STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 04/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite complaint investigation and a revisit survey was conducted on 4/13/18. New and repeat tags were cited during the survey. Event ID # 3S4811.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		5/14/18

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

Electronically Signed | 05/07/2018

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 580	Continued From page 1 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, interview with the pharmacist, interview with the nurse practitioner and record review the facility failed to notify the attending physician or nurse practitioner when Oxycodone needed a prescription to refill. The facility failed to notify the attending physician or nurse practitioner when the resident continued to experience unrelieved pain for 2 days. This was evident in 1 of 3 residents reviewed for pain management. (Resident #118) Findings included Resident #118 was admitted to the facility on 4/16/15 with cumulative diagnoses which included depression, anxiety disorder, cerebrovascular accident with left sided hemiparesis, pain in joints of left hand and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated 12/29/17 revealed Resident #118 was assessed as noted below:	F 580	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F580	

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F 580	Continued From page 2 " No long term or short-term memory loss. " On a scheduled and PRN (when every necessary) pain management. " Vocal complaints of pain. " Indicators of pain or possible pain observed daily. Review of the pain assessment dated 3/1/18 and signed on 3/5/18 revealed resident's daily pain level was 7 (seven)and the pain site was front left shoulder and generalized pain. Described the pain as dull, worst at night, interferes with repositioning and transfers. Review of the care plan targeted date of 3/29/18 revealed in part a focus of potential for actual acute and chronic pain. The goal included the resident would voice a minimal level of pain daily through the next review date. The interventions included to notify the physician if pain management was not effective. Record review of the April 2018 monthly physician orders included: " Acetaminophen 325 mg po daily (QD) and Acetaminophen 325 mg (2 tablets) by mouth (po) every 4 hours prn for pain or temperature above 100 degrees Fahrenheit. A drug used for the management of mild to moderate pain and fever reducer. " Oxycontin 10 mg CR 1 tablet twice a day po. Oxycontin is a controlled-release opioid analgesic. " Oxycodone 10 mg every 6 hours PRN. Oxycodone is a semisynthetic opioid used to treat moderate to severe pain. Interview on 4/10/18 at 2:50 PM with Resident #118 who stated that the facility ran out of her Oxycodone for several days (unable to state the exact date) and they (referring to the nurse) gave me Tylenol (Acetaminophen) and it did not help. An inquiry was made about the level of pain the	F 580	The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to notify the attending physician or nurse practitioner when the resident continued to experience unrelieved pain for 2 days □ was knowledge deficit. The provider was notified of the need of a hard prescription on 4/9/18 hall nurse for resident #118□s oxycodone. Oxycodone was ordered from the pharmacy on 4/10/18 and received by facility on 4/11/18 for Resident #118 to manage resident□s breakthrough pain. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/11/18 through 4/13/18, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and Staff Development Coordinator (SDC) assessed all residents for pain using a questionnaire or the Wong-Baker faces pain rating scale. Any negative findings were immediately addressed by the auditor, including notification of the physician as appropriate. This audit ensures there is no unrelieved pain. On 4/11/18 through 4/13/18 the facility consultants, director of nursing, assistant director of nursing, and staff development coordinator completed and audit of all	

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F 580	Continued From page 3 resident experienced when the Oxycodone was not available and the Tylenol (Acetaminophen) was administered. Resident #118 stated the intensity of pain level on a scale of 0 (no pain) to 10 (worst pain imaginable) was an eight before and after the administration of Tylenol (Acetaminophen). "I was still in pain." Continued interview with Resident #118 revealed "I get the Oxycodone for chronic pain in my left arm and legs and "every time I ask them (referring to the staff nurses) they tell me the Oxycodone has not come yet "from the pharmacy. Resident #118 revealed Oxycodone "relieved my pain." Review of the Medication Administration Record (MAR) revealed Acetaminophen 650 mg po was initialed as administered at 12 AM, 6 AM and 12PM on 4/9/18 and 4/10/18 at 12 PM. The response to the Acetaminophen was coded as #3 which indicated slightly effective. The Oxycodone was not available to be administered. Review of the progress notes revealed no indication that staff attempted to relieve the resident's pain when Acetaminophen was not effective. Nurse #5 (who administered the Acetaminophen at 12 AM, 6 AM on 4/9/18 and 4/10/18 at 12 PM) and documented the Acetaminophen was slightly effective was not available for interview. Review of the progress notes revealed no indication that the attending physician or nurse practitioner (NP) were notified about the need for the Oxycodone refill until 4/9/18 or that the resident had experienced pain without relief. Interview on 4/10/18 at 2:55 PM with Nurse #1 revealed she was unaware of the lack of Oxycodone, physician or NP notification or the reordering because she just returned to work. Interview via the phone on 4/10/18 at 3:36 PM	F 580	residents on pain medications to ensure medication was available as ordered by the physician. Any negative findings were addressed immediately by the auditor, including notification of the physician as appropriate. This audit ensured pain medications were available as ordered. By 5/14/18 all licensed nurses, including the newly hired licensed nurses and agency licensed nurses, will be in-serviced by the Staff Development Coordinator (SDC) on pain assessment, including documentation, completion of pain interventions, and notification of provider in the case that a medication needs to be reordered or the pain intervention is not effective. This in-service will be part of the orientation process for all newly hired licensed nurses, and agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SDC, QI nurse and/or Administrator will audit all progress notes 3 times weekly x 12 weeks, to include weekends, to identify if a resident has pain and that the appropriate interventions were taken and documented either on in the progress notes or on the MAR. This audit will documented on the Progress Note Review Audit Tool. The monthly QI committee will review the results of the progress note review audit tool monthly for 3 months for identification of trends, actions taken, and to determine	

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F 580	Continued From page 4 with the pharmacist from the contracted pharmacy was conducted. The pharmacist stated a new hard copy prescription was required for refills. However, the attending physician could have called the pharmacy for a 3-day supply pending obtaining the hard prescription. Observation on 4/10/18 at 5:30 PM revealed Resident #118 had facial grimacing and moaning suggestive of pain. An inquiry was made about the resident's comfort and pain. The resident stated she was in pain and Tylenol (Acetaminophen) had been given earlier but "I still am in pain at an 8 out of 10 level." Review of the MAR revealed on 4/10/18 at 12 noon Tylenol (Acetaminophen) had been administered. Interview on 4/12/18 at 9:15 AM with the Administrator and Director of Nurses was conducted. The Administrator indicated that she expected staff to notify the physician as soon as the narcotic was not available and the resident's pain was not relieved. Interview on 4/13/18 at 7::30 am with Nurse #3 revealed if a control substance was needed for pain relieve "I would call the pharmacy to have them call the physician for a script (prescription), use the back-up pharmacy or call the physician for another method of pain relief." Interview on 4/13/18 at 9:18 AM with the NP who stated the facility uses a communication book for non-emergencies located at the nurses' station. The NP stated she was told about needing a hard prescription on 4/9/18 and was available at the facility 5 (five) days a week. Further interview with the NP who stated the facility should have notified me when the hard prescription was needed and the pain could not be managed.	F 580	the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		5/14/18

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F 636	Continued From page 5	F 636		

§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication

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F 636	Continued From page 6 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete the annual comprehensive assessment for Resident #118. This was evident in 1 of 4 comprehensive assessments reviewed. Findings included: Resident #118 was admitted to the facility on 4/16/15 with cumulative diagnoses which included depression, anxiety disorder, cerebrovascular accident with left sided hemiparesis, pain in joints of left hand and osteoarthritis. Review of the annual Minimum Data Set (MDS) assessment dated 3/26/18 revealed the following were coded red which meant the sections were incomplete: " Section A - Identification Information " Section B - Hearing, Speech and Vision	F 636	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction.	

