the recommendations was brought back to the facility and the resident's physician wrote orders (based on the specialists recommendations). The DON noted the order for occupational therapy on 06/09/15 was written by the physician of Resident #63 and based on the recommendations by the orthopaedic physician. The DON stated the order was given to the rehabilitation director for services to be implemented. On 7/10/15 at 1:51 PM the occupational therapist (OTR) stated he was not aware of the 06/09/15 order for services for Resident #63. The OTR stated he had been working with Resident #63 since March 2015 and that she had been referred to restorative services when services were discontinued 05/15/15. The OTR stated new orders for rehabilitation therapy were given to the rehabilitation director during morning meetings. On 07/10/15 at 2:20 PM the rehabilitation director reported she was not aware of the 06/09/15 order for occupational therapy services for Resident #63. The rehabilitation director stated she was not at the morning meeting on 06/10/15 and did not know what happened to the order or why it had been overlooked. The rehabilitation director stated Resident #63 had been discharged from occupational therapy on 05/15/15 because she was not making progress in therapy but would be reassessed now that she was aware of the 06/09/15 order.	F 406		

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F 514 F 514 SS=B	Continued From page 40 483.75(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 record reviews and staff interviews, the facility failed to locate a Nurse Admission Assessment (Resident #74), provide weights on a closed medical record (Resident #109), and correctly transcribe a frequency order for medication administration (Resident #31) for 5 of 34 medical records reviewed for accuracy. The findings included: 1. Resident #74 was admitted to the facility 03/19/15 with diagnoses which included sepsis from a urinary tract infection, failure to thrive, and a pressure ulcer. An admission Minimum Data Set (MDS) dated 03/26/15 indicated the resident's cognition was intact. The MDS specified the resident required extensive assistance to total dependence on staff for activities of daily living. The MDS further specified the resident was admitted with an unhealed pressure ulcer measuring 3.5 centimeters (cm) by 3 cm.	F 514 F 514	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 514 With regards of the surveyors' concerns, Resident #74 is no longer a resident at the facility. Resident #109 had a weight of 119 lbs. on her closed medical record, was within her Ideal Body Weight, and was a Hospice patient. Resident # 31 had a clarification order written, stating," Senna Laxative 8.6 mg tablet, take 2 tablets by mouth BID. Hold for loose stools". The facility has determined that all residents are at risk for these alleged deficit practices. Admission Assessments are completed within 24 hours on all new admissions, reviewed by the Director of Nursing, ADON, and Unit Manager at the next morning clinical meeting, then placed in the medical record. The Admission Checklist is signed off by the Director of Nursing or ADON and placed in a binder. Admission weights are	

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F 514	Continued From page 41 A review of Resident #74's medical record including the thinned medical record revealed 2 documents entitled Pressure Ulcer Record. One document had the date of 03/25/15 as the date first observed with measurements of 5 cm by 3.2 cm provided in the initial assessment space. The document further contained spaces for weekly assessments. The first weekly assessment space contained the date of 03/25/15 with measurements of 5 cm by 3.2 cm. The other document had no date documented as the date first observed. The space provided for date first observed contained "on admission". Measurements of 3.5 cm by 3 cm were provided in the initial assessment space. The first weekly assessment on this document contained a date of 03/25/15 with measurements of 3.5 cm by 3 cm. Continued medical record review revealed no Nurse's Admission Assessment could be found in Resident #74's medical record. The information provided was unclear what the baseline was for measurements of the documented pressure ulcer. On 07/08/15 at 5:48 PM the Director of Nursing, Unit Manager, and the Medical Records Director were observed searching Resident #74's current medical record and thinned medical records. They were unable to find the Nursing Admission Assessment dated 03/19/15. The DON stated she was not the DON at the time this resident was admitted in March of 2015. She added the wound nurse providing wound care at the time of Resident #74's admission was no longer working at the facility as well as the nurse that was functioning as DON. The DON acknowledged the information to clear up the discrepancy of the wound measurement should have been on the Nurse's Admission Assessment. In an interview conducted on 07/10/15 at 6:30	F 514	obtained within 24 hours of admission and documented in the medical record by Restorative on the vital sign sheets and monthly weights are obtained by the 10th of each month and documented in the residents' medical records on the vital sign sheets. The Unit Manager and/or ADON monitor to ensure the weights are put in the chart. New physician orders are checked every 24 hours for completeness and accuracy of transcription and all orders are reviewed and double checked at month end changeover by the ADON and/or Unit Manager for accuracy, clarity, and for transcription errors. The facility has provided In-service programs to licensed nurses by 8/10/15 by the ADON and/or MDS Coordinator regarding transcribing physician orders correctly, 24 hour chart checks, completion and documentation of admission and monthly weights on the medical record. Licensed nurses are also in-serviced by the ADON and/or MDS by 8/10/15 regarding obtaining a complete and accurate Admission Assessment with 24 hours and placing in the medical record. The Director of Nursing, ADON, and the Unit Manager review all new admits at the morning clinical meeting for complete admission assessments on the medical records, and that admission weights are documented in the medical record. Medical Records clerk audits 5 random charts weekly times 4 weeks, then monthly times 3 to ensure medical records are complete. Vital sign sheets are audited monthly, after the 10th of the month by the Unit Manager, to ensure compliance of having weights recorded in the medical record.	

