STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27536

(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 272 SS=G	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		2/4/16

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

Electronically Signed | 01/29/2016

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to comprehensively assess the needs of a resident receiving a gastrostomy tube feeding for 1 of 4 residents (Resident #69) reviewed for Nutrition. The findings included: Resident #69 was admitted to the facility from a hospital on 10/29/15 with a cumulative diagnoses which included diabetes, a history of aspiration pneumonia, and placement of a gastrostomy tube on 10/21/15 (a surgical opening into the stomach whereby a feeding tube may be inserted). Resident #69 ' s admission orders dated 10/29/15 included the following tube feeding instructions: 120 milliliters (ml) Diabetisource via gastrostomy tube every 6 hours as a bolus feeding (provided at one time); 90 ml water flush after each feeding and 30 ml of water after each medication. Diabetisource is a tube feeding formulation designed for people with diabetes and stress induced high blood sugar levels. On 10/30/15 at 11:50 AM, a Physician ' s Telephone Order was received to change Resident #69 ' s gastrostomy feeding to Boost Glucose Control formula, given as one can (237 ml) every 6 hours. Boost Glucose Control is a nutritional formulation designed for people with diabetes; it is intended for use as an oral supplement. According to the manufacturer ' s product information, Boost Glucose Control is not intended as a tube feeding formulation. However, if a healthcare provider selected this product for a	F 272	1.The MDS nurse did a comprehensive significant change assessment for resident #69 on 2-4-16. The comprehensive significant change assessment addressed the residents nutritional needs and included the dieticians assessment. The dietician did a nutritional assessment on 1-16-16 for resident #69. The nutritional assessment included protein, calories and fluid amounts. On 2-11-16, protein powder was added and TP/ALB lab was drawn on Resident #69. When the new dietician reassessed resident #69 on 2-12-16, the current tube feeding order met the residents nutritional needs. 2. All tube fed residents were added to the February MDS schedule to have a comprehensive MDS completed by 2-24-16. The MDS nurse will do the comprehensive MDS. The comprehensive assessment on tube fed residents will address residents nutritional needs and will include dieticians assessment. All G tube residents had a nutritional assessment on 1-16-16 and 1-30-16 by dietician. All residents that are fed by tube had an addendum done to most recent nutrition/feed tube CAA 0n 2-4-16. The addendum was done by the MDS nurse and was based on dieticians assessment. The addendum included RD assessment of current feedings and flushes, compared usual weight to current weight, compared	

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F 272	Continued From page 2 tube feeding, 5 cans (1185 ml) were required to meet 100 percent of the Recommended Daily Intake (RDI) for essential nutrients. Four cans of Boost Glucose Control provided every 24 hours, as ordered, yielded 1000 calories with 56 grams of protein and 792 ml of free water daily (exclusive of the water flushes). Resident #69 did not receive any nutrition or fluids by mouth. The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered. The resident ' s admission Minimum Data Set (MDS) assessment dated 11/2/15 indicated Resident #69 had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her activities of daily living (ADLs). Resident #69 was reported to be 61 inches tall and weighed 125 pounds. The MDS assessment indicated she received 51% or more of her calories and 501 milliliters or more via a tube feeding. A review of Resident #69 ' s Care Area Assessment (CAA) Summary dated 11/3/15 addressed the use of a feeding tube. The summary read: " Feeding Tube: Triggered by Resident has a feeding tube present. Resident factor to consider: she has dx (diagnosis) of respiratory failure, sepsis, a-fib (atrial fibrillation), CHF (congestive heart failure), DM (diabetes), advanced dementia, HTN (hypertension) and others. She is NPO (nothing by mouth) and all fluids and nutrition are via feeding tube. Tube was present upon admission to SNF (Skilled Nursing Facility). She does not attempt to remove the tube. She does not move often. She	F 272	whether or not current feeding met current needs and evaluation of TP/ALB levels. All g tube resident were assessed by the newly contracted dietician on 2-12-16 and all g tube residents nutritional needs are being met. The dietician will do a nutritional assessment monthly on all residents fed by G tube. The dietician will do a nutritional assessment on all residents quarterly. 3. The MDS nurse is on the weight committee and will complete nutritional portion of the comprehensive assessments based on the dieticians assessment All Residents will be weighed on admission and at least monthly. The weight committee meets twice a week and includes Administrator, DON, Staff Developer, Social Worker and MDS Nurse. The weight committee will review all weights at least but not limited to monthly based on weight change of 5% in a month, 7.5% in 3 months and 10% in 6 months. The committee review all tube fed residents nutritional needs on a weekly basis and makes nutritional recommendations as needed. These recommendations include but not limited to notifying dietician, notify doctor, refer to Speech therapy, and add supplements. 4. On a monthly basis, for 3 months the administrator will audit all resident charts to ensure the dietician has written a nutritional assessment within 14 days of	

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F 272	Continued From page 3 is non-communicative. No noted abdominal distention. Current weight is 125 pounds. No referrals, will proceed with care plan to maintain tube and weight. " The CAA Summary did not include an analysis of the current weight compared to her usual body weight. The CAA did not address an assessment of the nutritional needs of this resident nor did it address an analysis of the current tube feeding orders and whether the current tube feeding met her nutritional requirements. The CAA did not include information provided by the facility ' s consultant dietitian; it indicated no referrals were planned. A review of Resident #69 ' s Weight Records included the following: 11/4/15 Weight = 118 pounds. 11/11/15 Weight = 111 pounds; 11/18/15 Weight = 105 pounds; 11/25/15 No weight was noted; and, 12/2/15 No weight was noted. A Physician ' s Telephone Order was written on 12/2/15 for weekly weights due to continuous weight loss (per weight committee). Resident #69 ' s tube feeding was increased to 320 ml every 6 hours. 320 ml of Boost Glucose Control given every 6 hours yielded approximately 1349 calories with 75.6 grams of protein and 1069 ml of free water daily (exclusive of the water flushes). The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered. A review of Resident #69 ' s Weight Record included the following: 12/9/15 Weight = 96 pounds;	F 272	admission. After 3 months, the audit will be performed quarterly. On a monthly basis, for 3 months, the administrator will audit the CAA□s of resident who are fed by gtube to ensure they have a CAA. After 3 months, the audit will be performed quarterly. Negative findings from these audits will be corrected in the appropriate time. Negative findings will also be sent to the next QA meeting for recommendations from the committee on how to decrease the number of negative findings	

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12/16/15 Weight = 98 pounds.
12/23/15 Weight = 97 pounds; and,
12/30/15 Weight = 96 pounds.

On 12/30/15 at 2:00 PM, the Nurse ' s Notes revealed a Stage 2 pressure area was found on Resident #69 ' s sacrum.

On 12/31/15, a Physician ' s Telephone Order was written to change the tube feeding formulation to Diabetisource and to initiate this feeding at 55 milliliters per hour (ml/hr) continuous feeding (versus the previously ordered bolus feeding schedule). Diabetisource provided at 55 ml/hr via continuous feed yielded 1584 calories with 79.2 grams of protein and 1080 ml of free water daily (exclusive of the tube feeding water flushes). The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered.

A review of Resident #69 ' s Weight Records included the following: 1/6/16 Weight = 102# pounds.

A review of Resident #69 ' s Medical Record revealed there were no Nutrition Progress Notes completed for this resident. A nutritional assessment was not available to estimate her calorie, protein, and/or fluid needs; nor was there an approximation of the calories, protein, and/or free water provided by the tube feeding ordered for the resident since her admission to the facility on 10/29/15.

An interview was conducted on 1/6/16 at 3:14 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported residents '

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weights were followed weekly by the facility ' s Weight Committee. The DON acknowledged Resident #69 ' s continuing weight loss was identified by the Committee and she was weighed weekly to follow the weights. No other assessments or interventions were reported.