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F 636	Continued From page 7 " Section E - Behavior " Section G- Functional Status " Section H -Bladder and Bowel " Section J - Health Conditions " Section L - Oral/Dental " Section M - Skin Condition " Section N - Medications " Section O - Special Treatments, Procedures and Programs " Section P - Restraints and Alarms On 4/10/18 at 3:28 PM with the MDS coordinator stated she was aware that MDS were not up-to-date because she was the only MDS coordinator to complete the assessment. The MDS coordinator indicated the color red on the MDS sections meant the section had not been completed. Continued interview with the MDS Coordinator revealed the Care Area Assessment (CAA) Summary and care plan could not have been completed because the annual MDS was incomplete. Interview on 4/12/18 at 9:15 AM with the Director of Nurses (DON) and administrator was held. The administrator stated 2 (two) MDS corporate consultants arrived on yesterday (4/11/18) to update the MDS. Three assessment nurses were here on 4/12/18 to catch up on assessments and fill in for the current MDS coordinator while on leave. The Corporate Representative notified us last week (4/6/18) that MDS assessments were not updated. Continued interview with the administrator revealed her expectation was for MDS assessments to be updated and completed as required.	F 636	F636 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to complete the annual comprehensive assessment for resident #118 □ was failure to follow established procedure. Annual comprehensive assessment for resident #118 was completed on 4/11/18 a corporate MDS consultant and accepted on 4/11/18 by the national repository. The procedure for implementing the acceptable plan of correction for the specific deficiency cited From 4/11/18 until 4/12/18 and 4/17/18 until 4/19/18, two corporate MDS consultants assisted the facility to achieve timely submission of comprehensive Minimum Data Set (MDS) assessments. On 4/13/18 and 4/20/18, one corporate MDS consultant assisted the facility to achieve timely submission of comprehensive MDS assessments. On 4/20/18, the facility consultant in-serviced the MDS Nurse on completing assessments timely. This in-service will be provided to any newly hired MDS Nurses during orientation.	

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F 636	Continued From page 8	F 636	By 5/14/18, all comprehensive assessments will be submitted timely and will accurately reflect each individual resident. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Administrator and/or DON will audit all completed MDS 100% weekly x 4 weeks then 50% of completed MDS weekly x 8 weeks to ensure all MDS assessments are completed timely and accurately reflect the resident. This audit will be documented on the MDS audit tool. The monthly QI committee will review the results of the MDS audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	
F 638	Qrtly Assessment at Least Every 3 Months	F 638		5/14/18

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F 638 SS=D	Continued From page 9 CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) within 14 days after the Assessment Reference Date (ARD) for 1 of 3 sampled residents reviewed for MDS assessments (Resident #6). The findings included: Resident #6 was admitted to the facility on 8/14/15 with a cumulative diagnoses which included non-Alzheimer ' s dementia, psychotic disorder, and anxiety disorder. A review of Resident #6 ' s last quarterly Minimum Data Set (MDS) assessment revealed the Assessment Reference Date (ARD) was 3/27/18. A review of this quarterly MDS assessment on 4/11/18 revealed the following sections were not completed at the time of the review: Sections A, B, E, G, H, J, L, M, N, O, and P. The facility ' s MDS Coordinator was not available for an interview. However, an interview was conducted on 4/13/18 at 10:57 PM with the Corporate Resident Assessment Instrument (RAI)/Reimbursement Consultant #1. During the interview, the consultant stated, "We knew there was a problem with the late assessments so they called us in to get them (the facility) caught up."	F 638	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F638 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to complete a quarterly Minimum Date Set (MDS) within 14 days after the Assessment Reference Date (ARD) □ was failure to follow established policy.	

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F 638	Continued From page 10 When asked about the quarterly MDS assessment for Resident #6, the consultant reported the assessment was completed on 4/12/18 (16 days after the ARD date) and that it should have been done by 4/10/18. The consultant stated this assessment was recognized as late and added, "We are aware of the problem." She reported that three consultants came into the facility on 4/11/18 to work on the MDS assessments, two consultants worked at the facility on 4/12/18, and she was the last consultant to stay on 4/13/18 to help get the assessments caught up. She stated when the consultants came to the facility on 4/11/18, there were 17 MDS assessments that were overdue. She reported the facility was now down to 4 assessments being overdue. An interview was conducted on 4/13/18 at 2:00 PM with the facility ' s Director of Nursing (DON) in the presence of Corporate Consultant #1. Upon inquiry, the DON stated her expectation was for the MDS assessments to be completed in a timely manner and on time.	F 638	Quarterly Minimum Data Set (MDS) assessment for resident #6 was submitted on 4/12/18 by a corporate MDS consultant, and accepted on 4/12/18 by the notational repository. The procedure for implementing the acceptable plan of correction for the specific deficiency cited Until From 4/11/18 until 4/12/18 and 4/17/18 until 4/19/18, two corporate MDS consultants assisted the facility to achieve timely submission of quarterly Minimum Data Set (MDS) assessments. On 4/13/18 and 4/20/18, one corporate MDS consultant assisted the facility to achieve timely submission of quarterly MDS assessments. On 4/20/18, the facility consultant in-serviced the MDS Nurse on completing assessments timely. This in-service will be provided to any newly hired MDS Nurses during orientation. By 5/14/18, all quarterly assessments will be submitted timely and will accurately reflect each individual resident. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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F 638	Continued From page 11	F 638	The Administrator and/or DON will audit all completed MDS 100% weekly x 4 weeks then 50% of completed MDS weekly x 8 weeks to ensure all MDS assessments are completed timely and accurately reflect the resident. This audit will be documented on the MDS audit tool. The monthly QI committee will review the results of the MDS audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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, staff and resident interviews and record reviews the facility staff delayed (3 hours) incontinence care and failed to	F 677	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific	5/14/18

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F 677	Continued From page 12 thoroughly cleanse the resident's skin after an incontinence episode (Resident #18) 2. The facility failed to follow the manufacturer's instruction to rinse the skin after use. (Resident #2). This was evident in 2 of 3 residents reviewed for incontinence care. The findings included: 1. Resident #18 was admitted to the facility on 4/18/17 with cumulative diagnoses which included cerebral vascular accident, diabetes, anemia and admitted with a stage 4 sacral wound. Review of the significant change Minimum Data Set (MDS) dated 1/22/18 revealed resident had short- term and long-term memory problems. He had the memory and recall of staff names and faces and that he resided in a nursing home. The MDS was coded as 3/2 for personal hygiene which required extensive assistance of one staff and coded 4/2 for bathing which required total assistance of one staff, always incontinent of bladder and stool. Required extensive assistance of 2 staff for bed mobility (turning side to side in bed). His vision was noted to be highly impaired. Review of the revised care plan dated 2/16/18 revealed a focus of resident at risk for further pressure ulcer development. The interventions in part included to cleanse perineal area well with each incontinence episode and to apply barrier cream per physician orders. Observation on 4/11/18 at 9:35 AM was made from the hallway of Resident #18's room as he was lying in bed with the covers over him and motioned to come into the room. The resident stated he was "wet" and had been waiting for 2 hours to get changed. His statement was repeated twice. When asked what time he first asked for assistance, the resident reported around 7:00 AM. Interview on 4/11/18 at 9:37 AM with Resident	F 677	deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F677 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency facility staff delayed incontinence care, failed to thoroughly cleanse the resident s skin after an incontinence episode, and failed to follow manufacturer s instruction to rinse the skin after use - was knowledge deficit. Resident #18 was provided incontinence care on 4/11/18 the CNA on the hall. Resident #2 was thoroughly cleansed after an incontinence episode on 4/11/18 the CNA on the hall. The procedure for implementing the acceptable plan of correction for the	

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F 677	Continued From page 13 #18 who stated he was waiting for someone to help him because he had an incontinent episode and had not received care since the night shift. When asked how he knew the timing, he referred to the large clock on the wall. Interview on 4/11/18 at 9:40 AM with Nurse # 4 revealed she only had one Nursing Assistant (NA) on the unit because the other scheduled NA was late for work. Further interview with Nurse #4 who stated administration (referring to the Director of Nurses and Administrator) was made aware that we needed another aide and the response was the scheduled NA was running late and no additional staff was provided. Interview on 4/11/18 at 9:54 AM with NA #1 revealed she just arrived at the facility (no time provided) because she was delayed. Interview on 4/11/18 at 10:01 AM with NA #2 revealed she positioned the resident and fed him. NA # 2 stated "I did not change him because I have not had a chance. Been the only aide since 7 AM. Several residents were calling for assistance needing care but was not able to get to everyone." Observation on 4/11/18 at 10:07 AM of incontinent care performed by NA #1 revealed she removed (3) briefs from the resident. One across his abdomen and 2 fastened. The resident had experience an incontinent episode of urine and stool. There was an offensive urine smell. NA #1 cleansed the groin and scrotum with rinse free foaming body wash. Repositioned the resident and cleansed his buttocks. Then applied Calmoseptic ointment. The resident's penis was not cleansed. The resident was noted to have a bandage on the sacrum with a brown colored substance like stool. There were no other skin issues observed. The wound care nurse was notified and the bandage was changed. Interview on 4/11/18 at 10:25 AM	F 677	specific deficiency cited On 4/16/18, the facility consultant in-serviced the Director of Nursing on providing ADL care for dependent residents and following manufacturer□s instructions. On 4/16/18, the Staff Development Coordinator (SDC) was in-serviced by the DON on providing timely ADL care for dependent residents and following manufacturer□s instructions. By 5/14/18, all nursing staff, including the newly hired nursing staff and agency staff, will be in-serviced by the SDC on providing timely ADL care for dependent residents and following manufacturer□s instructions. This in-service will be part of the orientation process for all newly hired nursing staff, and agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Director of Nursing, SDC, Quality assurance nurse and/or weekend manager on duty will audit a minimum of 20 residents a week x 4 weeks and then 10 residents a week x 8 weeks to ensure timely ADL care is provided to residents. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of	

