

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2020
NAME OF PROVIDER OR SUPPLIER BIG ELM RETIREMENT AND NURSING CENTERS			STREET ADDRESS, CITY, STATE, ZIP CODE 1285 WEST A STREET KANNAPOLIS, NC 28081		
(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	
E 000	Initial Comments	E 000			
F 000	INITIAL COMMENTS	F 000			
F 580 SS=D	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).	F 580		2/7/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/31/2020

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	<p>Continued From page 1</p> <p>(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.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§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 record review, staff, and physician interviews, the facility failed to seek clarification for an order to administer eye drop medications until the next post-surgical follow up appointment which was scheduled by the eye surgeon. The follow up appointment was cancelled, and the facility continued to administer the eye drops beyond the cancelled appointment date without notifying the eye surgeon for further instructions for one of one resident sampled for surgical</p>	F 580	<p>1) Resident #2 had the order for prednisolone/Ketorolac eye drops corrected and a follow up appointment was scheduled.</p> <p>2) Residents who are seen by outside physician services have the potential for the same deficient practice. The Director of Nursing and Unit Coordinator have completed audits of any residents that</p>		

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F 580	<p>Continued From page 2 follow up appointments (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on 10/12/12. The resident ' s cumulative diagnoses included: Diabetes, episcleritis (an inflammation of the white part of the eye), cataracts of the eyes, and glaucoma.</p> <p>Review of Resident #2 ' s most recent quarterly Minimum Data Set assessment with a reference date of 9/24/19 revealed the resident was coded for moderate cognitive loss. The resident was totally dependent on the assistance of two or more people for bed mobility, transferring (such as from the bed to a wheelchair), dressing, personal hygiene, and bathing.</p> <p>Review of Resident #2 ' s report of consultation from the eye surgeon dated 11/15/19 revealed the resident had a cataract surgery on the same date. The consultation revealed the eye surgeon had ordered prednisolone acetate ophthalmic suspension (a steroid medicine used to treat eye swelling) eye drops, 1 drop to the left eye twice a day and ketorolac ophthalmic solution (a nonsteroidal anti-inflammatory drug (NSAID) medication used to reduce swelling, pain, and burning or stinging after cataract surgery) 1 drop to the left eye every day. The two medications were ordered to be administered until the next post-surgical follow up appointment. The consultation report revealed a post-surgery appointment was scheduled on 12/10/19.</p> <p>Resident #2 ' s physician ' s orders contained an order dated 11/15/19 which was for prednisolone acetate ophthalmic suspension eye drops, 1 drop</p>	F 580	<p>had follow-up physician appointments by January 29, 2020 to ensure that orders from these physicians do not have open-ended or no stop dates and to clarify these orders with that respective physician and to clarify these orders for those residents identified. There were no other residents identified at that time showing a deficient practice.</p> <p>The Director of Nursing and Staff Development Coordinator has in-serviced the nursing staff (Registered Nurses/Licensed Practical Nurses) to notify and/or clarify open-ended physician orders from outside physician providers. The in-servicing began on January 28, 2020 and will conclude no later than February 7, 2020.</p> <p>3) There are no systemic changes needed at this time. The facility has policy and procedures to ensure that physician orders are followed by ensuring that physician orders from outside physician providers are clarified and that there are end-dates to a physician treatment or follow up on why a treatment is continued.</p> <p>4) The director of nursing and/or nurse supervisor will conduct audits of residents that have appointments from an outside physicians to review whether orders that are identified as open-ended are followed up with and clarified by facility RNs or LPNs.</p> <p>The audits will be completed weekly for four weeks, monthly for four months, and</p>		

