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	345296	A. BUILDING ______ B. WING ______	C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to honor resident's choices for frequency of showers for 2 of 3 residents sampled for choices (Resident #136 and #58). The findings included: 1. Resident #136 was readmitted to the facility on 03/08/16 with diagnoses which included heart disease, lung disease, generalized muscle weakness, chronic pain and osteoarthritis. A review of the most recent quarterly Minimum Data Set (MDS) dated 04/03/16 indicated Resident #136 was cognitively intact for daily decision making. The MDS further indicated Resident #136 required extensive assistance with hygiene and total assistance with bathing and exhibited no behaviors of rejection of care. A review of a care plan with an onset date of 03/08/16 revealed a problem of decreased independence due to weakness and chronic obstructive pulmonary disease and required assistance with activities of daily living (ADL).	F 242	1. "Residents bathing preferences updated to reflect what route and days they prefer to be bathed." 2. Care plan letter which is sent out quarterly to responsible parties has been changed to ask if "the current bathing schedule is still as desired. If not please let us know your preference so that we can change that for you." 3. Residents will continue to have choice of bath schedule on admission. With letter sent out to address any changes they would like to make in the future. 4. Any changes to bathing schedules from care plan letter receipt will be forwarded to QA x 2 months for review.	6/7/16

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

Electronically Signed | | 05/31/2016

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

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F 242	Continued From page 1	F 242		

The goals indicated in part Resident #136 would not have a decline in ADLs through next 90 days.

A review of bath schedules revealed Resident #136 was scheduled to receive a shower twice a week on Tuesday and Friday on second shift.

A review of a facility document titled ADL Hygiene and Bathing report for the last 30 days indicated Resident #136 received a shower as follows:
Wednesday 04/13/16
Friday 04/16/16
Wednesday 04/20/16
Saturday 04/30/16.

During an interview on 05/10/16 at 10:01 AM with Resident #136 he stated he was not able to choose how many times a week he took a shower. He further stated the facility chose for him how many times a week he took a shower but he would like more than the 2 per showers a week he was supposed to receive.

During an interview on 05/11/16 at 10:09 NA #1 stated residents were scheduled for 2 showers a week. NA #2 stated the NAs gave residents showers on first and second shift and usually 4-6 showers were given to residents on first and second shift.

During an interview on 05/12/16 at 2:04 PM with Nurse #5 she explained Resident #136 shaved himself and partially dressed himself but he required staff assistance with bathing. She stated Resident #136 was cooperative with care and he did not exhibit behaviors or reject care. She further stated Resident #136 received 2 showers a week on Tuesday and Friday.

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F 242	Continued From page 2 During an interview on 05/12/16 at 10:50 AM with the Nursing Supervisor she confirmed there was a shower book at the nurse's station for each hall that indicated the shower day for each resident. She confirmed residents were scheduled for 2 showers a week according to their room number. During an interview on 05/12/16 at 4:03 PM with the Director of Nursing she explained residents or their family were asked for their choice regarding showers on admission. She stated if a resident or family expressed a change in showers they could change the shower schedule for that day. She further stated residents or families lets them know when their schedule needed to change and confirmed there was no system in place to reassess the residents choice regarding the number of showers they received after they were admitted.. 2. Resident #58 was admitted to the facility on 12/05/07 with diagnoses which included psoriasis, atopic dermatitis (inflammation of the skin), heart disease, chronic obstructive lung disease, thyroid disease, rheumatoid arthritis, type II diabetes, anxiety, depression, dementia and a history of a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/11/16 revealed Resident #58 was cognitively intact for daily decision making. The MDS further indicated Resident #58 required extensive assistance with hygiene and bathing and exhibited no behaviors of rejection of care. A review of a care plan with an onset date of 01/06/15 indicated Resident #58 required assistance with activities of daily living related to	F 242		