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F 677	Continued From page 14 with NA #1 who initially stated that she cleansed the resident's penis. After continued interview NA #1 indicated the resident had a hole at the top of his penis and did not want to cleanse the resident's penis for fear it would burn. Record review revealed no skin issues with the resident's penis. Interview on 4/12/18 at 9:15 AM with the Administrator and Director of Nurses (DON) was conducted. The DON and the Administrator indicated that no one informed them that there was only one staff member on the unit for direct care on 4/11/18. Continued interview revealed the Administrator expectation was residents to receive proper and timely incontinence care. 2. Review of the manufacturer's instruction shampoo/body wash gel should be thoroughly rinsed off the body. Resident #2 was admitted to the facility on 4/18/17 with cumulative diagnoses which included Alzheimer's disease. Record review of the quarterly Minimum Data Set (MDS) dated 3/20/18 coded the resident as totally dependent on one staff for activities of daily living except for eating. Review of the revised care plan dated 2/22/18 revealed a focus for activities of daily living which required staff assistance due to cognition impairment and impaired mobility. The goal was to complete personal care with staff support. The interventions included total care of one person to bath and provide personal hygiene. Observation on 4/11/18 at 10:45 AM of incontinence care performed by Nursing Assistant (NA) #3. The resident had experienced an incontinent episode of urine and stool. The resident was cleansed with premoistened disposable washcloths. The foreskin was	F 677	continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 677	Continued From page 15 retracted and cleansed. Before a clean brief could be placed on the resident another urinary incontinence episode occurred. NA #3 obtained a basin of water and used the shampoo/body wash gel to cleanse the resident's buttocks and genitals. The gel was not rinsed off the resident's skin. Interview on 4/11/18 at 11 AM with NA #3 revealed the gel product was new and was not aware that the gel should be thoroughly rinsed off the skin and we were in serviced on the gel. Interview on 4/12/18 at 9:15 AM with the Administrator and Director of Nurses (DON) was conducted. The DON indicated the skin should be cleansed and thoroughly rinsed based on the manufacturer's instructions.	F 677		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, interview with the pharmacist, interview with the nurse practitioner and record review the facility failed to provide pain relief to Resident #118 for 2 (two) days. This was evident in 1 of 3 residents reviewed for pain management. Findings included: Resident #118 was admitted to the facility on 4/16/15 with cumulative diagnoses which included depression, anxiety disorder, cerebrovascular	F 697	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and	5/14/18

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F 697	Continued From page 16 accident with left sided hemiparesis, pain in joints of left hand and osteoarthritis Review of the quarterly Minimum Data Set (MDS) assessment dated 12/29/17 revealed Resident #118 was assessed as noted below: " No long term or short-term memory loss. " Modified independence with decision making in new situations. " No issues with mood or behaviors. " Extensive Activities of Daily Living except for eating. " On a scheduled and PRN (when every necessary) pain management. " No non-medication intervention. " Vocal complaints of pain. " Indicators of pain or possible pain observed daily. Review of the pain assessment dated 3/1/18 and signed on 3/5/18 revealed resident's daily pain level was 7 (seven)and the pain site was front left shoulder and generalized pain. Described the pain as dull, worst at night, interferes with repositioning and transfers. The assessment indicated that repositioning, positioning devices and medication makes the pain better. Continued review of the pain assessment revealed resident had prn medication order and was effective in relieving pain. Review of the care plan targeted date of 3/29/18 revealed in part a focus of potential for actual acute and chronic pain. The goal included the resident would voice a minimal level of pain daily through the next review date. The interventions included acknowledgement of the presence of pain and discomfort, administer pain medication as ordered and note effectiveness and document/report complaints and non-verbal signs of pain. Record review of the April 2018 monthly physician	F 697	that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F697 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency the facility failed to provide pain relief to resident #118 for two days- was knowledge deficit. The provider was notified on of the need of a hard prescription on 4/9/18 by hall nurse for resident #118s oxycodone. Oxycodone was ordered from the pharmacy on 4/10/18 and received by facility on 4/11/18 for Resident #118 to manage residents breakthrough pain. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/11/18 through 4/13/18, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and Staff Development Coordinator (SDC) assessed all residents for pain using a questionnaire or the Wong-Baker faces pain rating scale. Any negative findings	

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F 697	Continued From page 17 orders included: Acetaminophen 325 milligrams (mg) po daily (QD) and Acetaminophen 325 mg (2 tablets) po every 4 hours prn for pain or temperature above 100 degrees Fahrenheit. A drug used for the management of mild to moderate pain and fever reducer. " Abilify 2.5 mg po QD. Drug used for the treatment of mental health conditions. " Xanax 0.5 mg po every morning po and 0.25 mg every evening po. Drug used to treat anxiety. " Oxycontin 10 mg CR 1 tablet twice a day po. Oxycontin is a controlled-release opioid analgesic. " Oxycodone 10 mg every 6 hours PRN. Oxycodone is a semisynthetic opioid used to treat moderate to severe pain. Interview on 4/10/18 at 2:50 PM with Resident #118 who stated that the facility ran out of her Oxycodone for several days and they (referring to the nurse) gave me Tylenol (Acetaminophen and it did not help. An inquiry was made about the level of pain the resident experienced when the Oxycodone was not available and the Tylenol (Acetaminophen) was administered. Resident #118 stated the intensity of pain level on a scale of 0 (no pain) to 10 (worst pain imaginable) was an eight before and after the administration of Tylenol (Acetaminophen). "I was still in pain." Continued interview with Resident #118 revealed "I get the Oxycodone for chronic pain in my left arm and legs and "every time I ask them (referring to the staff) they tell me the Oxycodone has not come yet "from the pharmacy. Resident #118 stated Oxycodone "relieved my pain." Review of the Medication Administration Record (MAR) revealed on the back of the record indicated Oxycodone 10 mg po was administered on 4/7/18 at 2:30 AM or PM (illegible). On the	F 697	were immediately addressed by the auditor, including notification of the physician as appropriate. This audit ensures there is no unrelieved pain. By 5/14/18 all licensed nurses, including the newly hired licensed nurses and agency licensed nurses, will be in-serviced by the Staff Development Coordinator (SDC) on pain assessment, including documentation, completion of pain interventions, and notification of provider in the case that a medication needs to be reordered or the pain intervention is not effective. This in-service will be part of the orientation process for all newly hired licensed nurses, and agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SDC, quality assurance nurse and/or Administrator will audit all progress notes 3 times weekly x 12 weeks, to include weekends, to identify if a resident has pain and that the appropriate interventions were taken and documented either on in the progress notes or on the MAR. This audit will documented on the Progress Note Review Audit Tool. The monthly QI committee will review the results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for	