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F 580	<p>Continued From page 3</p> <p>to the left eye twice a day and ketorolac ophthalmic solution eye drops, 1 drop to the left eye every day. The two medications were ordered to be administered until the next post-surgical follow up appointment. The order did not contain a date for the next post-surgical follow up appointment. The order was signed as received and transcribed by Nurse #2 on 11/15/19.</p> <p>The December 2019 Medication Administration Record (MAR) for Resident #2 had prednisolone acetate ophthalmic suspension eye drops, 1 drop to the left eye twice a day (Continue until the next appointment on 12/10/19). The order date and the start date for the medication was 11/15/19. The eye drop medication was recorded as administered twice a day from 12/1/19 through 12/31/19 with the exception of one omitted afternoon dose on 12/6/19. Additionally, the MAR revealed the resident had ketorolac ophthalmic solution eye drops 1 drop to the left eye every day until the next appointment on 12/10/19. The order date and the start date for the medication was 11/15/19. The eye drop medication was recorded as administered every day from 12/1/19 through 12/31/19.</p> <p>The January 2020 Medication Administration Record (MAR) for Resident #2 was reviewed on 1/7/20. The MAR had prednisolone acetate ophthalmic suspension eye drops, 1 drop to the left eye twice a day (Continue until the next appointment on 12/10/19). The order date and the start date for the medication was 11/15/19. The eye drop medication was recorded as administered twice a day from 1/1/20 through 1/7/20. Additionally, the MAR revealed the resident had ketorolac ophthalmic solution eye</p>	F 580	<p>quarterly thereafter to ensure compliance. Results of these audits will be reviewed in the facility overall quality assurance program and corrective actions taken as identified.</p>		

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F 580	<p>Continued From page 4</p> <p>drops 1 drop to the left eye every day until the next appointment on 12/10/19. The order date and the start date for the medication was 11/15/19. The eye drop medication was recorded as administered every day from 1/1/20 through 1/7/20.</p> <p>An interview was conducted on 1/7/20 at 4:34 PM with Nurse #2. The nurse stated Resident #2 had a scheduled follow up appointment with the eye surgeon on 12/10/19 but the resident was unable to go. The nurse stated she had transcribed the physician ' s order to the MAR in November, and she stated she entered the information on the MAR regarding the medication to be administered until the next appointment on 12/10/19. The nurse reviewed the December and January MAR and stated the eye drop medications were administered each day since 12/10/19 and, according to the documentation on the December and January MARs, the resident was prescribed to receive prednisolone and ketorolac eye drop medication up until the next appointment on 12/10/19. The nurse stated Medication Aide (MA) #1 administered both eye drop medications during the morning medication pass on 1/7/20. The nurse stated she would call the eye doctor to get clarification if the eye drops should be continued or stopped. The nurse stated it was her expectation if a MA saw a medication was not to be administered after a certain date, the MA would come to the nurse and inform her.</p> <p>A phone interview was conducted with MA #1 on 1/9/20 at 12:26 PM. She stated she had administered the prednisolone and ketorolac eye drops the morning of 1/7/20. She said she had seen the information in the MAR regarding to administering the eye drops until 12/10/19,</p>	F 580			

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F 580	<p>Continued From page 5</p> <p>however she had not received any information to have discontinued the drops. The MA said she thought a follow up appointment later in the month may have been scheduled. She added she had not brought it to anyone ' s attention about having had administered the eye drops after the date on the MAR and had assumed a follow up appointment had already been scheduled.</p> <p>A second interview was conducted on 1/7/20 at 4:47 PM with Nurse #2. She said she spoke to the eye surgeon on 1/4/20 and had received an order from the eye surgeon to stop the prednisolone and ketorolac eye drops. The nurse stated she had transcribed the medication order on 11/15/19 and probably should have entered a stop date into the MAR when she transcribed the order to make sure the medication was not administered beyond the appointment date of 12/10/19.</p> <p>A phone interview was conducted on 1/9/20 at 11:57 AM with the eye surgeon. The eye surgeon stated Resident #2 had eye surgery on 11/15/19 and it was important that he saw the resident as a follow up after the surgery to assess her eyes and to see how the resident was doing after the surgery and if there were any new problems she may have been having. He said in addition to the need to follow up after the cataract surgery, the resident also had diagnoses which included episcleritis and glaucoma, which further added to the importance of a follow up appointment. He continued, he would have liked to have seen her sooner, but if the resident was not having any problems, the resident was most likely OK, however, he would not know for sure until he saw her at her next appointment. He said if the facility</p>	F 580			

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F 580	Continued From page 6 had to cancel the December appointment it was his expectation for them to have scheduled a follow up appointment during the initial phone call when the appointment was cancelled or soon after. Regarding the continuation of the medications beyond the originally scheduled follow up appointment of 12/10/19, he said the resident was unlikely to have had any negative impact. During a phone interview conducted on 1/9/20 at 12:33 PM with the Director of Nursing (DON) she stated she would have expected for a MA or a nurse to have brought it to someone ' s attention the eye drops were still being administered after 12/10/19 even though the eye surgeon follow up appointment on that date did not happen, so that the eye surgeon ' s office could be notified of the need for a follow up appointment to be scheduled.	F 580			
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.	F 732		2/7/20	