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F 242	Continued From page 3 impaired mobility, balance and range of motion to right lower extremity. The goals indicated Resident #58 would improve and maintain self-care activities within her level of ability through next review and interventions were listed in part to assist Resident #58 with activities of daily living to completion and encourage increased independence. A review of bath schedules revealed Resident #58 was scheduled to receive a shower twice a week on Wednesday and Saturday on first shift. A review of a facility document titled ADL Hygiene and Bathing Report provided by the facility indicated there were no showers listed as given during the last 30 days. During an interview on 05/10/16 at 11:06 AM Resident #58 stated she did not have a choice of how many showers she received but the facility staff chose it for her. She explained she usually got a couple of showers a week but she would like to go shower more often and stated at least 3-4 times a week because that's what she would do if she were at her home. During an interview on 05/11/16 at 10:09 NA #1 stated residents were scheduled for 2 showers a week. NA #2 stated the NAs gave residents showers on first and second shift and usually 4-6 showers were given to residents on first and second shift. During an interview on 05/12/16 at 10:50 AM with the Nursing Supervisor she confirmed there was a shower book at the nurse's station for each hall that indicated the shower day for each resident. She confirmed residents were scheduled for 2	F 242		

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F 242	Continued From page 4 showers a week according to their room number. During an interview on 05/12/16 at 4:03 PM with the Director of Nursing she explained residents or their family were asked for their choice regarding baths and showers. She stated if a resident or family expressed a change in baths or showers they could change the shower schedule for that day. She further stated residents or families lets them know when their bath schedule needed to change and confirmed there was no system in place to reassess the residents choice regarding the number of baths or showers they received after they were admitted.	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean bathroom for a shared restroom on the 300 hall for 1 of 5 bathrooms observed and the facility failed to remove dark brown stains from around the base of toilets in resident bathrooms and repair broken or missing tile at the base of toilets on 2 of 6 resident hallways. The findings included: 1. Observation of bathroom in room 307 on 05/09/16 at 2:56 PM revealed a terrible odor of feces, a soiled pull up was laying in the floor and	F 253	1. Bath room disinfected and pull up disposed of. All noted toilet bases scrubbed and caulked. 2. All toilets in use on halls 100 - 400 were checked for cleanliness and had bases cleaned and caulk applied. 3. Housekeeping to inspect rest rooms on halls 100 - 400 for cleanliness weekly x 2 months. As well as continue daily rounds for cleanliness. 4. Findings from weekly inspections to be	6/7/16

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F 253	Continued From page 5 there was feces smeared on the toilet seat. Interview with the Administrator on 05/09/16 at 2:59 PM revealed that he expected housekeeping department to clean the restroom and he would get them to take care of the issue. Interview with the Director of Housekeeping on 05/12/16 at 8:43 AM revealed that he had 12 housekeepers on staff that included floor technician and laundry aides. The Director of housekeeping stated that he had one housekeeper per hall on first shift and that they were responsible for cleaning resident rooms and bathrooms throughout the day. The Director of Housekeeping further stated that it was joint responsible of nursing and housekeeping to clean up any spills or messes that occur, nursing should have picked up the soiled pull up and then called the housekeeper to clean the toilet and housekeeping would have cleaned the toilet and notify nursing of the soiled pull up in the floor, so they would have worked together to get the mess cleaned up. In a follow up interview with the Administrator on 05/12/16 at 3:52 PM revealed that he expected nursing and housekeeping to communicate to each other to make sure resident rooms and bathrooms are cleaned daily and any messes or spills were also taken care of. 2. a. Observations of Room #101 on 05/10/16 at 11:23 AM revealed dark brown stains on the floor at the base of the toilet and tile was broken at base of toilet. Observations on 05/11/16 at 3:55 PM in the bathroom of room #101 revealed dark brown stains on the floor at the base of the toilet and tile was broken at base of toilet.	F 253	brought to QA committee x 2 months.	