A telephone interview was conducted on 1/6/16 at 3:44 PM with the facility ' s consultant Registered Dietitian (RD). During the interview, the consultant RD reported she typically tried to come to the facility once a month. However, the RD noted she hadn ' t been in the facility the past month. Upon further questioning, the RD reported her last nutrition consultation visit to the facility was approximately 10 weeks ago and prior to Resident #69 ' s admission date of 10/29/15. She reported the Dietary Manager for the facility did not have any clinical responsibilities whatsoever. When asked, the RD stated she usually checked on residents receiving a tube feeding when he/she was first admitted to the facility and when due for a quarterly assessment. She indicated residents with a tube feeding were also reviewed if he/she was losing weight or had another problem prior to the scheduled assessment date. The RD reported staff at the facility were able to contact her for a consultation as needed, but acknowledged no such request had been made since her last visit to the facility. Upon briefly reviewing Resident #69 ' s tube feeding orders, laboratory results and history of weight loss, the RD stated, " Yeah, that ' s something that should have been addressed. "

A telephone interview was conducted on 1/7/16 at 9:56 AM with the facility ' s MDS Nurse. During the interview, the MDS nurse reported she participated in the weekly Weight Committee

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F 272	Continued From page 6 meetings. However, she was unable to provide details related to any concerns identified for Resident #69. An interview was conducted on 1/7/16 at 1:33 PM with the facility ' s DON. The DON reported the facility ' s consultant RD normally reviewed the residents receiving a tube feeding to ensure the formulation and volume provided met his/her nutritional needs. However, the DON indicated she had not seen the RD in the building for quite a while. When asked if she would have expected the RD to have reviewed Resident #69 ' s tube feeding regimen to ensure she was getting enough calories to prevent weight loss, she stated, " Yes. " Upon inquiry as to who was responsible to ensure the resident was meeting her protein needs, the DON stated, " the doctor and the dietitian. "	F 272		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to assess and meet the nutritional needs of a resident for 1 of 3	F 314	1.Resident #69 has had a nutritional assessment done by the dietician. The nutritional assessment included the	2/4/16

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F 314	Continued From page 7 sampled residents (Resident #69) who was at a high risk for the potential development of pressure ulcers. The findings included: Resident #69 was admitted to the facility from a hospital on 10/29/15 with a cumulative diagnoses which included diabetes, a history of aspiration pneumonia, and placement of a gastrostomy tube on 10/21/15 (a surgical opening into the stomach whereby a feeding tube may be inserted). Resident #69 ' s admission orders dated 10/29/15 included the following tube feeding instructions: 120 milliliters (ml) Diabetisource via gastrostomy tube every 6 hours as a bolus feeding (provided at one time); 90 ml water flush after each feeding and 30 ml of water after each medication. Diabetisource is a tube feeding formulation designed for people with diabetes and stress induced high blood sugar levels. On 10/30/15 at 11:50 AM, a Physician ' s Telephone Order was received to change Resident #69 ' s gastrostomy feeding to Boost Glucose Control formula, given as one can (237 ml) every 6 hours. Boost Glucose Control is a nutritional formulation designed for people with diabetes; it is intended for use as an oral supplement. According to the manufacturer ' s product information, Boost Glucose Control is not intended as a tube feeding formulation. However, if a healthcare provider selected this product for a tube feeding, 5 cans (1185 ml) were required to meet 100 percent of the Recommended Daily Intake (RDI) for essential nutrients. Four cans of Boost Glucose Control provided every 24 hours, as ordered, yielded 1000 calories with 56 grams	F 314	protein, calories, and fluid amounts. The nutritional assessment was done on 1-16-16. Per nutritional assessment, resident #69 required additional calories, protein and fluid to promote healing and dietary recommendations were made. Resident #69□s feeding has been changed. Resident # 69 has an air mattress on bed. 2.The dietician did a nutritional assessment on all at risk resident that are fed via g tube on 1-16-16 and 1-30-16 to ensure nutritional needs were met and weight is maintained. All residents that are fed via g tube have had their orders changed to an enteral feeding formula. 3. All residents on admission receive Norton pressure ulcer scale assessment. A nutritional assessment will be done by dietician within14 days of admission. A resident may also be assessed for additional pressure relief devices, nutritional supplements, need for therapy intervention, more frequent turning and repositioning, and more frequently toileting. When a resident develops a pressure ulcer the facility will initiate TX and add arginade, vitamin C, Zinc and multi vitamins to promote healing. Once a wound is observed, a TP/ALB lab is drawn and will be drawn every 3 months. The doctor will also be notified. The dietician will be notified to do an additional nutritional assessment. The weight committee meets twice a week and includes Administrator, DON, Staff Developer, Social Worker and MDS	

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F 314	Continued From page 8 of protein and 792 ml of free water daily (exclusive of the water flushes). Resident #69 did not receive any nutrition or fluids by mouth. The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered. A review of Resident #69 ' s Admission Nursing Assessment & Review dated 10/29/15 revealed the resident was 61 inches tall and weighed 125 pounds (#). No skin breakdown or pressure ulcers were reported. No notes of edema (fluid retention) were made. Resident #69 ' s assessment of pressure ulcer potential using the Norton Pressure Ulcer Scale was also completed on 10/29/15. The resident ' s total Norton scale was 6 on a scale of 5 to 20. Based on the total Norton scale, Resident #69 was at a high risk for the potential development of pressure ulcers. The resident ' s admission Minimum Data Set (MDS) assessment dated 11/2/15 indicated Resident #69 had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her activities of daily living (ADLs). She was incontinent of bladder and bowel. No pressure ulcers were reported. A review of Resident #69 ' s Care Area Assessment Summary dated 11/3/15 addressed her risk for the development of pressure ulcers. The narrative read, in part: " Triggered by Resident is dependent in bed mobility and incontinent of bowel and bladder and at risk for developing pressure ulcers ...She has no pressure ulcers at this time. No skin breakdown and no treatments ...She has an anti-pressure	F 314	Nurse. The weight committee will review weights and make nutritional recommendations as needed. These recommendations include but not limited to notifying dietician, notify doctor, refer to Speech therapy, and add supplements. On a monthly basis, the dietician will do a nutritional assessment on residents that are fed via g tube and residents that have pressure ulcers. 4.On a monthly basis, for 3 months the administrator will audit all resident charts to ensure the dietician has written a nutritional assessment. Then the audit will be performed quarterly. On a weekly basis, for three months, the DON will monitor 2 at risk residents to help prevent pressure ulcers. After 3 months the monitoring will be performed quarterly. The monitoring will be observation and record review. The DON observes the residents skin for red areas at pressure points. The DON will also check resident record to see if they need supplements or vitamins. Negative findings from monitoring will be corrected. Negative findings will also be sent to the next QA meeting for recommendations from the committee on how to decrease the number of negative findings	

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mattress on her bed. She is turn(ed) and repositioned every 2 hours and as needed ...No referrals, will proceed with care plan to prevent pressure ulcers. "

A review of Resident #69 ' s Care Plan dated 11/3/15 included the following area of focus: Pressure Ulcer-Resident is at risk for skin breakdown related to decreased mobility and incontinence. The interventions included, in part: " All nutrition and fluids via feeding tube as ordered. " The interventions did not include a referral to the facility ' s consultant dietitian for an assessment of the resident ' s nutritional needs (either initially or on an as needed basis).

A review of Resident #69 ' s medical record included the following laboratory results dated 11/3/15: total protein = 5.0 (normal range = 6.5-8.0), and albumin = 2.4 (normal range = 3.0-5.5). Albumin is the most abundant protein in human blood plasma and is frequently used in blood test panels for general health screening. An albumin level of 2.4 may be indicative of moderate to severe visceral protein depletion.

A review of Resident #69 ' s Weight Records included the following: 11/4/15 Weight = 118 pounds.

Further review of Resident #69 ' s Weight Records included the following:
11/11/15 Weight = 111 pounds;
11/18/15 Weight = 105 pounds;
11/25/15 No weight was noted; and,
12/2/15 No weight was noted.

A review of the Physician ' s Progress Notes included a notation written on 12/2/15 which read,

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in part:
" Objective (O): Weight decrease gradual from 12 on 10/29 to 105 on 11/21.
Assessment/Plan (A/P): Weight loss: increase 320 ml every 6 hours from 240 ... "

A Physician ' s Telephone Order was written on 12/2/15 for weekly weights due to continuous weight loss (per weight committee). Resident #69 ' s tube feeding was increased to 320 ml every 6 hours. 320 ml of Boost Glucose Control given every 6 hours yielded approximately 1349 calories with 75.6 grams of protein and 1069 ml of free water daily (exclusive of the water flushes). The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered.

A review of Resident #69 ' s Weight Record included the following:
12/9/15 Weight = 96 pounds;
12/16/15 Weight = 98 pounds.
12/23/15 Weight = 97 pounds; and,
12/30/15 Weight = 96 pounds.

On 12/30/15 at 2:00 PM, the Nurse ' s Notes revealed a Stage 2 pressure area was found on Resident #69 ' s sacrum. Wound Records dated 12/30/15 revealed the pressure ulcer measured 1.4 x 1 x 0 centimeter (cm) with granulation tissue present. The date of the wound origin was noted as 12/30/15.

On 12/30/15, a Physician ' s Telephone Order was written for the following: Clean sacrum area with normal saline; apply Monistat and Medseptic every shift until healed. The order also initiated a multivitamin given once daily, 220 mg zinc given

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once daily, 500 mg vitamin C given once daily, and 1 pack of Arginaid (an amino acid supplement intended to promote wound healing) to be given twice daily until the area was healed (or for 90 days).