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F 732	Continued From page 7 §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 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 staff interview and review of required posted nursing staffing sheets dated 1/1/20, 1/2/20, 1/4/20, 1/5/20, 1/6/20, and 1/7/20, the facility failed to post accurate staffing information as compared to the Daily Nursing Staff Schedule for 7 days of the 7 days reviewed (7/25/19 through 7/31/19). Findings included: Review of the Posted Daily Nurse Staffing for 1/1/20 revealed the posted census was 46 residents. Further review revealed there was a total of 54 hours for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) and a total of 97.5 hours for Nursing Assistants (NAs).	F 732	1) The staffing sheets have been modified to separate the six licensed-only beds from the overall fifty-bed skilled certified beds to clearly identify staff available for the skilled patients. The administrator made a change to the bed-breakdown prior to the annual licensure inspection that increased the overall total beds from fifty to fifty-six. The director of nursing has reviewed the bed breakdown with the staffing coordinator and the weekend RN supervisor on 1/27/2020 to review the revised sheets and to ensure that the staffing to census breakdown is accurate.		

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F 732	Continued From page 8 Review of the Posted Daily Nurse Staffing for 1/2/20 revealed the posted census was 46 residents. Further review revealed there was a total of 54 hours for RNs and LPNs and a total of 105 hours for NAs. Review of the Posted Daily Nurse Staffing for 1/4/20 revealed the posted census was 46 residents. Further review revealed there was a total of 39 hours for RNs and LPNs and a total of 97.5 hours for NAs. Review of the Posted Daily Nurse Staffing for 1/5/20 revealed the posted census was 46 residents. Further review revealed there was a total of 39 hours for RNs and LPNs and a total of 90 hours for NAs. Review of the Posted Daily Nurse Staffing for 1/6/20 revealed the posted census was 47 residents for 7:00 AM to 3:00 PM and 48 residents for 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM. Further review revealed there was a total of 54 hours for RNs and LPNs and a total of 97.5 hours for NAs. Review of the Posted Daily Nurse Staffing for 1/7/20 revealed the posted census was 48 residents. Further review revealed there was a total of 54 hours for RNs and LPNs and a total of 105 hours for NAs. Review of the Daily Assignment sheets for 1/1/20, 1/2/20, 1/4/20, 1/5/20, 1/6/20, and 1/7/20 revealed there was a nurse (LPN or RN) assigned to the 200 Hall including rooms 209, 211, and 213 from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Further	F 732	2) The staffing sheets have been modified to separate the six licensed-only beds from the overall fifty-bed skilled certified beds to clearly identify staff available for the skilled patients. The administrator made a change to the bed-breakdown prior to the annual licensure inspection that increased the overall total beds from fifty to fifty-six. The director of nursing has reviewed the bed breakdown with the staffing coordinator and the weekend RN supervisor on 1/27/2020 to review the revised sheets and to ensure that the staffing to census breakdown is accurate. 3) The systemic changes were to add the additional six licensed only beds to the staffing sheets that originally were for the 50 skilled only beds. 4) The facility will conduct direct observation quality assurance rounds by the Director of Nursing, Staff Development, Unit Manager, and Weekend Supervisor of posted nurse staffing information. Direct observations will be conducted weekly for four (4) weeks, monthly for three (3) months, and quarterly thereafter. Findings will be reviewed during monthly quality assurance meetings and corrective actions taken as needed to ensure compliance.		