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F 253	Continued From page 6 Observations on 05/12/16 at 10:45 AM in the bathroom of room #101 revealed dark brown stains on the floor at the base of the toilet and tile was broken at base of toilet. b. Observations of Room #104 on 05/10/16 at 11:14 AM revealed dark brown stains on the floor at the base of the toilet. Observations on 05/11/16 at 3:58 PM in the bathroom of room #104 revealed dark brown stains on the floor at the base of the toilet. Observations on 05/12/16 at 10:49 AM in the bathroom of room #104 revealed dark brown stains on the floor at the base of the toilet. Observations of Room #110 on 05/10/16 at 12:51 PM revealed dark brown stains on the floor at the base of the toilet. Observations on 05/11/16 at 4:05 PM in the bathroom of room #110 revealed dark brown stains on the floor at the base of the toilet. Observations on 05/12/16 at 10:52 AM in the bathroom of room #110 revealed dark brown stains on the floor at the base of the toilet. Observations of Room #113 on 05/10/16 at 9 AM revealed dark brown stains on the floor at the base of the toilet. Observations on 05/11/16 at 4:07 PM in the bathroom of room #113 revealed dark brown stains on the floor at the base of the toilet. Observations on 05/12/16 at 10:54 AM in the bathroom of room #113 revealed dark brown stains on the floor at the base of the toilet. Observations of Room #114 on 05/10/16 at 12:44 PM revealed dark brown stains on the floor at the base of the toilet and missing tile at base of toilet. Observations on 05/11/16 at 4:10 PM in the	F 253		

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bathroom of room #114 revealed dark brown stains on the floor at the base of the toilet and missing tile at base of toilet.
Observations on 05/12/16 at 11:02 AM in the bathroom of room #114 revealed dark brown stains on the floor at the base of the toilet and missing tile at base of toilet.

Observations of Room #205 on 05/10/16 at 12:05 PM revealed dark brown stains on the floor at the base of the toilet.
Observations on 05/11/16 at 4:15 PM in the bathroom of room #205 revealed dark brown stains on the floor at the base of the toilet.
Observations on 05/12/16 at 11:05 AM in the bathroom of room #205 revealed dark brown stains on the floor at the base of the toilet.

During an interview on 05/12/16 at 3:10 PM with the Maintenance Director he explained when repairs were needed staff paged him on the overhead paging system but if he was out of the facility they called him on his cell phone. He further explained the facility used a work order system and any staff in the facility could fill out a work order for repairs and the work orders were kept on a clipboard at the nurse's station. He explained he checked the clipboard daily when he made rounds.

During an environmental tour on 05/12/16 at 3:30 PM with the Administrator and Maintenance Director they confirmed the tile around the base of the toilets in the resident's bathrooms were stained with dark brown stains. The Administrator stated the stains around the toilets or missing tile did not look good and he expected for the facility to look clean. He further stated he expected for staff to report to maintenance when repairs

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F 253	Continued From page 8 needed to be made.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to record a resident's significant weight loss for 1 of 3 sampled residents	F 278	1. Resident assessment has been adjusted with proper weight and significant weight loss coded.	6/7/16

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F 278	Continued From page 9 (Resident #148). The findings included: Resident #148 was admitted to the facility on 04/07/14 discharged to an assisted living facility on 08/24/15 and readmitted on 11/23/15 with diagnoses that included femur fracture, depressive disorder, dementia and others. A Minimum Date Set (MDS) dated 02/17/16 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident weighed 109 pounds but this was not a significant weight loss or gain for the resident. Review of Resident #148's medical record revealed the resident weights were: 08/17/15 131.9 pounds (lbs.) 11/23/15 135.4 lbs on readmission 12/03/15 136.6 lbs 01/04/16 113.4 lbs 02/01/16 108.9 lbs 02/18/16 114.7 lbs From 08/17/15 to 02/18/16 Resident #148 had experienced a significant weight loss of 13.0 percent weight loss in 6 months. On 05/12/16 at 1:25 PM the MDS Coordinator was interviewed and reviewed section K of the MDS dated 02/17/16 and reported that significant weight loss should have been coded for Resident #148. The MDS Coordinator explained that the facility's Registered Dietitian (RD) was responsible for completing section K of the MDS. She added that recently the facility had several new Registered Dietitians and they have had concerns with MDS section K assessments being coded correctly. On 05/12/16 at 3:00 PM a follow-up interview with conducted with the MDS Coordinator and she explained she spoke with the RD who revealed	F 278	2. February assessments will be audited for proper weight coding. Any issues will be corrected. 3. With each upcoming assessment accuracy will be monitored and checked through weekly weight and wound meeting. Any findings will be documented. 4. Findings will be brought to QA x 2 months for review.	