On 12/31/15, a Physician ' s Telephone Order was written to change the tube feeding formulation to Diabetisource and to initiate this feeding at 55 milliliters per hour (ml/hr) continuous feeding (versus the previously ordered bolus feeding schedule). Diabetisource provided at 55 ml/hr via continuous feed yielded 1584 calories with 79.2 grams of protein and 1080 ml of free water daily (exclusive of the tube feeding water flushes). The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered.

Wound Records dated 1/4/16 revealed Resident #69 ' s sacral pressure ulcer measured 1.5 x 1 x 0 centimeter (cm) with granulation tissue present.

A review of Resident #69 ' s Weight Records included the following: 1/6/16 Weight = 102# pounds.

On 1/7/16, Physician ' s Telephone Orders were written to clean the resident ' s Stage 2 pressure ulcer with normal saline; apply Hydrogel and cover with Opsite; and, check the resident ' s total protein and albumin via laboratory blood tests on the next lab day.

An observation was made of the resident ' s sacral pressure ulcer and treatment on 1/7/16 at 9:37 AM. The wound bed was pale with no drainage or odor noted. The wound measured 2

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x 1 x 0.2 cm.

A review of Resident #69 ' s Medical Record revealed there were no Nutrition Progress Notes completed for this resident. A nutritional assessment was not available to estimate her calorie, protein, and/or fluid needs; nor was there an approximation of the calories, protein, and/or free water provided by the tube feeding ordered for the resident since her admission to the facility on 10/29/15.

An interview was conducted on 1/6/16 at 3:14 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported residents ' weights were followed weekly by the facility ' s Weight Committee. The DON acknowledged Resident #69 ' s continuing weight loss was identified and the resident was weighed weekly to follow the weights. No other interventions were reported.

A telephone interview was conducted on 1/6/16 at 3:44 PM with the facility ' s consultant Registered Dietitian (RD). During the interview, the consultant RD reported her last nutrition consultation visit to the facility was prior to Resident #69 ' s admission date of 10/29/15. When asked, the RD stated she usually checked on residents receiving a tube feeding when he/she was first admitted to the facility and when due for a quarterly assessment. She indicated residents with a tube feeding were also reviewed if he/she was losing weight or had another problem prior to the scheduled assessment date. The RD reported staff at the facility were able to contact her for a consultation as needed, but acknowledged no such request had been made since her last visit to the facility. Upon briefly

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F 314	Continued From page 13 reviewing Resident #69 ' s tube feeding orders, laboratory results, weight loss, and pressure ulcer development, the RD stated, " Yeah, that ' s something that should have been addressed. " A telephone interview was conducted on 1/7/16 at 2:33 PM with the resident ' s Medical Doctor (MD). When asked how he decided on the initial choice of the tube feeding formulation and volume provided, the MD indicated he would typically continue with the hospital regimen upon discharge but may have went with the formulation the facility had available (referring to Boost Glucose Control). The physician reported Resident #69 had heart failure and required a fluid restriction. The MD reported his intention was maintenance and he wanted to increase the tube feeding calories provided to Resident #69, " judiciously. " He estimated the resident needed approximately 1000 calories a day and less than 1000 ml fluid daily to achieve this goal. A follow-up interview was conducted on 1/7/16 at 1:33 PM with the facility ' s DON. The DON reported the facility ' s consultant RD normally reviewed the residents receiving a tube feeding to ensure the nutrition formulation and volume provided met his/her nutritional needs. When asked if she would have expected the RD to have reviewed Resident #69 ' s tube feeding regimen to ensure the resident was getting enough calories, protein, and fluid, she stated, " Yes. " When asked if she thought the resident ' s pressure ulcer was preventable and could have been avoided, the DON replied, " honestly, yes. "	F 314		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		2/4/16

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F 325	Continued From page 14 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to assess and meet the nutritional needs of a resident receiving a gastrostomy tube feeding, resulting in weight loss for 1 of 4 sampled residents (Resident #69) reviewed for Nutrition. The findings included: Resident #69 was admitted to the facility from a hospital on 10/29/15 with a cumulative diagnoses which included diabetes, a history of aspiration pneumonia, and placement of a gastrostomy tube on 10/21/15 (a surgical opening into the stomach whereby a feeding tube may be inserted). Resident #69 ' s admission medication orders dated 10/29/15 included 20 milligrams (mg) furosemide to be given per gastrostomy tube once daily; NovoLog insulin to be given on a sliding scale basis; and 8 mg glimepiride (an antidiabetic agent) given by gastrostomy tube once daily.	F 325	1. Resident # 69 has had a nutritional assessment by dietician on 1-16-19 and stated was meeting nutritional needs and was adequate nutrition. The nutritional assessment included the protein, calorie, and fluid amounts The MDS nurse did a comprehensive significant change assessment for resident #69 on 2-4-16. Resident # 69s tube feeding was changed from Isosource to Diabeticsource. 2. The dietician did a nutritional assessment on all residents that are fed via g tube on 1-16-16 and 1-30-16 to make sure their nutritional needs were being met and weight could be maintained. The dietician did a nutritional assessment on all residents on 1-16-16. Residents that are fed via g tube have been changed to an enteral feeding formula. On 1-15-16 the weight committee reviewed all residents and made appropriate recommendations.	

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F 325	Continued From page 15 Resident #69 ' s admission orders dated 10/29/15 included the following tube feeding instructions: 120 milliliters (ml) Diabetisource via gastrostomy tube every 6 hours as a bolus feeding (provided at one time); 90 ml water flush after each feeding and 30 ml of water after each medication. Diabetisource is a tube feeding formulation designed for people with diabetes and stress induced high blood sugar levels. On 10/30/15 at 11:50 AM, a Physician ' s Telephone Order was received to change Resident #69 ' s gastrostomy feeding to Boost Glucose Control formula, given as one can (237 ml) every 6 hours. Boost Glucose Control is a nutritional formulation designed for people with diabetes; it is intended for use as an oral supplement. According to the manufacturer ' s product information, Boost Glucose Control is not intended as a tube feeding formulation. However, if a healthcare provider selected this product for a tube feeding, 5 cans (1185 ml) were required to meet 100 percent of the Recommended Daily Intake (RDI) for essential nutrients. Four cans of Boost Glucose Control provided every 24 hours, as ordered, yielded 1000 calories with 56 grams of protein and 792 ml of free water daily (exclusive of the water flushes). Resident #69 did not receive any nutrition or fluids by mouth. The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered. A review of Resident #69 ' s Admission Nursing Assessment & Review dated 10/29/15 revealed the resident was 61 inches tall and weighed 125 pounds (#). No skin breakdown or pressure ulcers were reported. No notes of edema (fluid	F 325	3. On a monthly basis, the dietician will do a nutritional assessment on residents that are fed via g tube. The dietician will do an assessment on all residents quarterly. The dietician will make recommendations. Depending on the recommendation, it will go to either the kitchen or the doctor. The doctor will decide whether or not to follow the recommendation These recommendations will go to doctor to make a decision. The MDS nurse is on the weight committee and will complete nutritional assessments based on the dieticians assessment. All Residents will be weighed on admission and at least monthly. The weight committee meets twice a week and includes Administrator, DON, Staff Developer, Social Worker and MDS Nurse. The weight committee will review all weights at least but not limited to monthly. All weights are reviewed monthly and recommendations made based on weight change of 5% in a month, 7.5% in 3 months and 10% in 6 months. The committee review all tube fed residents nutritional needs on a weekly basis and makes nutritional recommendations as needed. These recommendations include but not limited to notifying dietician, notify doctor, refer to Speech therapy, and add supplements. 4. On a monthly basis, for 3 months the administrator will audit all resident charts to ensure the dietician has written a nutritional assessment within 14 days of admission. After 3 months, the audit will	