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F 732	<p>Continued From page 9</p> <p>review revealed an NA assignment which included rooms 209, 211, and 213 from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM.</p> <p>During an entrance conference conducted with the Administrator on 1/6/20 at 9:22 AM the Administrator stated room 209, 211, and 213 had been changed to Home for the Aged (HA) beds and were not Skilled Nursing Facility (SNF) beds. He stated each room was semi-private, meaning there were two beds in each room, for a total of 6 HA beds. He stated all the other beds in the facility were SNF beds.</p> <p>An observation of the Posted Daily Nurse Staffing conducted on 1/6/20 at 9:33 AM revealed the posted census was 46 for the 7:00 AM to 3:00 PM shift.</p> <p>During an interview with Nurse #4 on 1/6/20 at 10:25 AM she stated the census of 46 posted on the Posted Daily Nurse Staffing included the residents whom were in the HA beds. She stated the HA beds included rooms 209, 211, and 213. She said there were 6 residents in the HA beds so the census without the residents in the HA beds would be 40. She also said the staffing including nurses and NAs on the Posted Daily Nurse Staffing included staff assigned to residents in the HA beds.</p> <p>An observation of the Posted Daily Nurse Staffing conducted on 1/7/20 at 3:10 PM revealed the posted census was 48 for the 7:00 AM to 3:00 PM shift.</p> <p>An observation of the Posted Daily Nurse Staffing conducted on 1/8/20 at 9:13 AM revealed the</p>	F 732			

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F 732	Continued From page 10 posted census was 48 for the 7:00 AM to 3:00 PM shift. An interview was conducted on 1/8/20 at 2:13 PM with the Staffing Coordinator (SC). The SC stated the census on the Posted Daily Nurse Staffing included the residents whom were in the HA beds, 209, 211, and 213. The SC further stated the staffing hours which were on the Posted Daily Nurse Staffing also included hours or time for care to residents in the HA beds. During an interview conducted with the Administrator on 1/8/20 at 12:46 PM he stated the beds in rooms 209, 211, and 213 had been reassigned since last year and that was a change. He further stated the census number had included residents in the HA beds and he would put a plan into place to ensure census and staffing numbers would be displayed accurately for the SNF beds and the HA beds.	F 732			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		2/7/20	

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F 761	<p>Continued From page 11 personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to assure safeguarding of medications and ensure that medications were secure when 1 medication was kept at the bedside for 1 of 1 sampled residents (Resident #37).</p> <p>The findings included:</p> <p>Resident #37 was admitted to the facility on 3/19/16 with diagnoses of dementia, anxiety, depression, rheumatoid arthritis and osteoporosis.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment dated 11/29/19 revealed the resident had a Brief Interview Mental Status (BIMS) of 13. She had limited recall.</p> <p>An observation on 1/6/20 at 9:48 AM revealed the resident had the medication, Trolamine Salicylate with lidocaine on the bedside table. The resident was observed asking the nurse aide for assistance with opening the bottle. The nurse aide was observed opening the bottle for the</p>	F 761	<p>1) Resident #37 has had her trolamine salicylate with lidocaine cream removed from her bedside and is being stored and administered by a nurse and stored in the facility medication carts.</p> <p>2) The facility completed a review of each residents bedside tables, bathrooms, and closet areas by the nurse supervisor on January 30, 2020 in order to identify if any other resident had medications stored properly. Residents identified during these rounds as having bedside medications, if any, will have an assessment completed to ensure if the resident is safe to administer and store their own medication in accordance with this requirement. As of 1/27/2020 the facility does not have anyone to have bedside medications.</p> <p>The staff development coordinator has in-serviced RNs, LPNs, and CNAs on the bedside medication procedure to include the policy and procedure, proper storage of medications including bedside, and for</p>		

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F 761	<p>Continued From page 12</p> <p>resident and handed it to the resident for use.</p> <p>A record review conducted on 1/6/20 revealed a medication order dated 10/18/19, for Trolamine Salicylate with lidocaine, a topical pain relief medication. Instructions included to apply a thin layer to affected areas TID and may keep at bedside.</p> <p>An observation and interview were done on 1/7/20 at 2:54 PM, the resident stated she had used the Trolamine Salicylate with lidocaine but it was not much help. The medication was on the bedside table.</p> <p>An interview with the resident on 1/6/20 at 9:48 AM revealed she took the medication when she needed it.</p> <p>On 1/8/20 at 10:45 AM during an interview, Resident #37 stated she was hurting bad and she had rubbed Trolamine Salicylate with lidocaine on her shoulders. She stated the nurse had helped her and the medication was in her bedside drawer.</p> <p>An interview was conducted with the MA#1 on 1/8/20 at 10:30 AM. She stated Resident #37 had an order for Trolamine Salicylate with lidocaine which she could keep at her bedside so she could use as needed.</p> <p>An interview on 1/8/20 at 10:51 AM with the Director of Nursing stated no medications should be kept at the bedside. She stated Resident #37 was a bit confused. She stated her Quality Assurance nurses did rounds and checked the bed sides to ensure no medications were left by families. The DON stated she would address this</p>	F 761	<p>staff to question if they see medications that are at the bedside for resident's cognitive ability to safely administer a bedside medication themselves as at times, family or visitors may bring something into the facility without discussing with staff.</p> <p>3) There are no systemic changes necessary. In this instance the nursing staff should have previously removed the topical cream from her bedside as she did not have proper storage nor could she effectively put the cream on according to its order.</p> <p>4) The director of nursing, unit manager, and 7PM-7AM charge nurse will conduct physical audits weekly for four weeks, monthly for four months, and quarterly thereafter to ensure compliance. Results of these audits will be reviewed with the facility's overall QAPI program and corrective actions taken as identified.</p>		