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F 278	Continued From page 10 she had not coded the significant weight loss on the MDS assessment because Resident #148 had been a readmission. The MDS Coordinator reported that since the facility was aware of the 6 month significant weight loss it should have been coded on the MDS.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide toe nail care for 1 of 5 residents reviewed for activities of daily living (ADL) (Resident #7). The finding included: Resident #7 was readmitted to the facility on 01/19/16 with diagnoses that included urinary tract infection, dementia, anemia, hypertension, depression, anxiety, diabetes mellitus, and chronic obstructive pulmonary disease. Review of the most recent quarterly minimum data set (MDS) dated 04/19/16 revealed that Resident #7 was moderately impaired for daily decision making and had both short and long term memory problems. The MDS further revealed that Resident #7 required total assistance of two staff members for bed mobility, transfers, toilet use, personal hygiene and bathing.	F 312	1. Nails for resident #7 were trimmed by nurse on 5/12/16. 2. Administrative nurses audited residents for nail issues on 5/18/16 to ensure no other residents had nail issues. 3. DON or designee will check resident nails weekly x 2 months to ensure continued compliance. 4. Audit findings will be brought to QA x 2 month for follow up.	6/7/16

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F 312	Continued From page 11	F 312		

Observations of Resident #7 on 05/11/16 at 10:09 AM in the shower room with 2 nursing assistants (NA) revealed that Resident #7 had been bathed, her hair washed, and her fingernails had been trimmed. Resident #7 toe nails were long and curled over the end of the toes on both feet. The large toe on each foot revealed a long nail that extended over the end of the toe and was approximately ¼ inch long on each foot.

Observation of Resident #7 on 05/12/16 at 9:03 AM revealed that her toe nails remained long and curled over the end of the toe and the large toenail on the big toe of both feet was approximately ¼ inch long.

Observation of Resident #7 on 05/12/16 at 10:10 AM revealed that her toe nails remained long and curled over the end of the toe and the large toenail on the big toe of both feet was approximately ¼ inch long.

Interview with NA # 1 and NA #2 on 05/11/16 at 10:09 AM revealed that they trimmed Resident #7's fingernails. They confirmed they had not trimmed Resident #7's toe nails and both stated that the podiatrist trimmed Resident #7's toe nails.

Interview with Nurse #4 on 05/12/16 at 10:10 AM revealed that nail care was provided on bath days or as needed. Nurse #4 confirmed that NA #1 and NA #2 had not reported to her yesterday on 05/11/16 after Resident #7's shower that Resident #7's toe nails needed to be trimmed. Nurse #4 observed Resident #7's toe nails and stated she would immediately take care of them.

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F 312	Continued From page 12 Interview with the Director of Nursing (DON) on 05/12/16 at 1:20 PM revealed that nail care is done by NA's during bath days or in between if needed and all diabetic residents were seen by the podiatrist who came to the facility every 90 days. The DON stated the nurses were able to trim toe nails as long as they were not too thick and then they would have to have the podiatrist trim them. The DON further stated the wound nurse had a special tool she used to cut thick toe nails and that was more comfortable for the residents, but the NA's were expected to let the nurse know that the nails needed to be trimmed. The DON also stated she would have to double check and see if Resident #7 had seen the podiatrist since her admission. In a follow up interview with the DON on 05/12/16 at 1:49 PM the DON stated she could not find where Resident #7 had ever seen the podiatrist but she would like her to see the podiatrist so she would add Resident #7 to the list for the June podiatry visit. Interview with the Administrator on 05/12/16 at 3:50 PM revealed he expected the NA's to report to the nurses when there were nails that they were unable to trim so that the nurses could trim them or arrange for the podiatrist to trim them.	F 312		
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	F 431		6/7/16