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F 325	Continued From page 16 retention) were made. The resident ' s admission Minimum Data Set (MDS) assessment dated 11/2/15 indicated Resident #69 had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her activities of daily living (ADLs). A review of Resident #69 ' s Care Area Assessment (CAA) Summary dated 11/3/15 addressed the use of a feeding tube. The summary read: " Feeding Tube: Triggered by Resident has a feeding tube present. Resident factor to consider: she has dx (diagnosis) of respiratory failure, sepsis, a-fib (atrial fibrillation), CHF (congestive heart failure), DM (diabetes), advanced dementia, HTN (hypertension) and others. She is NPO (nothing by mouth) and all fluids and nutrition are via feeding tube. Tube was present upon admission to SNF (Skilled Nursing Facility). She does not attempt to remove the tube. She does not move often. She is non-communicative. No noted abdominal distention. Current weight is 125 pounds. No referrals, will proceed with care plan to maintain tube and weight. " The CAA Summary did not include an analysis of the current weight compared to her usual body weight. The CAA did not address an assessment of the nutritional needs of this resident nor did it address an analysis of the current tube feeding orders and whether the current tube feeding met her nutritional requirements. The CAA did not include information provided by the facility ' s consultant dietitian; it indicated no referrals were planned.	F 325	be performed quarterly. On a monthly basis, for 3 months, the administrator will audit the CAA□s of resident who are fed by gtube to ensure they have a CAA. After 3 months, the audit will be performed quarterly. Negative findings from these audits will be corrected in the appropriate time. Negative findings will also be sent to the next QA meeting for recommendations from the committee on how to decrease the number of negative findings	

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A review of Resident #69 ' s Care Plan dated 11/3/15 included the following area of focus: Alteration in nutrition related to use of a feeding tube. There were no Interventions/Approaches which addressed Resident #69 ' s weight in the care plan. Additionally, no Interventions/Approaches addressed an assessment of the resident ' s nutritional needs or an analysis of the adequacy of her tube feeding in meeting these needs. The care plan Interventions/Approaches did not indicate a referral would be made to the consultant dietitian, either initially or on an as needed basis.

A review of Resident #69 ' s medical record included the following laboratory results dated 11/3/15: total protein = 5.0 (normal range = 6.5-8.0), and albumin = 2.4 (normal range = 3.0-5.5). Albumin is the most abundant protein in human blood plasma and is frequently used in blood test panels for general health screening. An albumin level of 2.4 may be indicative of moderate to severe visceral protein depletion.

A review of Resident #69 ' s Weight Records included the following: 11/4/15 Weight = 118 pounds.

A Nurse ' s Note dated 11/4/15 noted the resident had non-pitting edema to her right upper extremity. No other notations of edema were reported.

Further review of Resident #69 ' s Weight Records included the following:
11/11/15 Weight = 111 pounds;
11/18/15 Weight = 105 pounds;
11/25/15 No weight was noted; and,
12/2/15 No weight was noted.

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A review of the Physician ' s Progress Notes included a notation written on 12/2/15 which read, in part:
" Objective (O): Weight decrease gradual from 12 on 10/29 to 105 on 11/21.
Assessment/Plan (A/P): Weight loss: increase 320 ml every 6 hours from 240 ... "

A Physician ' s Telephone Order was written on 12/2/15 for weekly weights due to continuous weight loss (per weight committee). Resident #69 ' s dose of glimepiride was decreased from 8 mg to 4 mg once daily; her tube feeding was increased to 320 ml every 6 hours. 320 ml of Boost Glucose Control given every 6 hours yielded approximately 1349 calories with 75.6 grams of protein and 1069 ml of free water daily (exclusive of the water flushes). The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered.

A review of Resident #69 ' s Weight Record included the following:
12/9/15 Weight = 96 pounds;

A Physician ' s Progress Note dated 12/14/15 indicated, " ...Patient has been comfortable and stable. "

A review of Resident #69 ' s Weight Records included the following: 12/16/15 Weight = 98 pounds.

On 12/16/15 at 4:30 PM, a Physician ' s Telephone Order was written to discontinue Resident #69 ' s furosemide.

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Further review of Resident #69 ' s Weight Records included the following:
12/23/15 Weight = 97 pounds; and,
12/30/15 Weight = 96 pounds.

On 12/30/15 at 2:00 PM, the Nurse ' s Notes revealed a Stage 2 pressure area was found on Resident #69 ' s sacrum. A Physician ' s Telephone Order was written to initiate a multivitamin given once daily, 220 mg zinc to be given once daily, 500 mg vitamin C given once daily, and 1 pack of Arginaid (an amino acid supplement used to promote wound healing) to be given twice daily until the area was healed (or for 90 days).

On 12/31/15, a Physician ' s Telephone Order was written to change the tube feeding formulation to Diabetisource and to initiate this feeding at 55 milliliters per hour (ml/hr) continuous feeding (versus the previously ordered bolus feeding schedule). Diabetisource provided at 55 ml/hr via continuous feed yielded 1584 calories with 79.2 grams of protein and 1080 ml of free water daily (exclusive of the tube feeding water flushes). The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered.

A review of Resident #69 ' s Weight Records included the following: 1/6/16 Weight = 102# pounds.

A review of Resident #69 ' s Medical Record revealed there were no Nutrition Progress Notes completed for this resident. A nutritional assessment was not available to estimate her calorie, protein, and/or fluid needs; nor was there

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an approximation of the calories, protein, and/or free water provided by the tube feeding ordered for the resident since her admission to the facility on 10/29/15.

An interview was conducted on 1/6/16 at 3:14 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported residents ' weights were followed weekly by the facility ' s Weight Committee. The Committee consisted of the DON, the Social Worker, the MDS Nurse, and the Staff Development Coordinator. The DON reported this Committee would decide if someone needed to be on a weekly weight and if so, she would write the order per facility protocol and let the resident ' s MD know of the concerns. At that point, the DON reported the MD would decide if a nutritional supplement should be ordered for the resident. The DON acknowledged Resident #69 ' s continuing weight loss was identified by the Committee and she was weighed weekly to follow the weights. No other interventions were reported.

A telephone interview was conducted on 1/6/16 at 3:44 PM with the facility ' s consultant Registered Dietitian (RD). During the interview, the consultant RD reported she typically tried to come to the facility once a month. However, the RD noted she hadn ' t been in the facility the past month. Upon further questioning, the RD reported her last nutrition consultation visit to the facility was approximately 10 weeks ago and prior to Resident #69 ' s admission date of 10/29/15. She reported the Dietary Manager for the facility did not have any clinical responsibilities whatsoever. When asked, the RD stated she usually checked on residents receiving a tube feeding when he/she was first admitted to the

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facility and when due for a quarterly assessment. She indicated residents with a tube feeding were also reviewed if he/she was losing weight or had another problem prior to the scheduled assessment date. The RD reported staff at the facility were able to contact her for a consultation as needed, but acknowledged no such request had been made since her last visit to the facility. Upon briefly reviewing Resident #69 ' s tube feeding orders, laboratory results and history of weight loss, the RD stated, " Yeah, that ' s something that should have been addressed. "

A telephone interview was conducted on 1/7/16 at 10:58 AM with Resident #69 ' s family member. Upon inquiry, the family member reported the resident ' s usual adult weight was, " in the 120 ' s. " Additionally, the family member reported during the months prior to and during her admission to the hospital and facility, the resident did not experience any problems with fluid retention.

A telephone interview was conducted on 1/7/16 at 2:33 PM with the resident ' s Medical Doctor (MD). When asked how he decided on the initial choice of the tube feeding formulation and volume provided, the MD indicated he would typically continue with the hospital regimen upon discharge but may have went with the formulation the facility had available (referring to Boost Glucose Control). The physician reported Resident #69 had heart failure and required a fluid restriction. When asked if he had considered more nutrient-dense formulations intended for fluid-restricted patients, the MD indicated he did not. The MD reported his intention was maintenance and he wanted to increase the tube feeding calories provided to

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F 325	Continued From page 22 Resident #69, " judiciously. " He estimated the resident needed approximately 1000 calories a day and less than 1000 ml fluid daily to achieve this goal. A follow-up interview was conducted on 1/7/16 at 1:33 PM with the facility ' s DON. The DON reported the facility ' s consultant RD normally reviewed the residents receiving a tube feeding to ensure the formulation and volume provided met his/her nutritional needs. However, the DON indicated she had not seen the RD in the building for quite a while. When asked if she would have expected the RD to have reviewed Resident #69 ' s tube feeding regimen to ensure she was getting enough calories to prevent weight loss, she stated, " Yes. " Upon inquiry as to who was responsible to ensure the resident was meeting her protein needs, the DON stated, " the doctor and the dietitian. "	F 325		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8%, for 2 of 7 residents (Resident #6 and Resident #53) observed during medication pass.	F 332	1. Medication error reports were written on resident #6 and resident # 53. The doctor was notified and the responsible party was notified. There was no adverse outcome for resident #6 or Resident # 53. One nurse that was involved attended the inservice on 2-3-16 by SDC. The other nurse involved had passed away.	2/4/16