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F 697	Continued From page 18 front of the MAR for 4/8/18 were the initials of Nurse #5-who documented twice without a time-that Oxycodone 10 mg had been administered. The block under Nurse #5 initials was a superimposed marking with an x-mark. Review of the progress notes did not have documentation of the administration times associated with Nurse #5. Continued review of the MAR revealed Acetaminophen 650 mg po was initialed as administered at 12 AM, 6 AM and 12PM on 4/9/18 and 4/10/18 at 12 PM. The response to the Acetaminophen was coded as #3 which indicated slightly effective. Review of the progress notes revealed no indication that staff attempted to relieve the resident's pain when Acetaminophen was not effective. Nurse #5 (who administered the Acetaminophen at 12 AM, 6 AM on 4/9/18 and 4/10/18 at 12 PM) was not available for interview. Interview on 4/10/18 at 2:55 PM with Nurse #1 revealed she was unaware of the lack of Oxycodone or the reordering because she just returned to work. Observation of the narcotic box on 4/10/18 at 3:05 PM revealed no Oxycodone 10 mg po for Resident #118. Interview via the phone on 4/10/18 at 3:36 PM with the pharmacist from the contracted pharmacy was conducted. An inquiry was made regarding the process for reordering control substances. The pharmacist stated a new hard copy prescription was required. Continued interview the pharmacist stated the facility can reorder 3 days before the drug was to run out and a sticker was placed on the medication card to alert staff that the Oxycodone was getting low and needed to be reordered. The pharmacist	F 697	continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 697	Continued From page 19	F 697		

indicated the hard copy prescription dated 4/9/18 was received on 4/9/18 at the pharmacy. Further interview with the pharmacist who stated that the Oxycodone was processed and filled on 4/10/18 and would leave the pharmacy around 6:30 PM-7:30 PM and be delivered on 4/10/18 to the facility (unsure of the exact time of delivery to the facility). Additionally, the pharmacist indicated that the attending physician could have called the pharmacy for a 3-day supply pending obtaining the hard prescription.
Interview on 4/10/18 at 5:20 PM with Medication Assistant #3 stated she was unaware of Oxycodone not being available.
Observation on 4/10/18 at 5:30 PM revealed Resident #118 had facial grimacing and moaning suggestive of pain. An inquiry was made about the resident's comfort and pain. The resident stated she was in pain and Tylenol (Acetaminophen) had been given earlier but "I still am in pain at an 8 out of 10 level." Review of the MAR revealed on 4/10/18 at 12 noon Tylenol (Acetaminophen) had been administered.
On 4/10/18 at 5:40 PM the administrator was made aware of the resident's expressions of pain. Record review of the MAR revealed the resident was administered Oxycodone 10 mg po on 4/11/18 at 12:01 AM and 6:10 AM for complaints of pain. The response and effectiveness of the Oxycodone was coded as 1 (one) which represented effective.
Observation and interview on 4/11/18 at 3:08 PM with Resident #118 revealed resident was lying in bed awake. Resident #118 stated the facility got her medication and received her Oxycodone for pain and felt "better."
Interview on 4/12/18 at 9:15 AM with the Administrator and Director of Nurses was conducted. The Administrator indicated that she

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F 697	Continued From page 20 expected staff to re order medications in a timely manner to manage the resident's pain. Interview on 4/13/18 at 7:3:30 am with Nurse #3 revealed if a control substance was needed for pain relief "I would call the pharmacy to have them call the physician for a script, use the back-up pharmacy or call the physician for another method of pain relief." Interview on 4/13/18 at 9:18 AM with the Nurse Practitioner (NP) who stated a communication book for non-emergencies was located at the nurses' station. The NP stated she was told about needing a hard script on 4/9/18. Further interview with the NP revealed she was available at the facility 5 (five) days a week.	F 697		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		5/14/18

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F 725	Continued From page 21 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident interviews, nurse practitioner (NP) interview and staff interviews, the facility failed to provide sufficient nursing staff to provide showers as preferred in 1 of 4 sampled residents reviewed for self-determination (Resident #36) and complete the annual comprehensive assessment for Resident #118 in 1 of 4 comprehensive assessments reviewed. Findings included: 1. F561: Based on record review and resident and staff interviews, the facility failed to honor a resident's preferences regarding the frequency of showers provided for 1 of 4 sampled residents reviewed for self-determination (Resident #36). 2. F636: Based on record review and staff interviews the facility failed to complete the annual comprehensive assessment for Resident #118. This was evident in 1 of 4 comprehensive assessments reviewed. Interview on 4/10/18 at 6:17 PM with Nurse #8 stated she worked on 4/3/18 and 4/4/18 with only 1 (one) Nursing Assistant (NA) and "did the best we could." Some residents were left in bed because we could not use the hydraulic lift to transfer residents because two (2) people were needed to use the lift. At his time Nurse #8 stated she was not sure which residents were not transferred out of bed. Continued interview with	F 725	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for implementing the acceptable plan of correction. F725 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency – the facility failed to provide sufficient nursing staff to provide showers as preferred and to complete the annual comprehensive assessment for resident #118.	

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F 725	Continued From page 22 Nurse #8 revealed the unit had four (4) residents that were dependent on staff for feeding and they were fed. Interview on 4/10/18 at 6:25 PM with NA #7 stated every weekend that she worked the facility was short staffed for NA and unable to do rounds and provide care for incontinence. On the 400-resident unit staff must transfer residents back to bed earlier then 7 PM because some staff leave at 7 PM. NA #7 stated additional staff was needed for resident care. Administration (unsure of who she meant) put staff on the schedule that were not assigned to work that shift just to complete the staffing form. "I was placed on the schedule but was not assigned to work." Further interview with NA #8 revealed she was not sure of the actual dates. Interview on 4/11/18 at 6:15 AM with NA #8 who stated she worked on the 100 and 200 resident hall ways by herself on 4/8/18. She reported she could on meet the resident's needs to provide incontinent care and answer call lights in a timely manner. An interview was conducted on 4/11/18 at 7:00 AM with Nurse #9. During the interview, Nurse #9 reported she had worked at the facility with 1 (one) NA on 100/200 halls, and 1 (one) on 300/400 halls and 1 (one) nurse to oversee 3 medication aides administering medications. Continued interview with Nurse #9 stated the impact of not having enough staff was "Everything." She elaborated by saying the residents do not get changed as often or may not get assisted with their meals like they should. Interview on 4/12/18 at 3:05 PM with the Administrator stated Resident #007 was	F 725	On 4/14/18, resident # 36 received a shower per resident preference by the CNA on the hall. Annual comprehensive assessment for resident #118 was completed on 4/11/18 by a corporate MDS consultant and accepted on 4/11/18 by the national repository. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/13/18, the facility signed a contract with a staffing agency to provide sufficient nursing staffing. On 5/4/18, the facility began offering a sign on bonus for certified nursing assistants, licensed practical nurses, and registered nurses. On 4/10/18, a second Certified Nursing Assistant (CNA) was hired to join the shower team. On 4/18/18, the facility consultant in-serviced the director of nursing (DON) on providing showers per resident preference On 4/18/18, the Staff Development Coordinator (SDC) was in-serviced by the DON on providing showers per resident preference. By 5/14/18, all nursing staff, including the newly hired nursing staff, and agency will be in-serviced by the SDC on providing	

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F 725	Continued From page 23 transferred to bed at 5:00 PM on 4/6/18 because the assigned NA was leaving at 7PM so staff wanted to put her to bed early because a mechanical lift was required. Interview was conducted with NA #6 on 4/12/18 at 4:45 PM. During the interview, NA #6 reported she did showers for residents at the facility. She reported there was a shower schedule located at the nursing station to indicate the shower days for residents. NA #9 reported the NAs on the floor may not have time to give showers to the residents but she herself cannot give showers to 120 residents.	F 725	showers per resident choice and the documentation of showers given. This in-service will be part of the orientation process for all newly hired nursing staff, including agency staff. From 4/11/18 until 4/12/18 and 4/17/18 until 4/19/18, two corporate MDS consultants assisted the facility to achieve timely submission of comprehensive Minimum Data Set (MDS) assessments. On 4/13/18 and 4/20/18, one corporate MDS consultant to assist the facility in achieving timely submission of comprehensive MDS assessments. On 4/20/18, the facility consultant in-serviced the MDS Nurse on completing assessments timely. This in-service will be provided to any newly hired MDS Nurses during orientation. By 5/14/18, all comprehensive assessments will be submitted timely and will accurately reflect each individual resident. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SDC, QI nurse and/or weekend manager on duty will audit a minimum of 20 residents a week x 4 weeks and then 10 residents a week x 8 weeks to ensure showers are provided per resident choice. This audit will be documented on the Resident Care Audit Tool. The Administrator and/or DON will audit	