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F 761	Continued From page 13 immediately and she would have nurses check the bedsides.	F 761			
F 842 SS=C	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 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,	F 842		2/7/20	

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F 842	<p>Continued From page 14</p> <p>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.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident, physician, and staff interviews, the facility failed to maintain accurate medical records regarding code status for 2 of 20 residents reviewed regarding code status (Residents #196 and #243) and continued to administer eye drop medications after a transcribed stop date for 1 of 1 resident reviewed</p>	F 842	<p>1) The facility social worker has reviewed the code status's for resident's #196 and #243 and has ensured that each portion of that code is accurately documented and reflects the desires for that resident to include updates of physician orders face sheet, Do-Not-Resuscitate (DNR) and</p>		

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F 842	<p>Continued From page 15 for surgical follow up appointments (Resident #2).</p> <p>Findings included:</p> <p>1. Resident #196 was admitted to the facility on 12/20/19. The resident ' s admission diagnoses included: femur fracture, osteoarthritis, and diabetes.</p> <p>Review of Resident #196 ' s most recent Minimum Data Set (MDS) revealed a comprehensive admission assessment with an Assessment Reference Date (ARD) of 12/25/19. The resident was coded as having been cognitively intact and as having required extensive to total assistance of one person for all Activities of Daily Living (ADLs) including bed mobility, transfer (such as from a bed to a wheelchair), and toileting, except for eating for which she was coded as having been independent.</p> <p>Resident #196 ' s Medical Orders for Scope of Treatment (MOST) was discovered in the medical record in Advanced Directives, with an effective date of 12/20/19, had the resident ' s Cardio Pulmonary Resuscitation (CPR) choice for when the resident was discovered with no pulse and not breathing as Do Not Resuscitate (DNR/no CPR). Further review of the Advanced Directives portion of the medical record revealed a yellow or goldenrod stop sign Do Not Resuscitate Order with an effective date of 12/20/19.</p> <p>A review completed of Resident 196 ' s physician ' s orders revealed an order for the resident to be a full code, dated 12/21/19.</p> <p>The January monthly orders for Resident #196</p>	F 842	<p>Medical Orders for Stop of Treatment (MOST forms).</p> <p>Resident #2 had the order for prednisolone/Ketorolac eye drops corrected by the unit manager and a follow up appointment was scheduled.</p> <p>2) An audit was conducted on 1/28/2020 by the unit nurse manager of each resident's chart to ensure the facility has accurate records pertaining to code status. There were 8% (4 residents)that were identified having face sheets that were not accurate to reflect the Do not Resuscitate (DNR)order. Those resident's identified, if any, having conflicting directions for advanced directives on the face sheet, physician orders, DNR and MOST forms will have new forms completed and signed to ensure accurate records as needed.</p> <p>Nursing staff, to include Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), have been in-serviced on the advanced directives policy and importance of information be accurate in those records. The Director of Nursing and Staff Development Coordinator has in-serviced the nursing staff (RNs/LPNs) to notify and/or clarify open-ended physician orders from outside physician providers to ensure accurate records. The in-servicing began on January 28, 2020.</p> <p>In addition to the nursing staff, the facility director of nursing has in-serviced the</p>		