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F 332	Continued From page 23 The findings included: 1) A review of the facility ' s policy, " Nasogastric/Gastric Tube Medication Administration " (not dated) included the following procedural guideline: " 6. Flush the tube before and after medication administration with 1-2 ounces of water. Flush with 1-2 ounces water between medication administration. " Resident #6 was admitted to the facility on 1/27/14. Her cumulative diagnoses included status post placement of a gastrostomy tube (a surgical opening into the stomach whereby a feeding tube may be inserted). A review of Resident #6 ' s physician ' s medication orders included a current order for 50 milligrams (mg)/5 milliliters (ml) docusate liquid to be given as 10 mls (100 mg) via gastrostomy tube three times daily. On 1/6/16 at 1:08 PM, Nurse #2 was observed as she measured 10 milliliters of 50 mg/5 ml docusate liquid into a cup for administration to Resident #6 via her gastrostomy tube. Docusate is a medication used as a stool softener. Nurse #2 poured the docusate liquid into a syringe and administered the medication through the resident ' s gastrostomy tube. The nurse then used approximately 30 mls of water to flush the tube after the medication was administered. An interview was conducted with Nurse #2 on 1/6/16 at 1:30 PM. Upon inquiry, the nurse acknowledged she flushed the gastrostomy tube after administering the medication (not before). She reported she would only flush the tubing with	F 332	2. All residents in the facility do not have the potential to be affected by high med error rate. An inservice for all nursing staff including prn staff was held on 2-3-16 by the Staff Developer and accurate medication administration and proper administration of medication via g-tube was discussed. The inservice included the right of med administration, the difference between senna versus senna with stool softener, proper storage of meds that can and can□t be stored in refrigerator, and latest pharmacy audit was discussed. 3. On a quarterly basis, the Staff Developer will hold a nursing inservice on med administration and the inservice will include but not limited to Gtube med administration, proper med storage, and general principles of medication administration. Proper procedure for med administration via g tube has been written on MAR. 4. On a weekly basis, for 3 month, the DON will monitor one nurse during med pass. The med pass will be on 2 residents, one who receives meds by mouth and the other resident by g tube. The DON monitoring will be on different shifts and will include a Saturday or Sunday. The DON will rotate shifts to be monitored. After 3 months the DON will monitor on a quarterly basis. For 3 months, Pharmacy will watch one nurse during a med pass also. After 3 months the pharmacy will also monitor quarterly. Negative findings from audit will be	

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F 332	Continued From page 24 water before medication administration if a physician ' s order specifically indicated to do so. If no order was written for this, the Nurse #2 reported she would only flush the gastrostomy tube with water after a medication was administered. An interview was conducted on 1/6/16 at 1:35 PM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked what her expectation was in regards to flushing a gastrostomy tube with water before and/or after medication administration. The DON reported she could not speak for anyone else, but indicated that she herself would check tube placement and if it was okay, she would not typically flush the tube with water before administering medication. A follow-up interview was conducted on 1/7/16 at 1:33 PM with the DON. During the follow-up interview, the DON indicated she would expect a gastrostomy tube to be flushed with water before and after medication administration in accordance with the facility ' s policy. The DON also reported there was a need to educate the nursing staff in regards to medication administration for a resident with a gastrostomy tube. 2) On 1/6/16 at 8:53 AM, Nurse #1 was observed preparing medications for administration to Resident #53. The medications pulled for administration included one tablet from a stock bottle containing 8.6 milligrams (mg) senna and 50 mg docusate (a combination medication containing a stimulant laxative and stool softener). The nurse was observed as she administered the senna/docusate tablet to	F 332	corrected. Negative findings will also be sent to the next QA meeting for recommendations from the committee on how to improve outcomes.	

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F 332	Continued From page 25 Resident #53. A review of Resident #53 ' s physician ' s medication orders included a current order for 8.6 mg senna laxative to be given as one tablet by mouth twice daily. An interview was conducted with Nurse #1 on 1/6/16 at 9:45 AM. Upon review of Resident #53 ' s January 2016 Medication Administration Record (MAR) and the manufacturer ' s labeling on the stock bottle of the senna/docusate tablet given to Resident #53, the nurse acknowledged the tablet administered to Resident #53 during the medication administration was not the medication prescribed. The nurse confirmed the prescribed medication (containing 8.6 mg senna as a single active ingredient) was available in the floor stock kept on the medication cart. Nurse #1 indicated the combination medication containing both senna and docusate was the medication residents usually received. However, she reported Resident #53 should have been given a tablet containing senna only, not the combination senna/docusate tablet. An interview was conducted with the facility ' s Director of Nursing (DON) on 1/7/16 at 1:33 PM. During the interview, the DON indicated her expectation would be for the nurses to give medications as ordered by the physician. She noted that if the order was just for senna, then the resident should have been given only senna. The DON stated, " They (the nurses) just need to read the order and follow it. "	F 332		
F 361 SS=D	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS	F 361		2/4/16

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F 361	Continued From page 26 The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to complete a nutritional assessment for residents that required interventions for weight loss or mechanically-altered diets for 2 of 2 residents reviewed (Resident #69 and Resident #23) receiving an enteral tube feeding. The findings included: 1) Resident #69 was admitted to the facility from a hospital on 10/29/15 with a cumulative diagnoses which included diabetes, a history of aspiration pneumonia, and placement of a gastrostomy tube on 10/21/15 (a surgical opening into the stomach whereby a feeding tube may be inserted). Resident #69 ' s admission orders dated 10/29/15 included the following tube feeding instructions:	F 361	1. On 1-16-16, the dietician did a nutritional assessment on resident #69 and Resident # 23. The tube feeding was changed for both residents. Both residents get an enteral feeding formula. Resident #23 was referred to Speech therapy. Resident #23 is receiving ST and OT services. 2. Nutritional assessments were done on all residents that may be in need of a mechanically altered diet. All residents being fed via g tube have been changed to an enteral feeding formula. All residents being fed via g tube have had a nutritional assessment by dietician. The dietician will do an assessment on all g tube residents monthly. The dietician will do an assessment on all residents quarterly. All tube fed residents were added to the February MDS schedule to have a	

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F 361	Continued From page 27 120 milliliters (ml) Diabetisource via gastrostomy tube every 6 hours as a bolus feeding (provided at one time); 90 ml water flush after each feeding and 30 ml of water after each medication. Diabetisource is a tube feeding formulation designed for people with diabetes and stress induced high blood sugar levels. On 10/30/15 at 11:50 AM, a Physician ' s Telephone Order was received to change Resident #69 ' s gastrostomy feeding to Boost Glucose Control formula, given as one can (237 ml) every 6 hours. Boost Glucose Control is a nutritional formulation designed for people with diabetes; it is intended for use as an oral supplement. According to the manufacturer ' s product information, Boost Glucose Control is not intended as a tube feeding formulation. However, if a healthcare provider selected this product for a tube feeding, 5 cans (1185 ml) were required to meet 100 percent of the Recommended Daily Intake (RDI) for essential nutrients. Four cans of Boost Glucose Control provided every 24 hours, as ordered, yielded 1000 calories with 56 grams of protein and 792 ml of free water daily (exclusive of the water flushes). Resident #69 did not receive any nutrition or fluids by mouth. The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered. The resident ' s admission Minimum Data Set (MDS) assessment dated 11/2/15 indicated Resident #69 had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her activities of daily living (ADLs). Resident #69 was reported to be 61 inches tall and weighed 125 pounds. The	F 361	comprehensive MDS completed by 2-24-16. The staff developer audited all residents physician order and checked all resident dietary orders and compared the audit to the snack sheet on 1-28-16. Staff developer then made appropriate referrals to Speech Therapy. 3. On 1-19-16, the facility signed a contract with Health Care Services Group to provide the facility with a dietician. On a monthly basis, the dietician will do a nutritional assessment on residents that are fed via g tube and residents with pressure ulcers. On a monthly basis, the dietician will do a nutritional assessment on residents that are fed via g tube. The dietician will do an assessment on all residents quarterly. The dietician will make recommendations. Depending on the recommendation, it will go to either the kitchen or the doctor. The doctor will decide whether or not to follow the recommendation. The MDS nurse is on the weight committee and will complete nutritional portion of the comprehensive assessments based on the dietician assessment. The weight committee will review all weights at least but not limited to monthly. All weights are reviewed monthly and recommendations made based on weight change of 5% in a month, 7.5% in 3 months and 10% in 6 months. The committee review all tube fed residents nutritional needs on a weekly basis and makes nutritional recommendations as needed. These recommendations include but not limited to notifying dietician, notify doctor, refer to Speech therapy, and add supplements.	