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Continued From page 13
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 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 date a vial of tuberculin purified protein (TB serum) when opened from 1 of 2 medication refrigerators and failed to remove expired insulin from 1 of 3 medication carts.

The findings included:

A review of the facilities policy titled "Medication

F 431

1. Undated TB serum and expired insulin removed from use.

2. Administrative nurses will have checked all carts/med rooms for any other expired medications by 6/2/16.

3. Pharmacy consultant to audit carts/med rooms for expired meds x 2 months and

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F 431	Continued From page 14 Storage in the Facility" dated June 2012 read in part outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closure are immediately from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. 1. Observation on 05/11/16 at 11:42 AM of the rehab unit medication room refrigerator revealed an opened vial of Tuberculin purified protein (TB serum) that contained no date to indicate when it had been opened. Interview with Nurse #2 on 05/11/16 at 11:45 AM revealed that they usually date everything when they open it and that the Tuberculin purified protein (TB serum) is good up to 30 days after opening. Nurse #1 stated that she believed it was opened on Monday and should have been dated after being opened. Interview with the Director of Nursing (DON) on 05/12/16 at 1:25 PM stated that all nursing staff should date anything they open and the vial of Tuberculin purified protein (TB serum) should have been dated when opened so it could be discarded in 30 days after being opened. Interview with the Administrator on 05/12/16 at 3:49 PM revealed he expected the TB serum to have been dated when opened so that it could be discarded at the appropriate time. 2. Observations on 05/11/16 at 3:15 PM of the 100 hall medication cart revealed a bottle of Lantus insulin that was dated as being opened on 04/11/16. The observation further revealed a	F 431	document findings. 4. Findings will be forwarded to QA x 2 months for review and further action if necessary.	

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F 431	Continued From page 15 bottle of Novolog insulin dated as being opened on 04/10/16. Interview with the consultant Pharmacist on 05/11/16 at 3:25 PM revealed that the Lantus insulin and Novolog insulin were both good for 28 days after opening. Interview with Nurse #3 on 05/11/16 at 3:35 PM confirmed that the Lantus insulin should have been discarded on 05/09/16 and the Novolog insulin should have discarded on 05/08/16. Nurse #3 stated she would discard both vials and obtain new ones. Interview with the DON on 05/12/16 at 1:25 PM revealed that each vial of insulin was to be dated when opened and that each medication cart had a sheet that listed how long each insulin vial was good for after opening. The DON stated she expected the nurses to refer to that sheet to know when to discard the insulin and confirmed that both vials of insulin should have been discarded per the facility protocol. Interview with the Administrator on 05/12/16 at 3:49 PM revealed he expected the insulin vials to be discarded on or prior to the expiration date.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		6/7/16

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F 514	Continued From page 16 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete medical record documentation for intensity of pain according to a pain scale from 0 for no pain to 10 for worst pain to determine effectiveness of pain medications given to 2 of 6 residents sampled for pain (Resident #136 and #77). The findings included: 1. Resident #136 was readmitted to the facility on 03/08/16 with diagnoses which included heart disease, lung disease, generalized muscle weakness, chronic pain and osteoarthritis. A review of the most recent quarterly Minimum Data Set (MDS) dated 04/03/16 indicated Resident #136 was cognitively intact for daily decision making. The MDS further indicated Resident #136 had frequent pain. A review of a care plan titled Pain with onset date of 03/08/16 indicated goals in part that Resident #136 would verbalize pain relief with medications. The interventions indicated in part to check location, frequency, duration and intensity of pain and document assessment and report increased pain trend to physician.	F 514	1. Nurses in serviced on 6/3/16 to document pain intensity with each administration of pain medication. 2. MAR's will be audited by 6/6/16 to ensure pain is being documented appropriately. 3. DON or designee will monitor MAR's for pain documentation weekly x 2 months to ensure continued compliance. 3. Findings will be brought to QA for follow up and review x 2 months	