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F 842	<p>Continued From page 16</p> <p>included a physician ' s order for the resident to be a full code dated 12/23/19. At the bottom of the monthly physician ' s orders in the section labeled code status (No Code/Full Code) the resident was documented as having been a no code.</p> <p>A review was completed of Resident #196 ' s face sheet, with a printed date of 12/27/19 at 9:39 AM. The documentation next to Code Status was "No Code" or Do Not Resuscitate (DNR/no Cardiopulmonary Resuscitation (CPR)).</p> <p>A record review was conducted in conjunction with an interview with Nurse #5 on 1/7/20 at 2:38 PM. The review revealed a Resident #196 ' s medical record had a MOST form indicating the resident was a DNR dated 12/20/19, a goldenrod/stop sign indicating the resident was a DNR dated 12/20/19, and she stated Resident #196 was a DNR. The nurse further stated sometimes there was a DNR sticker on the binder edge of the hard chart to also indicate the resident was a DNR but Resident #196 ' s chart did not have such sticker. The nurse reviewed the resident ' s face sheet and stated the resident was a DNR or no code. The nurse stated the resident ' s code status could also be verified in the physician ' s orders and when the nurse reviewed the resident ' s physician ' s orders she stated the resident had a physician ' s order dated 12/21/19 for the resident to have been a full code. The nurse further reviewed the medical record and discovered the resident ' s January monthly orders and stated the resident had an order to be a full code but at the bottom of the monthly order sheet the resident was documented as having been a no code. The nurse stated the resident ' s code status should match and be consistent in</p>	F 842	<p>admissions/marketing and social services director on procedures for advance directive sections of the face sheet and to ensure accurate records for advance directives for new admissions.</p> <p>3) The facility has modified its admission system to ensure that admission records pertaining to the face sheets are accurate with the facility physician orders, MOST forms, and DNRs. The admissions/marketing and/or social services director will be responsible for final completion of the face sheet at admission and as updated as needed and ensure the information on the face sheet is accurate with advanced directive MOST forms, DNRs, and physician orders. The prior practice was the admitting nurses were to finalize the face sheets at the time of admission.</p> <p>In addition, there are no systemic changes needed at this time for the eye drops. The facility has policy and procedures to ensure that physician orders are followed by ensuring that physician orders from outside physician providers are clarified and that there are end-dates to a physician treatment or follow up on why a treatment is continued.</p> <p>4) The facility social worker will complete audits weekly of the accuracy with advanced directives for one month and then monthly thereafter to ensure compliance with accurate records pertaining to Advanced Directives.</p>		

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F 842	<p>Continued From page 17 the medical record.</p> <p>During an interview conducted on 1/7/20 at 2:44 PM with the Unit Manager she stated the resident ' s code status should match regarding her review of Resident #196 ' s code status on the January monthly orders.</p> <p>An interview was conducted with the Director of Nursing (DON) on 1/7/20 at 2:47 PM. The DON stated the resident ' s code status had changed after her admission and parts of the medical record were not updated. The DON stated it was important for all resident ' s code status to be consistent and clear throughout the medical record and she would initiate an audit of every resident ' s medical record to ensure all resident ' s code status met this criterion.</p> <p>During an interview conducted with Resident #196 on 1/7/20 at 3:07 PM she stated when she was initially admitted she had thought she hadn ' t wanted to be coded if something were to happen. She continued, she had thought about it more and then decided she had wanted CPR in case something were to happen and it was then when she had requested to have her status be changed to a full code.</p> <p>2. Resident #243 was originally admitted to the facility on 5/16/19. The resident ' s cumulative diagnoses included: pneumonia, history of acute respiratory failure with hypoxia (low oxygen), mild cognitive impairment, chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), generalized weakness, dementia, and anxiety.</p> <p>Review of Resident #243 ' s most recent MDS</p>	F 842	<p>Results of these audits will be reviewed through the facility Quality Assurance and Performance Improvement program and corrective actions taken as necessary to achieve compliance.</p> <p>The director of nursing and/or nurse supervisor will conduct audits of residents that have appointments from an outside physicians to review whether orders that are identified as open-ended are followed up with and clarified by facility RNs or LPNs.</p> <p>The audits will be completed weekly for four weeks, monthly for four months, and quarterly thereafter to ensure compliance. Results of these audits will be reviewed in the facility overall quality assurance program and corrective actions taken as identified.</p>		