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F 361	Continued From page 28 MDS assessment indicated she received 51% or more of her calories and 501 milliliters or more via a tube feeding. A review of Resident #69 ' s Care Area Assessment (CAA) Summary dated 11/3/15 addressed the use of a feeding tube. The summary read: " Feeding Tube: Triggered by Resident has a feeding tube present. Resident factor to consider: she has dx (diagnosis) of respiratory failure, sepsis, a-fib (atrial fibrillation), CHF (congestive heart failure), DM (diabetes), advanced dementia, HTN (hypertension) and others. She is NPO (nothing by mouth) and all fluids and nutrition are via feeding tube. Tube was present upon admission to SNF (Skilled Nursing Facility). She does not attempt to remove the tube. She does not move often. She is non-communicative. No noted abdominal distention. Current weight is 125 pounds. No referrals, will proceed with care plan to maintain tube and weight. " The CAA Summary did not include an analysis of the current weight compared to her usual body weight. The CAA did not address an assessment of the nutritional needs of this resident nor did it address an analysis of the current tube feeding orders and whether the current tube feeding met her nutritional requirements. The CAA did not include information provided by the facility ' s consultant dietitian; it indicated no referrals were planned. A review of Resident #69 ' s Care Plan dated 11/3/15 included the following area of focus: Alteration in nutrition related to use of a feeding tube. There were no Interventions/Approaches which addressed Resident #69 ' s weight in the	F 361	4. On a monthly basis, for 3 months the administrator will audit all resident charts to ensure the dietician has written a nutritional assessment within 14 days of admission. After 3 months, the audit will be performed quarterly. On a monthly basis, for 3 months, the administrator will audit the CAA□s of resident who are fed by gtube to ensure they have a CAA. After 3 months, the audit will be performed quarterly. Negative findings from these audits will be corrected in the appropriate time. Negative findings will also be sent to the next QA meeting for recommendations from the committee on how to decrease the number of negative findings	

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care plan. Additionally, no Interventions/Approaches addressed an assessment of the resident ' s nutritional needs or an analysis of the adequacy of her tube feeding in meeting these needs. The care plan Interventions/Approaches did not indicate a referral would be made to the consultant dietitian, either initially or on an as needed basis.

A review of Resident #69 ' s medical record included the following laboratory results dated 11/3/15: total protein = 5.0 (normal range = 6.5-8.0), and albumin = 2.4 (normal range = 3.0-5.5). Albumin is the most abundant protein in human blood plasma and is frequently used in blood test panels for general health screening. An albumin level of 2.4 may be indicative of moderate to severe visceral protein depletion.

A review of Resident #69 ' s Weight Records included the following:
11/4/15 Weight = 118 pounds.
11/11/15 Weight = 111 pounds;
11/18/15 Weight = 105 pounds;
11/25/15 No weight was noted; and,
12/2/15 No weight was noted.

A Physician ' s Telephone Order was written on 12/2/15 for weekly weights due to continuous weight loss (per weight committee). Resident #69 ' s tube feeding was increased to 320 ml every 6 hours. 320 ml of Boost Glucose Control given every 6 hours yielded approximately 1349 calories with 75.6 grams of protein and 1069 ml of free water daily (exclusive of the water flushes). The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the

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tube feeding ordered.

A review of Resident #69 ' s Weight Record included the following:
12/9/15 Weight = 96 pounds;
12/16/15 Weight = 98 pounds.
12/23/15 Weight = 97 pounds; and,
12/30/15 Weight = 96 pounds.

On 12/30/15 at 2:00 PM, the Nurse ' s Notes revealed a Stage 2 pressure area was found on Resident #69 ' s sacrum.

On 12/31/15, a Physician ' s Telephone Order was written to change the tube feeding formulation to Diabetisource and to initiate this feeding at 55 milliliters per hour (ml/hr) continuous feeding (versus the previously ordered bolus feeding schedule). Diabetisource provided at 55 ml/hr via continuous feed yielded 1584 calories with 79.2 grams of protein and 1080 ml of free water daily (exclusive of the tube feeding water flushes). The resident ' s medical record did not include an assessment of her nutritional needs or an approximation of the nutritional content of the tube feeding ordered.

A review of Resident #69 ' s Weight Records included the following: 1/6/16 Weight = 102# pounds.

A review of Resident #69 ' s Medical Record revealed there were no Nutrition Progress Notes completed for this resident. A nutritional assessment was not available to estimate her calorie, protein, and/or fluid needs; nor was there an approximation of the calories, protein, and/or free water provided by the tube feeding ordered for the resident since her admission to the facility

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An interview was conducted on 1/6/16 at 3:14 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported residents ' weights were followed weekly by the facility ' s Weight Committee. The DON acknowledged Resident #69 ' s continuing weight loss was identified by the Committee and she was weighed weekly to follow the weights. No other assessments or interventions were reported.

A telephone interview was conducted on 1/6/16 at 3:44 PM with the facility ' s consultant Registered Dietitian (RD). During the interview, the consultant RD reported she typically tried to come to the facility once a month. However, the RD noted she hadn ' t been in the facility the past month. Upon further questioning, the RD reported her last nutrition consultation visit to the facility was approximately 10 weeks ago and prior to Resident #69 ' s admission date of 10/29/15. She reported the Dietary Manager for the facility did not have any clinical responsibilities whatsoever. When asked, the RD stated she usually checked on residents receiving a tube feeding when he/she was first admitted to the facility and when due for a quarterly assessment. She indicated residents with a tube feeding were also reviewed if he/she was losing weight or had another problem prior to the scheduled assessment date. The RD reported staff at the facility were able to contact her for a consultation as needed, but acknowledged no such request had been made since her last visit to the facility. Upon briefly reviewing Resident #69 ' s tube feeding orders, laboratory results and history of weight loss, the RD stated, " Yeah, that ' s something that should have been addressed. "

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An interview was conducted on 1/7/16 at 1:33 PM with the facility ' s DON. The DON reported the facility ' s consultant RD normally reviewed the residents receiving a tube feeding to ensure the formulation and volume provided met his/her nutritional needs. However, the DON indicated she had not seen the RD in the building for quite a while. When asked if she would have expected the RD to have reviewed Resident #69 ' s tube feeding regimen to ensure she was getting enough calories to prevent weight loss, she stated, " Yes. " Upon inquiry as to who was responsible to ensure the resident was meeting her protein needs, the DON stated, " the doctor and the dietitian. "

An interview was conducted on 1/7/16 at 2:00 PM with the facility ' s Administrator. During the interview, the Administrator was asked what role he expected the consultant dietitian to have in providing nutritional care for Resident #69. The Administrator stated he expected the consultant dietitian, " To see her people timely. "

2)

Resident #23 was admitted on 8/3/15. Diagnoses included protein calorie malnutrition, dementia, gastrostomy insertion (feeding tube), anemia, urinary tract infections, and heart failure.

A record review of the MDS quarterly assessment dated 10/31/15 revealed the resident is severely cognitively impaired. The resident is totally

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dependent with one assist with all activities of daily living (ADL's) except transfers, which required a two-person assist. The resident was always incontinent of bowel and bladder and had a gastrostomy tube for feedings and a mechanically altered diet.

A record review of the care plan revealed an updated care plan on 11/2/15 for nutrition related to the feeding tube. Approaches included to monitor for dehydration, signs and symptoms of aspiration, monitor intake and output each shift, keep head of the bed elevated, check for gastrostomy tube placement prior to feedings and notify physician if dislodged.

A record review of the resident's record dated 7/15/15 revealed the resident was sent to the hospital for gastrostomy tube insertion (feeding tube) due to poor oral intake and weight loss. The tube was inserted on 7/31/15. The resident was readmitted to the facility on 8/3/15. The resident was started on one can of tube feeding every six hours via the tube. On 8/6/15, the Speech Therapist ordered that the resident may have pleasure feedings of thin liquids and a pureed diet. Continued review of the record revealed a physician ' s order written on 8/3/15 to administer the tube feeding four times daily at 6 am, 12 noon, 6 pm and midnight. There were no orders for any nutrional supplements for this resident.

A record review from the Administrator revealed the Dietary Manager had not been to the facility since October 2, 2015. There were no records indicating Resident #23 had been seen or assessed by the Dietician since her readmission on 8/3/15.

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A record review of the activity of daily living (ADL) log which is updated each shift by the NA ' s, revealed the resident consumes approximately 25 - 50% of her meals and occasionally 75% of her meals since August 2015. The resident also consumed some or most of the liquids on her tray.

An observation of resident #23 on 1/6/15 at 8:30 am revealed an alert and oriented to self only resident. She was sitting upright in bed. NA #1 was beginning to feed the resident at this time. The meal tray was pureed with thin liquids.