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F 514	Continued From page 17 A review of monthly physician's orders for dated 04/01/16 through 04/30/16 indicated Norco 5-325 milligrams (mg) by mouth every 4 hours as needed for pain. A review of Medication Administration Records dated 04/01/16 through 04/30/16 revealed pain medication was administered as follows: 04/01/16 at 12:00 PM Norco 5-325 mg by mouth for general pain but there was no documentation of the pain intensity. 04/02/16 at 9:45 AM Norco 5-325 mg by mouth for general pain but there was no documentation of the pain intensity. 04/02/16 at 1:45 PM Norco 5-325 mg by mouth for general pain but there was no documentation of the pain intensity. 04/05/16 at 4:30 AM Norco 5-325 mg by mouth for low back pain but there was no documentation of the pain intensity. 04/06/16 at 6:20 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/07/16 at 4:00 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/07/16 at 8:45 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/08/16 at 9:30 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/08/16 at 2:00 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/08/16 at 6:00 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/11/16 at 10:00 PM Norco 5-325 mg by mouth	F 514		

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F 514	Continued From page 18 for back pain but there was no documentation of the pain intensity. 04/12/16 at 5:00 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/12/16 at 9:00 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/13/16 at 8:10 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/14/16 at 8:15 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/15/16 at 7:15 AM Norco 5-325 mg by mouth for back and shoulder pain but there was no documentation of the pain intensity. 04/15/16 at 2:35 PM Norco 5-325 mg by mouth for back and shoulder pain but there was no documentation of the pain intensity. 04/16 /16 at 5:30 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/18/16 at 4:30 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/19/16 at 6:20 PM Norco 5-325 mg by mouth for back and shoulder pain but there was no documentation of the pain intensity. 04/20/16 at 9:00 PM Norco 5-325 mg by mouth for back and shoulder pain but there was no documentation of the pain intensity. 04/21/16 at 5:35 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/22/16 at 5:40 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/22/16 at 12:25 PM Norco 5-325 mg by mouth	F 514		

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F 514	Continued From page 19 for back and shoulder pain but there was no documentation of the pain intensity. 04/22/16 at 8:30 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/26/16 at 8:30 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/27/16 at 8:00 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/27/16 at 8:30 PM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. 04/28/16 at 7:30 AM Norco 5-325 mg by mouth for back pain but there was no documentation of the pain intensity. During an interview on 05/12/16 at 10:50 AM with the Nursing Supervisor she confirmed nurses were expected to document intensity of pain on the MAR and should document it according to a pain scale of 0 for no pain up to 10 for worst pain. During an interview on 05/12/16 at 4:03 PM with the Director of Nursing she stated she expected for nurses to document the resident's intensity of pain when they gave resident's pain medication. She further stated she expected nurses to document what kind of pain it was and the intensity of pain according to the pain scale from 0 which indicated no pain to 10 worst pain. She stated if a resident was requesting pain medication frequently she would expect to see the intensity of pain documented in order to determine if the resident needed something stronger for pain. 2. Resident #77 was re-admitted to the facility on	F 514		

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F 514	Continued From page 20	F 514		

09/16/15 with diagnoses which included heart disease, generalized muscle weakness, chronic obstructive lung disease, diabetes type II, chronic kidney disease, depression and history of a stroke.

A review of the most recent quarterly Minimum Data Set (MDS) dated 04/05/16 indicated Resident #77 was cognitively intact for daily decision making. The MDS further indicated Resident #77 had frequent pain.