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F 725	Continued From page 24	F 725	all completed MDS 100% weekly x 4 weeks then 50% of completed MDS weekly x 8 weeks to ensure all MDS assessments are completed timely. This audit will be documented on the MDS audit tool. The staffing scheduler will report in morning meeting the staffing for the current day and report vacant shifts for the week and the status of the filling of the vacancies. The SDC and/or DON will share weekly with the Department head team the open nursing positions that center is currently advertising to fill, how many applicants have applied and the number of new employees hired in the past week. The facility will utilize the contract agency to fill vacant tracks of time until permanent employees can be hired and oriented. The facility will follow the attendance policy to address tardies and absences. The facility will offer incentive bonuses to employees who sign up for extra shifts to help fulfill the facilities staffing needs. We will maintain sufficient staff by utilizing staff members who normally do not provide direct patient care but have the training and/or license to provide direct care in the event the facility does not have sufficient staffing. The monthly QI committee will review the results of the Resident Care Audit tool and MDS audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator	

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F 725	Continued From page 25	F 725	and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		5/14/18

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F 732	Continued From page 26 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to retain staff posting data. Findings included: Record review on 4/13/18 of the daily staff posting revealed no staff posting data for February 2018 and no staff posting data for March 1, 2018 to March 14, 2018. Interview with the Assistant Director of Nurses (ADON) on 4/13/18 at 2:30 PM revealed the scheduler was responsible for the daily posting and filing of the forms. However, on 4/13/18 the scheduler resigned and the Director of Activities and herself were now responsible. Later at 2:45 PM on 4/13/18, the ADON returned who indicated she was unable to locate the above missing staff posting and expected the staff posting be maintained. On 4/23/18 an email was received from the administrator with attachments of the daily nurse staffing for February 1-12, 2018, February 17-28, 2018 and March 2018. There was no daily staff posting for 2/13/18-2/16/18.	F 732	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F732 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and	

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F 732	Continued From page 27	F 732	Rehabilitation center regarding the process that lead to this deficiency □ facility failed to retain staff posting data □ was knowledge deficit. On 4/22/18, the Activities Director (AD) was able to locate the missing nurse staffing posting information for the month of February 2018 and March 1st through the 14th of 2018 excluding dates 2/13/18 to 2/16/18. Administrator sent staff posting information to survey team lead for February 2018 and March 1st - 14th, 2018 excluding 2/13/18 to 2/16/18 on 4/23/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/20/18, the facility consultant in-serviced the director of nursing (DON) and Administrator on posted nurse staffing information retention. On 4/20/18, the Assistant Director of Nursing (ADON) and AD were in-serviced by the DON/Administrator on posted nurse staffing information retention. By 5/14/18 all people involved with scheduling (ADON and AD), will be in-serviced by the Administrator, DON and/or SDC on retention of staff posting information. This in-service will be part of the orientation process for all newly hired staff involved with scheduling. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 732	Continued From page 28	F 732	and/or in compliance with the regulatory requirements The DON, SDC, QI nurse and/or Administrator will audit staff posting retention weekly x 12 weeks, to include weekends, to ensure all dates are accounted for and nurse staffing information is posted and accurate. This information will be recorded on the Staffing Posting Retention Audit tool. The monthly QI committee will review the results of the Staffing Posting Retention audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		5/14/18

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F 755	Continued From page 29 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review and pharmacy, consultant pharmacist, and staff interviews, the facility failed to maintain an accurate accounting of all controlled medications for 1 of 4 sampled residents (Resident #118) reviewed who received a controlled medication prescribed on an as needed basis. The findings included:	F 755	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure	

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F 755	Continued From page 30 Resident #118 was admitted to the facility on 4/16/15. A review of Resident #118 ' s medication orders revealed a physician ' s order was written on 2/12/18 for 10 milligrams (mg) oxycodone (an opioid pain medication) to be given as one tablet by mouth every 6 hours as needed. Oxycodone is a controlled medication. A review of Resident #118 ' s February 2018 Medication Administration Record (MAR) indicated 33 doses of 10 mg oxycodone were administered to the resident from 2/13/18 to 2/28/18 on the following dates: --On 2/13/18, 3 doses of oxycodone were documented as administered; --On 2/14/18, 3 doses of oxycodone were documented as administered; --On 2/15/18, 2 doses of oxycodone were documented as administered; --On 2/16/18, 2 doses of oxycodone were documented as administered; --On 2/17/18, 3 doses of oxycodone were documented as administered; --On 2/18/18, 1 dose of oxycodone was documented as administered; --On 2/19/18, 1 dose of oxycodone was documented as administered; --On 2/20/18, 3 doses of oxycodone were documented as administered; --On 2/21/18, 2 doses of oxycodone were documented as administered; --On 2/22/18, 3 doses of oxycodone were documented as administered; --On 2/23/18, 2 doses of oxycodone were documented as administered; --On 2/24/18, 1 dose of oxycodone was documented as administered; --On 2/25/18, no doses of oxycodone were documented as administered;	F 755	that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F755 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency failure to maintain an accurate accounting of all controlled medications for 1 of 4 resident s sampled- was failure to follow established policy. On 4/10/18, resident #118 had oxycodone reordered from the pharmacy and it arrived on 4/11/18 with the proper documentation of medication received and the correct receipt/count sheet was started by the RN hall nurse and the RN supervisor. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/10/18 and 4/11/18, the facility consultants, director of nursing, assistant director of nursing, and staff development coordinator completed and audit of all controlled substances ensuring counts were correct with correct documentation.	

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F 755	Continued From page 31 --On 2/26/18, 1 dose of oxycodone was documented as administered; --On 2/27/18, 3 doses of oxycodone were documented as administered; --On 2/28/18, 3 doses of oxycodone were documented as administered. A review of Resident #118 ' s March 2018 MAR indicated 43 doses of 10 mg oxycodone were administered to the resident on the following dates: --On 3/1/18, 2 doses of oxycodone were documented as administered; --On 3/2/18, 2 doses of oxycodone were documented as administered; --On 3/3/18, 1 dose of oxycodone was documented as administered; --On 3/4/18, no doses of oxycodone were documented as administered; --On 3/5/18, 1 dose of oxycodone was documented as administered; --On 3/6/18, 3 doses of oxycodone were documented as administered; --On 3/7/18, 3 doses of oxycodone were documented as administered; --On 3/8/18, 3 doses of oxycodone were documented as administered; --On 3/9/18, 3 doses of oxycodone were documented as administered; --On 3/10/18, 2 doses of oxycodone were documented as administered; --On 3/11/18, no doses of oxycodone were documented as administered; --On 3/12/18, 1 dose of oxycodone was documented as administered; --On 3/13/18, 2 doses of oxycodone were documented as administered; --On 3/14/18, 2 doses of oxycodone were documented as administered;	F 755	Any negative findings were addressed/investigated immediately by the auditor, including notification of the physician as appropriate. On 4/16/18, the facility consultant in-serviced the director of nursing (DON) on controlled substances and proper documentation. On 4/16/18, the Staff Development Coordinator (SDC) was in-serviced by the DON on controlled substances and proper documentation. By 5/14/18, all licensed nurses and medication aides, including the newly hired licensed nurses and medication aides and agency staff, will be in-serviced by the SDC on controlled substances and proper documentation. This in-service will be part of the orientation process for all newly hired licensed nurses, medication aides, and agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SDC, and/or MDS nurse will audit all medication carts 3 times a week x 12 weeks to ensure the controlled substance count is correct including documentation. This audit will be documented on the controlled medication audit tool. The monthly QI committee will review the results of the controlled medication audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 32 --On 3/15/18, 2 doses of oxycodone were documented as administered; --On 3/16/18, no doses of oxycodone were documented as administered; --On 3/17/18, 1 dose of oxycodone was documented as administered; --On 3/18/18, 1 dose of oxycodone was documented as administered; --On 3/19/18, 1 dose of oxycodone was documented as administered; --On 3/20/18, 2 doses of oxycodone were documented as administered; --On 3/21/18, 3 doses of oxycodone were documented as administered; --On 3/22/18, no doses of oxycodone were documented as administered; --On 3/23/18, 1 dose of oxycodone was documented as administered; --On 3/24/18, 1 dose of oxycodone was documented as administered; --On 3/25/18, no doses of oxycodone were documented as administered; --On 3/26/18, no doses of oxycodone were documented as administered; --On 3/27/18, 1 dose of oxycodone was documented as administered; --On 3/28/18, 2 doses of oxycodone were documented as administered; --On 3/29/18, 1 dose of oxycodone was documented as administered; --On 3/30/18, 1 dose of oxycodone was documented as administered; --On 3/31/18, 1 dose of oxycodone was documented as administered. A review of Resident #118 ' s April 2018 MAR on 4/10/18 indicated 18 doses of 10 mg oxycodone were administered to the resident thus far during the month:	F 755	continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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--On 4/1/18, 1 dose of oxycodone was documented as administered to Resident #118;
--On 4/2/18, 2 doses of oxycodone were documented as administered;
--On 4/3/18, 2 doses of oxycodone were documented as administered;
--On 4/4/18, 3 doses of oxycodone were documented as administered;
--On 4/5/18, 2 doses of oxycodone were documented as administered;
--On 4/6/18, 2 doses of oxycodone were documented as administered;
--On 4/7/18, 3 doses of oxycodone were documented as administered;
--On 4/8/18, 3 doses of oxycodone were documented as administered.