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F 514	Continued From page 42 PM, the Administrator stated she expected all medical records were complete. 2. Resident # 109 was admitted to the facility on 05/26/14 with diagnoses including Alzheimer's disease and cerebrovascular disease. Resident # 109 deceased on 07/28/14. An admission Minimum Data Set (MDS) dated 06/02/14 indicated Resident # 109 had severe cognitive impairment for daily decision making and required extensive assistance of staff with all activities of daily living including eating. The Care Area Assessment summary for nutrition indicated the resident was on a pureed diet and had a 28 pound weight loss since February 2014 but was still within her ideal body weight range. The care plan addressed nutrition and indicated the resident was fed by staff. Review of the closed medical record for Resident # 109 revealed no weights were available on the chart. An interview on 07/10/15 at 2:20 PM with the Certified Dietary Manager (CDM) about the resident's weights revealed the former owner of the facility instructed staff not to put residents' weights on the medical record. The CDM stated she didn't know what the policy of the new owner was regarding weights since the change of ownership on 06/01/15. The CDM provided a list of weights for Resident # 109 that was included with a list of other residents' weights. The CDM stated she had kept them in her office in case they were needed during the annual survey then planned to discard them.	F 514	The Director of Nursing, ADON, and the Medical Records clerk report to the monthly QA Committee meeting regarding the plan of correction, monthly audits, and admission assessment completeness to ensure consistent substantial compliance. These measures are in place by August 11, 2015.	

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F 514	Continued From page 43 3. Resident #31 was admitted to the facility 10/20/10 with diagnoses which included muscle weakness, debility, vascular dementia, cerebrovascular accident with hemiplegia and hypothyroidism. Review of the monthly physician orders and Medication Administration Records (MARs) in the medical record of Resident #31 noted the following: April 2015 monthly physician orders and MAR included an order for, "Senna Laxative 8.6 milligram tablet. Take 2 tabs orally twice a day (BID). Hold for loose stools." May 2015, June 2015 and July 2015 monthly physician orders and MARs included this same order as, "Senna Laxative 8.6 milligram tablet. Take 2 tabs by mouth VUS. Hold for loose stools." On 07/10/15 at 2:14 PM the Director of Nursing (DON) stated the facility switched pharmacy services between April 2015 and May 2015. The DON stated the new pharmacy transcribed all resident physician orders into their system. The DON stated she did not know what VUS meant and that the order should have read BID. The DON stated Nurse #7 reviewed the May 2015 MAR for Resident #31 on 04/28/15 to reconcile the May orders. The DON stated when a nurse reviewed the MAR they focused on the medication, dosage and times of administration. The DON stated Nurse #7 was not available to be interviewed and that Nurse #7 missed the transcription error related to the Senokot for Resident #31. The DON reviewed the May, June and July 2015 MARs for Resident #31 and noted the Senokot was given BID as ordered by the physician.	F 514		

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F 514	Continued From page 44 On 07/10/15 at 6:00 PM the administrator stated she was not working at the facility at the time the new pharmacy services were contracted but would have expected the MAR and monthly physician orders to be an accurate reflection of the physician orders.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520	This Credible Allegation of Compliance (C.A.C.) AND Plan of Correction ("POC") has been prepared and timely submitted within the allotted timeframe of the received Statement of Deficiencies as mandated by the state and federal law as a condition to participate in the Medicare and Medicaid programs. Submission of this CAC and POC is not a legal admission that a deficiency exists or that the Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the interest of the facility, its Administrator, any employees, agents, or other individuals who draft or may be discussed in this CAC and POC. In addition, preparation and submission of the CAC and POC does not constitute an admission or agreement of any kind or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F 520 With regards to the surveyor's concerns, the facility conducted an Adhoc QA Committee meeting on August 6th, 2015 to initiate implementation and monitor the interventions of the Plan of Correction from the Annual Survey ending 7/10/15. The facility has determined that all residents are at risk for this alleged deficit practice.	8.11.15