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F 842	<p>Continued From page 18</p> <p>revealed a quarterly assessment with an ARD of 12/10/19. The resident was coded as having been unable to complete the cognitive interview and as having short and long-term memory problems. The resident ' s cognitive skills for daily decision making was coded as moderately impaired and as having displayed inattention, disorganized thinking, and an altered level of consciousness during the assessment period. The resident required total assistance for all ADLs including bed mobility, transfer (such as from a bed to a wheelchair), and toileting, and eating.</p> <p>An observation of the binder edge of Resident #243 ' s medical record revealed a DNR sticker.</p> <p>A review was completed on 1/8/20 at 9:46 AM of Resident #243 ' s face sheet, with a printed date of 5/20/19 at 7:43 AM. The review revealed documentation next to Code Status was "Full Code" or attempt life saving measures including CPR.</p> <p>Resident #243 ' s medical record Advanced Directives portion of the medical record had a yellow or goldenrod stop sign Do Not Resuscitate Order with an effective date of 12/31/19.</p> <p>An interview was conducted with the DON on 1/8/20 at 9:51 AM. The DON stated an audit had been completed to ensure the physician ' s orders for each resident ' s code status was correct and up to date but had not initiated the process to update the face sheets yet.</p> <p>3. Resident #2 was admitted to the facility on 10/12/12. The resident ' s cumulative diagnoses included: Diabetes, episcleritis (an inflammation of the white part of the eye), cataracts of the</p>	F 842			

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F 842	<p>Continued From page 19 eyes, and glaucoma.</p> <p>Review of Resident #2 ' s most recent quarterly Minimum Data Set assessment with a reference date of 9/24/19 revealed the resident was coded for moderate cognitive loss. The resident was totally dependent on the assistance of two or more people for bed mobility, transferring (such as from the bed to a wheelchair), dressing, personal hygiene, and bathing.</p> <p>Review of Resident #2 ' s report of consultation from the eye surgeon dated 11/15/19 revealed the resident had a cataract surgery on the same date. The consultation revealed the eye surgeon had ordered prednisolone acetate ophthalmic suspension (a steroid medicine used to treat eye swelling) eye drops, 1 drop to the left eye twice a day and ketorolac ophthalmic solution (a nonsteroidal anti-inflammatory drug (NSAID) medication used to reduce swelling, pain, and burning or stinging after cataract surgery) 1 drop to the left eye every day. The two medications were ordered to be administered until the next post-surgical follow up appointment. The consultation report revealed a post-surgery appointment was scheduled on 12/10/19.</p> <p>Resident #2 ' s physician ' s orders contained an order dated 11/15/19 which was for prednisolone acetate ophthalmic suspension eye drops, 1 drop to the left eye twice a day and ketorolac ophthalmic solution eye drops, 1 drop to the left eye every day. The two medications were ordered to be administered until the next post-surgical follow up appointment. The order did not contain a date for the next post-surgical follow up appointment. The order was signed as received and transcribed by Nurse #2 on</p>	F 842			

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F 842	<p>Continued From page 20 11/15/19.</p> <p>The December 2019 Medication Administration Record (MAR) for Resident #2 had prednisolone acetate ophthalmic suspension eye drops, 1 drop to the left eye twice a day (Continue until the next appointment on 12/10/19). The order date and the start date for the medication was 11/15/19. The eye drop medication was recorded as administered twice a day from 12/1/19 through 12/31/19 with the exception of one omitted afternoon dose on 12/6/19. Additionally, the MAR revealed the resident had ketorolac ophthalmic solution eye drops 1 drop to the left eye every day until the next appointment on 12/10/19. The order date and the start date for the medication was 11/15/19. The eye drop medication was recorded as administered every day from 12/1/19 through 12/31/19.</p> <p>The January 2019 Medication Administration Record (MAR) for Resident #2 was reviewed on 1/7/20. The MAR had prednisolone acetate ophthalmic suspension eye drops, 1 drop to the left eye twice a day (Continue until the next appointment on 12/10/19). The order date and the start date for the medication was 11/15/19. The eye drop medication was recorded as administered twice a day from 1/1/20 through 1/7/20. Additionally, the MAR revealed the resident had ketorolac ophthalmic solution eye drops 1 drop to the left eye every day until the next appointment on 12/10/19. The order date and the start date for the medication was 11/15/19. The eye drop medication was recorded as administered every day from 1/1/20 through 1/7/20.</p> <p>An interview was conducted on 1/7/20 at 4:34 PM</p>	F 842			