An observation was conducted on 4/10/18 at 3:05 PM of the 200 Hall medication cart. The observation revealed there were no oxycodone 10 mg tablets currently stored on the cart for Resident #118.

On 4/10/18 at 3:05 PM, the facility ' s Director of Nursing (DON) was asked for the most recent Controlled Substance Receipt/Count Sheet (a declining inventory record) for Resident #118 ' s oxycodone. The Controlled Substance Receipt/Count Sheet for the oxycodone could not be located.

A telephone interview was conducted on 4/10/18 at 3:56 PM with Pharmacist #1. Pharmacist #1 represented the pharmacy contracted by the facility to dispense medications. During the interview, the pharmacist reported a prescription for 120 tablets of 10 mg oxycodone was last dispensed for Resident #118 on 2/12/18.

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Upon their request, an interview was conducted on 4/11/18 at 10:00 AM with the facility ' s Administrator and Corporate Consultant #2. The Administrator reported an initial audit was done last night (4/10/18) for controlled medications on all of the medication carts. She reported the facility was currently re-auditing the medication cart in question on the 200 Hall. The Administrator reported they were also counting the doses of oxycodone documented as administered (according to the MAR) for Resident #118.

A follow-up interview was conducted on 4/11/18 at 11:14 AM with the Administrator and Corporate Consultant #2. The Administrator reported there were 26 - 10 mg tablets of Resident #118 ' s oxycodone that could not be accounted for (from 2/13/18 to date). The Administrator reported she would be notifying the police, filing a 24-hour, 5-day report with the State, and notifying the Drug Enforcement Agency (DEA) of the missing controlled medication.

An interview was conducted on 4/11/18 at 4:17 PM with Corporate Consultant #1, Corporate Consultant #2, and Corporate Consultant #3. During the interview, the consultants detailed the process they followed to determine the number of missing oxycodone tablets. The consultants reported 94 tablets of 10 mg oxycodone were documented on the MAR as administered to Resident #118 from 2/13/18 to 4/8/18 (33 doses in February, 43 doses in March, and 18 doses in April). A review of the pharmacy records indicated 120 tablets of 10 mg oxycodone were delivered the evening of 2/12/18, which left 26 doses unaccounted for. The consultants confirmed the Controlled Substance

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F 755	Continued From page 35 Receipt/Count Sheet for Resident #118 ' s oxycodone could not be located. An interview was conducted on 4/12/18 at 11:15 PM with the facility ' s consultant pharmacist. During the interview, the consultant pharmacist was asked what role she had in the reconciliation of controlled medications at the facility. The pharmacist reported each month she review the narcotic books on the halls. When asked if she had identified any concerns regarding controlled medications, the consultant pharmacist stated her biggest concern was in regards to the "holes" on the MAR and the declining inventory (referring to missing documentation). The consultant pharmacist stated she included information on the concerns identified in her monthly reports to the facility ' s Administrator and DON. An interview was conducted on 4/13/18 at 2:00 PM with the DON. During the interview, the DON reported she would expect the Controlled Substance Receipt/Count Sheet to be retrievable for all controlled medications to allow for the accounting of the medications. The DON also stated she would expect the documentation on a resident ' s MAR to match the declining inventory record on the Controlled Substance Receipt/Count Sheet.	F 755		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		5/14/18

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agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 37 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and consultant pharmacist, nurse practitioner, and staff interviews, the facility failed to maintain consistent and accurate documentation regarding the administration of controlled medications on the Medication Administration Record (MAR) and Controlled Substance Receipt/Count Sheet (a declining inventory record) for 4 of 4 sampled residents reviewed who received oxycodone (an opioid pain medication) prescribed on an as needed basis (Resident #118, Resident #009, Resident #005, and Resident #004). The findings included: 1) Resident #118 was admitted to the facility on 4/16/15. A review of Resident #118 ' s medication orders revealed a physician ' s order was written	F 842	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction.	

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F 842	Continued From page 38 on 2/12/18 for 10 milligrams (mg) oxycodone to be given as one tablet by mouth every 6 hours as needed. Oxycodone is a controlled medication. A review of the last 30 days of documentation related to the administration of 10 mg oxycodone to Resident #118 was conducted. The Controlled Substance Receipt/Count Sheet for the 10 mg oxycodone was not available for this period of time. The Controlled Substance Receipt/Count Sheet is a declining inventory record which would provide information on the date and number of oxycodone tablets withdrawn from the controlled medication inventory for administration to Resident #118. In addition, Resident #118 ' s March 2018 and April 2018 Medication Administration Record (MAR) were identified to have discrepancies on each of the following dates: --On 3/17/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. --On 3/18/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. --On 3/21/18, 3 doses of oxycodone were documented as administered on the front of the MAR. However, 1 dose of oxycodone was documented as administered to the resident on the back of the MAR. --On 3/27/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR.	F 842	F842 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency □ facility failed to maintain consistent and accurate documentation regarding the administration of controlled medication on the Medication Administration Record (MAR) and Controlled Substance Receipt/Count sheet- was failure to follow policy and procedure. On 4/10/18, resident #118 had oxycodone reordered from the pharmacy and it arrived on 4/11/18 with the proper documentation of medication received and the correct receipt/count sheet was started by RN hall nurse and RN Supervisor. On 4/10/18, resident # 009 has oxycodone reordered from the pharmacy and it arrived on 4/10/18 with the proper documentation of medication received and the correct receipt/count sheet was started by LPN hall nurse and RN supervisor. On 4/10/18, resident #005□s Medication administration record and declining count sheet for oxycodone were reviewed by the Staff Development Coordinator to ensure as of 4/10/18 the declining narcotic count sheet was correct to match the number of pills currently present. On 4/10/18, resident #004□s Medication	

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F 842	Continued From page 39 --On 3/29/18, no doses of oxycodone were documented as administered on the front of the MAR. However, 1 dose of oxycodone was documented as administered to the resident on the back of the MAR. --On 3/30/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. --On 3/31/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR --On 4/3/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, 2 doses of oxycodone were documented as administered to the resident on the back of the MAR. --On 4/8/18, 3 doses of oxycodone were documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. An interview was conducted on 4/12/18 at 11:15 PM with the facility ' s consultant pharmacist. During the interview, the consultant pharmacist was asked if she had identified any concerns regarding controlled medications. The consultant pharmacist stated her biggest concern was in regards to the "holes" on the MAR and the declining inventory (referring to missing documentation). The consultant pharmacist stated she included information on the concerns identified in her monthly reports to the facility ' s Administrator and DON.	F 842	administration record and declining count sheet for oxycodone were reviewed by the Director of Nursing to ensure as of 4/10/18 the declining narcotic count sheet was correct to match the number of pills currently present. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/10/18 and 4/11/18, the facility consultants, director of nursing, assistant director of nursing, and staff development coordinator completed and audit of all controlled substances ensuring counts were correct with correct documentation. Any negative findings were addressed/investigated immediately by the auditor, including notification of the physician, pharmacy, and other agencies as appropriate. On 4/16/18, the facility consultant in-serviced the director of nursing (DON) on controlled substances and proper documentation. On 4/16/18, the Staff Development Coordinator (SDC) was in-serviced by the DON on controlled substances and proper documentation. By 5/14/18, all licensed nurses and medication aides, including the newly hired licensed nurses and medication aides and agency staff, will be in-serviced by the SDC on controlled substances and proper documentation. This in-service will be part of the orientation process for all newly hired licensed nurses, medication aides, and agency staff.	