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F 520	Continued From page 45 Based on observations, record reviews, and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2014. This was for 5 recited deficiencies which were originally cited in April of 2014 on a recertification investigation and on the current recertification survey. The deficiencies were in the areas of choices, professional standards, wellbeing, accuracy of clinical records, and quality assessment and assurance. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F242: Choices: Based on record review and staff interview the facility failed to honor a resident's choice about being given psychotropic medication for 1 of 3 residents reviewed for choices (Resident # 103). During the recertification survey of 04/10/14, the facility was cited for F242 for failing to provide showers to residents per resident's choice of frequency and what time of day. On the current recertification survey, the facility was again recited for failing to allow a resident to make a choice of refusing a psychotropic drug the resident did not want. b. F281: Professional Standards: Based on staff interviews and record reviews the facility failed to transcribe and implement the physician's order for lab work for 1 of 7 residents reviewed for unnecessary medications (Resident #34). During the recertification survey of 04/10/14, the facility was cited for F281 for failing to obtain labs as ordered by the physician. On the current	F 520	The facility provided In-service program to the QA Committee by the Director of Nursing by 8/6/15 regarding the policy and procedures and regulatory compliance for maintaining the monitoring of interventions for the plan of correction to sustain consistent substantial compliance. The Ad hoc Committee meeting discussed the Annual survey, the F-Tags received and the plan of correction being submitted. Plans were formulated for the discussion at QA monthly meeting to discuss the monitoring of the implementations in place and to make recommendations for further implementation and monitoring, if indicated. Individuals of the Committee are called on monthly to give reports on the areas they are assigned to monitor. The committee consists of the Director of Nursing, a physician who may participate quarterly but receive a copy of the monthly meeting minutes, and at least three other Interdisciplinary staff members. These measures are in place by August 11, 2015.	

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F 520	Continued From page 46 recertification survey, the facility was again recited for obtaining labs as ordered by the physician. c. F309: Wellbeing: Based on observations, staff and resident interviews and record reviews the facility failed to provide follow up assessment after initial treatment related to an eye injury, medications as ordered by the physician, and pain medication before a dressing change for 3 of 8 residents reviewed for wellbeing. (Residents #64,#4, and #74). During the recertification survey of 04/10/14, the facility was cited for F309 for failing to administer medications as ordered by the physician. On the current recertification survey, the facility was again recited for not administering medications as order by the physician. In addition the facility failed to obtain a follow up appointment for a resident that received an eye injury and offer or provide pain medication to a resident before a dressing change procedure. d. F514: Accuracy of Clinical Records: Based on record reviews and staff interviews, the facility failed to locate a Nurse Admission Assessment in the medical record (Resident #74), provide weights on a closed medical record (Resident #109), and correctly transcribe a frequency order for medication administration (Resident #31) for 3 of 34 medical records reviewed for accuracy. During the recertification survey of 04/10/14, the facility failed to provide lab results to the physician for review and failed to do skin assessments on residents with pressure ulcers. On the current recertification survey, the facility failed to maintain complete medical records and correctly transcribe a frequency order for a medication. e. F520: Based on observations, record reviews,	F 520		

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F 520	Continued From page 47 and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2014. This was for 5 recited deficiencies which were originally cited in April of 2014 on a recertification investigation and on the current recertification survey. The deficiencies were in the areas of choices, professional standards, wellbeing, accuracy of clinical records, and quality assessment and assurance. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. During the recertification survey of 04/10/14, the facility failed to have the correct disciplines on the Quality Assurance Committee, such as the Medical Director and failed to address infection control issues. On the current recertification survey, the facility continued to fail in allowing residents choices about aspects of care, to obtain labs as ordered by the physician, maintain highest practicable potential for physical wellbeing, and maintain accuracy of clinical records. An interview was conducted with the Administrator on 07/10/15 at 6:30 PM. The Administrator acknowledged the facility had experienced turnover with management staff including the Administrator and Director of Nursing positions. The Administrator stated she had not been Administrator for most of the year. She added she was unable provide a reason for the facility failing to maintain an effective Quality Assessment and Assurance Committee.	F 520		