A review of monthly physician's orders dated 04/01/16 through 04/30/16 indicated in part MAPAP (Tylenol) 325 milligrams (mg) take 2 tablets by mouth every 6 hours as needed for pain.

A review of Medication Administration Records dated 04/01/16 through 04/30/16 revealed pain medication was administered as follows:
04/01/16 at 8:00 PM Tylenol 650 mg by mouth for neck pain but there was no documentation of the pain intensity.
04/05/16 at 8:00 PM Tylenol 650 mg by mouth for neck pain but there was no documentation of the pain intensity.
04/06/15 at 8:00 PM Tylenol 650 mg by mouth for headache but there was no documentation of the pain intensity.
04/09/16 at 8:00 PM Tylenol 650 mg by mouth for headache but there was no documentation of the pain intensity.
04/10/16 at 8:00 PM Tylenol 650 mg by mouth for neck pain but there was no documentation of the pain intensity.
04/12/16 at 8:00 PM Tylenol 650 mg by mouth for left foot pain but there was no documentation of the pain intensity.

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F 514	Continued From page 21 04/14/16 at 8:00 PM Tylenol 650 mg by mouth for neck pain but there was no documentation of the pain intensity. 04/19/16 at 8:00 PM Tylenol 650 mg by mouth for headache but there was no documentation of the pain intensity. 04/23/16 at 8:00 PM Tylenol 650 mg by mouth for headache but there was no documentation of the pain intensity. 04/24/16 at 8:00 PM Tylenol 650 mg by mouth for neck pain but there was no documentation of the pain intensity. 04/26/16 at 8:15 PM Tylenol 650 mg by mouth for pain but there was no documentation of the pain intensity. During an interview on 05/12/16 at 10:50 AM with the Nursing Supervisor she confirmed nurses were expected to document intensity of pain on the MAR and should document it according to a pain scale of 0 for no pain up to 10 for worst pain. During an interview on 05/12/16 at 4:03 PM with the Director of Nursing she stated she expected for nurses to document the resident's intensity of pain when they gave resident's pain medication. She further stated she expected nurses to document what kind of pain it was and the intensity of pain according to the pain scale from 0 which indicated no pain to 10 worst pain. She stated if Resident #77 was requesting pain medication frequently or routinely she would expect to see the intensity of pain documented in order to determine if the resident needed something stronger for pain.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		6/7/16

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F 520	Continued From page 22 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for one recited deficiency which was originally cited in April 2015 on a recertification survey and and on the current recertification survey. The deficiency was in the area of housekeeping and maintenance services. The continued failure of the facility during two federal	F 520	1. Audit conducted by 6/1/16 of facility to identify any housekeeping/maintenance issues. 2. Audit to be conducted monthly x 2 months to ensure compliance. 3. All findings to be brought to QA committee for review and recommendation x 2 months.	

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F 520	Continued From page 23 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: F253 Housekeeping and Maintenance Services: The facility was recited for F253 for failing to maintain a clean bathroom for a shared restroom on the 300 hall for 1 of 5 bathrooms observed and the facility failed to remove dark brown stains from around the base of toilets in resident bathrooms and repair broken or missing tile at the base of toilets on 2 of 6 resident hallways. F253 was originally cited during a recertification survey on 04/09/15 for failure to maintain the veneer of the resident bedroom doors so that the doors were not gouged, chipped or peeling. This was observed on 27 bedroom doors and 5 common room doors located on 5 of 5 halls. During an interview on 05/12/16 at 4:40 PM the Administrator explained during the last recertification survey in 2015 the facility was cited for doors and it was a major renovation item. He further explained the citation was for a different issue than the issues found on the current recertification survey. He stated maintenance staff had been going around the facility and touching up walls and other areas and he had instructed staff to be careful to avoid damage. He further stated he expected for staff and department managers to report damage to maintance when they observed it.	F 520	4. QA committee will decide in our July meeting if this audit should continue further based on findings.	