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F 842	Continued From page 40 An interview was conducted on 4/13/18 at 9:20 AM with the Nurse Practitioner (NP) who helped care for residents at the facility. During the interview, the record-keeping discrepancies between the front of the MAR, the back of the MAR, and the Controlled Substance Receipt/Count Sheet were discussed. When asked what source of information she used in the decision-making process to care for the residents, the NP reported she would sometimes use the declining inventory sheet in the narcotic binder on the med cart (the Controlled Substance Receipt/Count Sheet); and sometimes the front of the MAR when looking back to a previous month to review the history of resident ' s medication use. The NP indicated she was not aware there may be discrepancies between these records. An interview was conducted on 4/13/18 at 2:00 PM with the DON. During the interview, the DON discussed the process she expected nursing staff to follow when administering a controlled medication on an as needed basis. The DON stated the resident needed to be assessed and the MAR checked to be sure a current order was in place and the timing was appropriate to give the medication prior to administering the medication. Once the medication was determined to be appropriate for administration, the nurse was expected to pull the medication from the med cart, sign the med out on the Controlled Substance Receipt/Count Sheet, and give the medication to the resident. When the nurse returned to the med cart, she was expected to document the medication administration by putting her initials on the front of the MAR. The DON also indicated she expected the nurse to write on the back of the MAR the date/time the med was given, the name of the medication, the	F 842	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SDC, and/or MDS nurse will audit all medication carts 3 times a week x 12 weeks to ensure the controlled substance documentation is correct. This audit will be documented on the controlled medication audit tool. The monthly QI committee will review the results of the controlled medication audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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indication, and the results or effectiveness of it. The DON stated she expected the documentation on a resident ' s MAR to be consistent and match the declining inventory record on the Controlled Substance Receipt/Count Sheet. The DON also reported she expected the Controlled Substance Receipt/Count Sheet to be retrievable for all controlled medications.

2) Resident #009 was admitted to the facility on 2/13/18. A review of Resident #009 ' s medication orders revealed a physician ' s order was written on 3/16/18 for 10 milligrams (mg) oxycodone (an opioid pain medication) to be given as one tablet by mouth every 6 hours as needed for pain. Oxycodone is a controlled medication.

A review of the last 30 days of documentation related to the administration of 10 mg oxycodone to Resident #009 was conducted. The Controlled Substance Receipt/Count Sheet for the 10 mg oxycodone was not available for this period of time. The Controlled Substance Receipt/Count Sheet is a declining inventory record which would provide information on the date and number of oxycodone tablets withdrawn from the controlled medication inventory for administration to Resident #009. In addition, Resident #009 ' s March 2018 and April 2018 Medication Administration Record (MAR) were identified to have discrepancies on each of the following dates:
--On 3/16/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR.
--On 3/18/18, 1 dose of oxycodone was documented as administered on the front of the

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MAR. However, 2 doses of oxycodone were documented as administered to the resident on the back of the MAR.
--On 3/19/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR.
--On 3/20/18, 2 doses of oxycodone were documented as administered on the front of the MAR. However, 1 dose of oxycodone was documented as administered to the resident on the back of the MAR.
--On 3/21/18, 3 doses of oxycodone were documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR.
--On 3/23/18, 2 doses of oxycodone were documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR.
--On 3/24/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR.
--On 3/26/18, 2 doses of oxycodone were documented as administered on the front of the MAR. However, 1 dose of oxycodone was documented as administered to the resident on the back of the MAR.
--On 4/1/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR.
--On 4/3/18, 2 doses of oxycodone were

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documented as administered on the front of the MAR. However, 1 dose of oxycodone was documented as administered to the resident on the back of the MAR.
--On 4/6/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR.
--On 4/7/18, 2 doses of oxycodone were documented as administered on the front of the MAR. However, 1 dose of oxycodone was documented as administered to the resident on the back of the MAR.
--On 4/8/18, 3 doses of oxycodone were documented as administered on the front of the MAR. However, 1 dose of oxycodone was documented as administered to the resident on the back of the MAR.

An interview was conducted on 4/12/18 at 11:15 PM with the facility ' s consultant pharmacist. During the interview, the consultant pharmacist was asked if she had identified any concerns regarding controlled medications. The consultant pharmacist stated her biggest concern was in regards to the "holes" on the MAR and the declining inventory (referring to missing documentation). The consultant pharmacist stated she included information on the concerns identified in her monthly reports to the facility ' s Administrator and DON.

An interview was conducted on 4/13/18 at 9:20 AM with the Nurse Practitioner (NP) who helped care for residents at the facility. During the interview, the record-keeping discrepancies between the front of the MAR, the back of the MAR, and the Controlled Substance

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Receipt/Count Sheet were discussed. When asked what source of information she used in the decision-making process to care for the residents, the NP reported she would sometimes use the declining inventory sheet in the narcotic binder on the med cart (the Controlled Substance Receipt/Count Sheet); and sometimes the front of the MAR when looking back to a previous month to review the history of resident ' s medication use. The NP indicated she was not aware there may be discrepancies between these records.

An interview was conducted on 4/13/18 at 2:00 PM with the DON. During the interview, the DON discussed the process she expected nursing staff to follow when administering a controlled medication on an as needed basis. The DON stated the resident needed to be assessed and the MAR checked to be sure a current order was in place and the timing was appropriate to give the medication prior to administering the medication. Once the medication was determined to be appropriate for administration, the nurse was expected to pull the medication from the med cart, sign the med out on the Controlled Substance Receipt/Count Sheet, and give the medication to the resident. When the nurse returned to the med cart, she was expected to document the medication administration by putting her initials on the front of the MAR. The DON also indicated she expected the nurse to write on the back of the MAR the date/time the med was given, the name of the medication, the indication, and the results or effectiveness of it. The DON stated she expected the documentation on a resident ' s MAR to be consistent and match the declining inventory record on the Controlled Substance Receipt/Count Sheet. The DON also reported she expected the Controlled Substance

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Receipt/Count Sheet to be retrievable for all controlled medications.

3) Resident #005 was admitted to the facility on 3/20/18. A review of Resident #005 ' s medication orders revealed a physician ' s order was written on 3/20/18 for 5 milligrams (mg) oxycodone (an opioid pain medication) to be given as one tablet by mouth every 6 hours as needed for pain. Oxycodone is a controlled medication.

A review of the last 30 days of documentation for the administration of 5 mg oxycodone to Resident #005 was conducted. Resident #005 ' s Medication Administration Records (MAR) and Controlled Substance Receipt/Count Sheet (a declining inventory record) included discrepancies over the past 30 days on each of the following dates:
--On 3/22/18, 1 dose of oxycodone was documented as administered on the front and back of the MAR.
However, the Controlled Substance Receipt/Count Sheet indicated 3 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #005.
--On 3/24/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, 2 doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 2 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #005.
--On 3/25/18, 3 doses of oxycodone were documented as administered on the front of the MAR. However, 2 doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance

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Receipt/Count Sheet indicated 3 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #005.
--On 3/26/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 3 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #005.

A review of Resident #005 ' s physician orders revealed the 5 mg oxycodone initiated on 3/20/18 was discontinued on 3/27/18. A new order was received on 3/29/18 for 5 mg oxycodone to be given by mouth as one tablet every 4 hours as needed for pain rated as 1-5 (on a pain rating scale of 0-10) and two tablets of 5 mg oxycodone to be given by mouth every 4 hours as need for pain rated as 6-10.