An interview with Nurse #2 regarding the resident ' s appetite on 1/6/15 at 9:59 am revealed the resident eats an average of 25- 50% with each meal. The resident is on a tube feeding four times per day and has had no difficulties with swallowing or choking during her meals. The resident had regular bowel movements, no nausea or vomiting and no infection. Nurse #2 revealed the resident had been eating since 8/6/15 in addition to her tube feedings. The gastrostomy tube was placed on 8/3/15 due to the resident ' s failure to thrive and decreased oral intake. A continued review revealed the weight had improved ranging from 148 - 152 since August. The resident ' s weight prior to the tube insertion was 134 pounds.

An interview with NA (Nursing Assistant) #1 on 1/6/15 at 10:25 am revealed the resident ate 25% of her breakfast and usually ate about 25% at lunch. The NA reported she does not like some of the pureed food, but the ones she does like she tried to encourage her to eat. The NA further reported she would sometimes drink all her liquids and sometimes just take sips. The NA

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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revealed the resident had no difficulty with swallowing when she fed her.

An observation of Resident #23 on 1/7/15 at 12:45 pm revealed NA #1 assisting the resident to eat. The resident was observed having no difficulties with swallowing.

An interview with NA #2 on 1/7/15 at 4:00 pm revealed the resident would eat about 25% of her dinner meal. She would drink sips or her liquid or the whole cup. The NA reported the resident had no difficulty with swallowing.

A phone interview with the Dietician on 1/6/16 at 3:07 pm revealed she was the dietary consultant for the facility. She reported she was trying to come once a month, but had some issues so she had not been there for about 10 weeks. She reported she would do assessments on residents who are reported as losing weight, had aspiration pneumonia or a problem before the quarterly assessment. In addition, if a resident comes in on a tube feed she would do an assessment on them.

An interview with the Speech Therapist on 1/7/15 at 5:00 pm revealed the resident would be reevaluated if the nursing staff sent a referral. The ST revealed this resident would have been an ideal candidate to reevaluate to a more appropriate diet due to her adequate oral intake. She further reported that no referrals were done to reevaluate this resident. The ST stated that in order to make any changes to the resident ' s diet she would need to consult the dietician after reevaluating the resident.

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F 361	Continued From page 36 An interview with the Nursing Supervisor on 1/7/15 revealed that she did not know why no attempts were made to advance Resident # 23 to a more appropriate diet. The nursing supervisor reported she had no problems with swallowing and she was not considered a risk for aspirating or choking. She did not know why the resident was still on a pureed diet. An interview with the Director of Nursing on 1/7/15 revealed that her expectation of the nurse ' s would be not to suggest changing the diet. The DON reported that we usually wait for a family member to request a change in the diet. If a family member did not suggest a change, then her expectation was that the Dietician should re-evaluate the resident to a more appropriate diet. The DON reported she was aware that a dietician has not assessed her since her admission after getting a gastrostomy tube placed.	F 361		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to prepare food in a form designed to meet individual nutritional needs for 1 of 1 residents (resident #23) The findings included:	F 365	1. Resident #23 has been referred to speech therapy on 1-21-16. ST evaluated resident #23 on 1-21-16. ST wrote orders to work with resident #23 for 5Xwk for 4 wks. The appropriateness of the mechanically altered diet is being addressed and changes will be made as	2/4/16

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F 365	Continued From page 37 Resident #23 was admitted on 8/3/15. Diagnoses included protein calorie malnutrition, dementia, gastrostomy insertion (feeding tube), anemia, urinary tract infections, and heart failure. A record review of the MDS quarterly assessment dated 10/31/15 revealed the resident is severely cognitively impaired. The resident is totally dependent with one assist with all activities of daily living (ADL's) except transfers, which required a two-person assist. The resident was always incontinent of bowel and bladder and had a gastrostomy tube for feedings and a mechanically altered diet. A record review of the care plan revealed an updated care plan on 11/2/15 for nutrition related to the feeding tube. Approaches included to monitor for dehydration, signs and symptoms of aspiration, monitor intake and output each shift, keep head of the bed elevated, check for gastrostomy tube placement prior to feedings and notify physician if dislodged. A record review of the resident's record revealed the resident was sent to the hospital for gastrostomy tube insertion (feeding tube) due to poor oral intake and weight loss. The tube was inserted on 7/31/15. The resident was readmitted to the facility on 8/3/15. The resident was started on one can of tube feeding every six hours via the tube. On 8/6/15, the Speech Therapist ordered that the resident may have pleasure feedings of thin liquids and a pureed diet. A record review from the Administrator revealed the Dietary Manager had not been to the facility since October 2, 2015. There were no records indicating Resident #23 had been seen or	F 365	indicated from the Speech Therapist. 2. All resident diets were reviewed by staff developer on 1-28-16. Staff developer audited all physicians order and checked dietary orders then compared audit sheet to snack sheet. She then made appropriate ST referrals based on audit. 3. Therapy manager will ensure completion of resident screening on a quarterly basis by observation and/or record review. New Hires will also be orientated on therapy referral forms. The staff developer inserviced all nursing staff including prn staff, about therapy referral forms on 2-3-16. All nursing staff will be inserviced quarterly on ST referral forms. 4.On a monthly basis, the staff developer will review all resident diet orders. After 3 months the audit will be quarterly. The staff developer will audit the physicians order and dietary order then compare the audit sheet to the snack sheet. Negative findings from audit will be corrected. Negative findings will also be sent to the next QA meeting for recommendations from the committee on how to improve outcomes.	

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assessed by the Dietician since her readmission on 8/3/15.

An observation of resident #23 on 1/6/15 at 8:30 am revealed an alert and oriented to self only resident. She was sitting upright in bed. NA #1 was starting to feed the resident at this time. The meal tray was pureed with thin liquids.

An interview with Nurse #1 regarding the resident ' s appetite on 1/6/15 at 9:59 am revealed the resident eats an average of 25- 50% with each meal. The resident is on a tube feeding four times per day. The resident has had no difficulties with swallowing or choking during her meals. The resident had regular bowel movements, no nausea or vomiting and no infection. Nurse #1 revealed the resident had been eating since 8/6/15 in addition to her tube feedings. The gastrostomy tube was placed on 8/3/15 due to the resident ' s failure to thrive and decreased oral intake. The resident ' s weight had improved ranging from 148 - 152 since August. The resident ' s weight prior to the tube insertion was 134 pounds.

An interview with NA #1 on 1/6/15 at 10:25 am revealed the resident ate 25% of her breakfast and usually ate about 25% at lunch. The NA reported she does not like some of the pureed food, but the ones she does like she tried to encourage her to eat. The NA further reported she would sometimes drink all her liquids and sometimes just take sips. The NA revealed the resident had no difficulty with swallowing when she fed her.

An observation of Resident #23 on 1/7/15 at 12:45 pm revealed an NA assisting the resident to

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eat lunch. The resident was observed having no difficulties swallowing a pureed diet.

An interview with NA #2 on 1/7/15 at 4:00 pm revealed the resident would eat about 25% of her dinner meal. She would drink sips of her liquid or the whole cup. The NA reported the resident had no difficulty with swallowing with her pureed diet or thin liquids.

An interview with the Speech Therapist (ST) on 1/7/15 at 5:00 pm revealed the resident would be reevaluated if the nursing staff sent a referral. The ST revealed this resident would have been an ideal candidate to reevaluate to a more appropriate diet due to her adequate oral intake. She further reported that no referrals were done by nursing to reevaluate this resident.

An interview with the Nursing Supervisor on 1/7/15 revealed that she did not know why no attempts were made to advance Resident # 23 to a more appropriate diet. The nursing supervisor reported she had no problems with swallowing and she was not considered a risk for aspirating or choking. She did not know why the resident was still on a pureed diet.

An interview with the Director of Nursing on 1/7/15 revealed that her expectation of the nurse ' s would be not to suggest changing the diet. The DON reported that we usually wait for a family member to request a change in the diet. If a family member did not suggest a change, then her expectation was that the Dietician should re-evaluate the resident to a more appropriate diet. The DON reported she was aware that a dietician has not assessed her since her admission after getting a gastrostomy tube

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F 365	Continued From page 40 placed.	F 365		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to initiate the process for replacement of lost dentures for 1 of 3 Medicaid residents that needed dental assistance (Resident #19). The findings included: Resident #19 was admitted to the facility on 2/28/12. The diagnoses included difficulty swallowing. The quarterly Minimum Data Set (MDS) dated 12/21/15, indicated the resident ' s cognition was intact and no concerns were coded regarding swallowing or chewing. The MDS under dental appliances was not coded for dentures. Review of the dental history reports done by the dentist documented on 4/28/15, 9/4/15 and 11/17/15. The report indicated Resident #19 had upper and lower dentures that had been	F 412	Resident #19 went to Henderson Family Dentistry on 1-28-16 and had impressions done. Resident #19 has a follow up appointment with Henderson Family Dentistry on 2-11-16. On 1-11-16, all residents were audited for denture needs and appropriate action was taken. On a monthly basis, for 3 months, the Staff Developer will audit residents for changes in denture needs. After 3 months, the Staff Developer will audit residents on a quarterly basis about denture care and will take the appropriate action. Negative findings from monitoring will be corrected in a timely manner. Negative findings will also be sent to the next QA meeting for recommendations from the committee on how to improve outcomes.	2/4/16

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re-aligned on each of listed visits.

During an observation on 1/5/16 at 2:12PM, Resident #19 was in her room eating a sandwich and a cup of fruit. She did not have her bottom dentures in place. She could not recall the last time she had seen the dentist. She stated " I had been waiting a month for them (staff) to get back with me on my dentures. Some things are hard to chew without them, so I do the best I can " . Resident #19 indicated her preference was to have both top and bottom dentures.

During an interview on 1/6/16 at 10:00AM, the Nurse Supervisor stated the resident had some dental concerns and had lost her dentures. The Nurse Supervisor added they were currently waiting for Medicaid approval for new dentures. Nurse supervisor explained the resident ' s complaint was she was missing her teeth. The Nurse Supervisor indicated the last time she had seen Resident #19 ' s dentures was in November of 2015. She indicated a note was left with the doctor for medical clearance on 11/17/15 and her diet was changed on 12/9/15 to a soft diet. The Nurse Supervisor explained the process included the physician would do a letter for medical clearance. Then the letter would be sent to the dentist and a referral would also be sent to Medicaid. It could take up to 6 months for approval. She was unable to present the letter upon request. She further stated she contacted the dentist office on 1/6/16 and there was no current record of dental request for replacement of dentures.

During a follow up interview on 1/6/16 at 10:46AM, Resident #19 indicated that certain meats and foods were hard to chew without the

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dentures. " I have been just waiting for them to get back with me. So far my gums haven ' t started hurting, but if it goes any longer I am sure they will start hurting. Some of the meats are not as tender in my mouth, so I just leave it on my plate. "

During a follow-up interview on 1/6/16 at 11:30AM, the Nurse Supervisor stated that she had spoken with the physician 1/6/16 and the order for dentist to complete referral for replacement was not completed therefore it was done today. She added the expectation would be for staff to remove the resident's dentures at night and place them in the denture cup. She indicated being unaware of where the dentures were currently located at this time.

During an observation on 1/6/16 at 12:30PM, Resident #19 reported the meat in the stroganoff was a little chewy, if she had her teeth "I could have had an easier time chewing the meat. I did what I could with these few teeth. If I had my teeth I could get a good grip on the meat."

During an interview on 1/6/16 at 2:19PM, the Director of Nursing, indicated the expectation would be for staff to remove the dentures and put them in the provided dental cups. She further stated she was aware of what happened with Resident #19's dentures since November and there was no system in place to check whether residents had their dentures. She added that when resident are admitted the Social Worker would inform residents and family the facility not responsible loss or missing dentures. It could be followed up with insurance or Medicare.

During an interview on 1/7/16 at 4:41PM, the

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F 412	Continued From page 43 Social Worker indicated the expectation would be for the physician to do a medical letter for denture replacement. The Social Worker stated once the medical clearance was completed by the dentist it would be sent to Medicaid for replacement if the resident had not had a repair or replacement in the past 10 years. The Social Worker confirmed the letter had not been done and the referral had not been completed for Medicaid. During an interview on 1/6/16 at 5:03PM, the Administrator stated the expectation was for staff to search for any lost personal items. Staff was responsible for ensuring residents personal items such as dentures and hearing aids be placed in appropriate container and put away safely. The Administrator added the Social Worker and Director of Nursing were responsible for ensuring the paperwork process was complete for referral for evaluations or replacement of dentures and hearing aids.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		2/4/16

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F 431	Continued From page 44 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store a medication as specified by the manufacturer in 1 of 1 medication store rooms. The findings included: An observation of the medication store room on 1/7/16 at 10:13 AM revealed an unopened bottle of 2% - 0.5% dorzolamide-timolol ophthalmic (eye) solution labeled for Resident #86 was stored in the refrigerator. The refrigerator temperature at the time of the observation was 42o Fahrenheit (F). The ophthalmic solution was labeled as having been dispensed from the pharmacy on 12/28/15. The manufacturer ' s product information indicated 2% - 0.5%	F 431	1. Resident #86 eye drops were removed from the refrigerator in the med room. 2. All eye drops that don□t require refrigeration have been removed from the refrigerator in the medication room. On 2-3-16, the staff developer inserviced all nursing staff including prn staff, on proper storage of meds that can and can□t be stored in refrigerator. 3. On a quarterly basis, the Staff Developer will hold a nursing inservice on med administration and the inservice will include but not limited to Gtube med administration, proper med storage, and general principles of medication administration. 4.On a weekly basis for three months., the	

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F 431	Continued From page 45 dorzolamide-timolol ophthalmic solution should be stored at room temperature between 68o F - 77o F. Dorzolamide-timolol ophthalmic solution is a combination medication used to treat glaucoma. A review of Resident #86 ' s January 2016 Physician Orders revealed there was a current order for 2% - 0.5% dorzolamide-timolol ophthalmic solution to be instilled as 1 drop into each eye every morning. An interview was conducted on 1/7/16 at 11:33 AM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported she would have expected this medication to be stored at room temperature in accordance with the manufacturer ' s recommendations. She acknowledged she would not have expected this ophthalmic solution to be stored in the refrigerator.	F 431	DON will audit the medication room and med carts. After 3 months the audit will be performed on a quarterly basis by DON. On a monthly basis for three months, the pharmacy will audit the med room for proper storage. After three months the pharmacy will monitor on a quarterly basis. Negative findings from monitoring will be corrected. Negative findings will also be sent to the next QA meeting for recommendations from the committee on how to improve outcomes.	
F 520 SS=D	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.	F 520		2/4/16

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F 520	Continued From page 46 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: Based on record review and interviews with the facility staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for two recited deficiencies which were originally cited in April of 2015 on a recertification survey and subsequently recited on the current recertification survey. The deficiencies were in the areas of a medication error rate of 5% or more (F332) and storage of medications (F431). The continued failure of the facility during two 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: a) F332: Failure to be free of a medication error rate of 5% or more. Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error	F 520	1. Medication storage and Medication error rate will be discussed at QA meeting and the plan of correction for the two tags will be discussed. The facility owner will re educate the QA committee on the facility QA policy. 2. The QA committee will be re educated on the facility QA policy by the facility owner. 3. The QA committee will meet monthly for the 6 months then will resume quarterly meetings. Audits, consultation reports and items of interest will be reviewed at the meeting. 4. Audits, consulation reports and items of interest will be presented at the QA meeting. The committee will review and discuss the information for possible trends and make re- evaluations if needed.	

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rate of 8%, for 2 of 7 residents (Resident #6 and Resident #53) observed during medication pass.

During the recertification survey of 4/16/15, the facility was cited for F332 for failure to maintain a medication error rate less than 5%. Three medication errors were identified from a total of 29 opportunities during the medication pass observation, resulting in a 10% medication error rate. The facility failed to maintain a medication error rate of 5% or less on the current recertification survey.

b) F431: Labeling and storage of biologicals and drugs. Based on observations and staff interviews, the facility failed to store a medication as specified by the manufacturer in 1 of 1 medication store rooms.

During the recertification survey of 4/16/15, the facility was cited for F431 for failing to remove and properly dispose of loose pills and maintain a clean storage environment in 2 of 3 medication carts observed for medication storage. The facility failed to ensure medication was stored properly on the current recertification survey.

An interview was conducted on 1/7/16 at 2:00 PM with the facility ' s Administrator, with a follow-up interview conducted on 1/7/16 at 4:55 PM. During the interviews, the Administrator reported the facility ' s QAA Committee met quarterly. Committee members included himself, the Director of Nursing, the MDS (Minimum Data Set assessment) Nurse, the Social Worker, consultant pharmacist, and the Medical Director. The Administrator indicated the QAA Committee met to review and discuss routine concerns, including medication administration, labs,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27536

(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 520	Continued From page 48 accuracy of the Medication Administration Records (MARs), and resident weights. He indicated staff were expected to monitor and audit changes in the facility ' s system related to deficiencies from previous years. He reported systems related to both the F332 (medication pass) and F431 (expired medications) citations continued to be followed by the facility.	F 520		