--On 3/30/18, no doses of oxycodone were documented as administered on the front or back of the MAR. However, the Controlled Substance Receipt/Count Sheet indicated 2 tablets of 5 mg oxycodone were withdrawn from the controlled medication inventory for Resident #005.
--On 4/1/18, 4 tablets of oxycodone were documented as administered on the front of the MAR. However, 2 tablets of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet was not available for 4/1/18 at the time of the review to indicate how many tablets were withdrawn from the controlled medication inventory for Resident #005.
--On 4/2/18, 2 tablets of oxycodone were documented as administered on the front of the

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MAR. However, no tablets of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet was not available for 4/2/18 at the time of the review to indicate how many tablets were withdrawn from the controlled medication inventory for Resident #005.
--On 4/3/18, 4 tablets of oxycodone were documented as administered on the front of the MAR. However, 2 tablets of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet was not available for 4/3/18 at the time of the review to indicate how many tablets were withdrawn from the controlled medication inventory for Resident #005.
--On 4/5/18, no tablets of oxycodone were documented as administered on either the front or back of the MAR. However, the Controlled Substance Receipt/Count Sheet indicated 4 tablets of oxycodone were withdrawn from the controlled medication inventory for Resident #005.
--On 4/6/18, 4 tablets of oxycodone were documented as administered on the front of the MAR. However, 3 tablets of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 6 tablets of oxycodone were withdrawn from the controlled medication inventory for Resident #005.
--On 4/7/18, 8 tablets of oxycodone were documented as administered on the front of the MAR. However, 4 tablets of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 10 tablets of oxycodone were withdrawn from the controlled medication inventory for Resident #005.

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F 842	Continued From page 48 --On 4/8/18, 7 tablets of oxycodone were documented as administered on the front of the MAR. However, no tablets of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 6 tablets of oxycodone were withdrawn from the controlled medication inventory for Resident #005. --On 4/9/18, 6 tablets of oxycodone were documented as administered on the front of the MAR. However, no tablets of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 6 tablets of oxycodone were withdrawn from the controlled medication inventory for Resident #005. --On 4/10/18, 4 tablets of oxycodone were documented as administered on the front of the MAR. However, 3 tablets of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 2 tablets of oxycodone were withdrawn from the controlled medication inventory for Resident #005. An interview was conducted on 4/12/18 at 11:15 PM with the facility ' s consultant pharmacist. During the interview, the consultant pharmacist was asked if she had identified any concerns regarding controlled medications. The consultant pharmacist stated her biggest concern was in regards to the "holes" on the MAR and the declining inventory (referring to missing documentation). The consultant pharmacist stated she included information on the concerns identified in her monthly reports to the facility ' s Administrator and DON. An interview was conducted on 4/13/18 at 9:20	F 842		

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AM with the Nurse Practitioner (NP) who helped care for residents at the facility. During the interview, the record-keeping discrepancies between the front of the MAR, the back of the MAR, and the Controlled Substance Receipt/Count Sheet were discussed. When asked what source of information she used in the decision-making process to care for the residents, the NP reported she would sometimes use the declining inventory sheet in the narcotic binder on the med cart (the Controlled Substance Receipt/Count Sheet); and sometimes the front of the MAR when looking back to a previous month to review the history of resident ' s medication use. The NP indicated she was not aware there may be discrepancies between these records.

An interview was conducted on 4/13/18 at 2:00 PM with the DON. During the interview, the DON discussed the process she expected nursing staff to follow when administering a controlled medication on an as needed basis. The DON stated the resident needed to be assessed and the MAR checked to be sure a current order was in place and the timing was appropriate to give the medication prior to administering the medication. Once the medication was determined to be appropriate for administration, the nurse was expected to pull the medication from the med cart, sign the med out on the Controlled Substance Receipt/Count Sheet, and give the medication to the resident. When the nurse returned to the med cart, she was expected to document the medication administration by putting her initials on the front of the MAR. The DON also indicated she expected the nurse to write on the back of the MAR the date/time the med was given, the name of the medication, the indication, and the results or effectiveness of it.

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The DON stated she expected the documentation on a resident ' s MAR to be consistent and match the declining inventory record on the Controlled Substance Receipt/Count Sheet. The DON also reported she expected the Controlled Substance Receipt/Count Sheet to be retrievable for all controlled medications.

4) Resident #004 was admitted to the facility on 3/15/18. A review of Resident #004 ' s medication orders revealed a physician ' s order was written on 3/15/18 for 5 milligrams (mg) oxycodone (an opioid pain medication) to be given as one-half tablet (2.5 mg) by mouth every 8 hours as needed for pain. Oxycodone is a controlled medication.

A review of the last 30 days of documentation for the administration of 2.5 mg oxycodone to Resident #004 was conducted. Resident #004 ' s Medication Administration Records (MAR) and Controlled Substance Receipt/Count Sheet (a declining inventory record) included discrepancies over the past 30 days on each of the following dates:
--On 3/21/18, no doses of oxycodone were documented as administered on the front or back of the MAR.
However, the Controlled Substance Receipt/Count Sheet indicated 1 dose of oxycodone was withdrawn from the controlled medication inventory for Resident #004.
--On 3/24/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, 2 doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 2 doses of oxycodone were withdrawn from the controlled

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medication inventory for Resident #004.
--On 3/29/18, no doses of oxycodone were documented as administered on the front of the MAR. However, 2 doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 3 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #004.
--On 3/30/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 1 dose of oxycodone was withdrawn from the controlled medication inventory for Resident #004.
--On 3/31/18, 1 dose of oxycodone was documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 2 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #004.
--On 4/2/18, 1 dose of oxycodone was documented as administered on both the front and back of the MAR. However, the Controlled Substance Receipt/Count Sheet indicated 2 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #004.
--On 4/3/18, no doses of oxycodone were documented as administered on the front or back of the MAR.
However, the Controlled Substance Receipt/Count Sheet indicated 2 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #004.

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F 842	Continued From page 52 --On 4/4/18, no doses of oxycodone were documented as administered on the front or back of the MAR. However, the Controlled Substance Receipt/Count Sheet indicated 1 dose of oxycodone was withdrawn from the controlled medication inventory for Resident #004. --On 4/6/18, no doses of oxycodone were documented as administered on the front or back of the MAR. However, the Controlled Substance Receipt/Count Sheet indicated 1 dose of oxycodone was withdrawn from the controlled medication inventory for Resident #004. --On 4/7/18, 2 doses of oxycodone were documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 3 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #004. --On 4/8/18, 2 doses of oxycodone were documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 1 dose of oxycodone was withdrawn from the controlled medication inventory for Resident #004. --On 4/9/18, 2 doses of oxycodone were documented as administered on the front of the MAR. However, no doses of oxycodone were documented as administered to the resident on the back of the MAR. The Controlled Substance Receipt/Count Sheet indicated 3 doses of oxycodone were withdrawn from the controlled medication inventory for Resident #004.	F 842		

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An interview was conducted on 4/12/18 at 11:15 PM with the facility ' s consultant pharmacist. During the interview, the consultant pharmacist was asked if she had identified any concerns regarding controlled medications. The consultant pharmacist stated her biggest concern was in regards to the "holes" on the MAR and the declining inventory (referring to missing documentation). The consultant pharmacist stated she included information on the concerns identified in her monthly reports to the facility ' s Administrator and DON.

An interview was conducted on 4/13/18 at 9:20 AM with the Nurse Practitioner (NP) who helped care for residents at the facility. During the interview, the record-keeping discrepancies between the front of the MAR, the back of the MAR, and the Controlled Substance Receipt/Count Sheet were discussed. When asked what source of information she used in the decision-making process to care for the residents, the NP reported she would sometimes use the declining inventory sheet in the narcotic binder on the med cart (the Controlled Substance Receipt/Count Sheet); and sometimes the front of the MAR when looking back to a previous month to review the history of resident ' s medication use. The NP indicated she was not aware there may be discrepancies between these records.

An interview was conducted on 4/13/18 at 2:00 PM with the DON. During the interview, the DON discussed the process she expected nursing staff to follow when administering a controlled medication on an as needed basis. The DON stated the resident needed to be assessed and the MAR checked to be sure a current order was in place and the timing was appropriate to give

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F 842	Continued From page 54 the medication prior to administering the medication. Once the medication was determined to be appropriate for administration, the nurse was expected to pull the medication from the med cart, sign the med out on the Controlled Substance Receipt/Count Sheet, and give the medication to the resident. When the nurse returned to the med cart, she was expected to document the medication administration by putting her initials on the front of the MAR. The DON also indicated she expected the nurse to write on the back of the MAR the date/time the med was given, the name of the medication, the indication, and the results or effectiveness of it. The DON stated she expected the documentation on a resident ' s MAR to be consistent and match the declining inventory record on the Controlled Substance Receipt/Count Sheet.	F 842		