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F 842	<p>Continued From page 21</p> <p>with Nurse #2. The nurse stated Resident #2 had a scheduled follow up appointment with the eye surgeon on 12/10/19 but the resident was unable to go. The nurse stated she had transcribed the physician ' s order to the MAR in November, and she stated she entered the information on the MAR regarding the medication to be administered until the next appointment on 12/10/19. The nurse reviewed the December and January MAR and stated the eye drop medications were administered each day since 12/10/19 and, according to the documentation on the December and January MARs, the resident was prescribed to receive prednisolone and ketorolac eye drop medication up until the next appointment on 12/10/19. The nurse stated Medication Aide (MA) #1 administered both eye drop medications during the morning medication pass on 1/7/20. The nurse stated she would call the eye doctor to get clarification if the eye drops should be continued or stopped. The nurse stated it was her expectation if a MA saw a medication was not to be administered after a certain date, the MA would come to the nurse and inform her.</p> <p>A phone interview was conducted with MA #1 on 1/9/20 at 12:26 PM. She stated she had administered the prednisolone and ketorolac eye drops the morning of 1/7/20. She said she had seen the information in the MAR regarding to administering the eye drops until 12/10/19, however she had not received any information to have discontinued the drops. The MA said she thought a follow up appointment later in the month may have been scheduled. She added she had not brought it to anyone ' s attention about having had administered the eye drops after the date on the MAR and had assumed a follow up appointment had already been</p>	F 842			

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F 842	<p>Continued From page 22 scheduled.</p> <p>A second interview was conducted on 1/7/20 at 4:47 PM with Nurse #2. She said she spoke to the eye surgeon on 1/4/20 and had received an order from the eye surgeon to stop the prednisolone and ketorolac eye drops. The nurse stated she had transcribed the medication order on 11/15/19 and probably should have entered a stop date into the MAR when she transcribed the order to make sure the medication was not administered beyond the appointment date of 12/10/19.</p> <p>A phone interview was conducted on 1/9/20 at 11:57 AM with the eye surgeon. The eye surgeon stated Resident #2 had eye surgery on 11/15/19 and the eye drops were ordered to help the resident recover from the surgery and were to be continued until the scheduled follow up appointment on 12/10/19. The eye surgeon stated he was aware the resident ' s follow up appointment had been cancelled. He said it was important to see the resident for the follow up after the cataract surgery due to the resident also having had diagnoses of episcleritis and glaucoma. He continued, he would have liked to have seen her sooner, but if the resident was not having any problems, the resident was most likely OK, however, he would not know for sure until he saw her at her next appointment. He said if the facility had to cancel the December appointment it was his expectation for them to have scheduled a follow up appointment during the initial phone call when the appointment was cancelled or soon after and he would have also expected the facility to have contacted him regarding the continuation or discontinuation of the eye drops. Regarding the facility ' s continuation of the medications</p>	F 842			

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F 842	Continued From page 23 beyond the originally scheduled follow up appointment of 12/10/19, he said the resident was unlikely to have had any negative impact. During a phone interview conducted on 1/9/20 at 12:33 PM with the Director of Nursing (DON) she stated she would have expected for a MA or a nurse to have brought it to someone ' s attention the eye drops were still being administered after 12/10/19 even though the eye surgeon follow up appointment on that date did not happen. The DON stated it was her expectation to contact the eye surgeon ' s office and obtain a clarification order whether to have continued or discontinued the eye drop medications after the 12/10/19 follow up appointment was cancelled.	F 842			
F 883 SS=C	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		2/7/20	

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F 883	<p>Continued From page 24</p> <p>was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and staff interviews, the facility failed to provide residents or their representative with education regarding the benefits and potential side effects of the influenza</p>	F 883	<p>1)The facility mailed and provided the consent forms for all residents and/or their responsible parties in October 2019 but did not include the updated CDC flu</p>		

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F 883	<p>Continued From page 25</p> <p>immunization for 5 of 5 residents reviewed for the influenza immunization (Residents #2, 22, 25, 36, and 37).</p> <p>Findings included: The facility ' s policy "Vaccination of Residents" with a revision date of 2016 was reviewed and it stated, in part:</p> <p>a. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations.</p> <p>b. Provision of such education shall be documented in the resident ' s medical record.</p> <p>1. Resident #2 was admitted to the facility on 10/12/2012 with diagnoses to include diabetes and hypertension.</p> <p>A review of Resident #2 ' s medical chart revealed a signed consent for the influenza immunization and administration of the vaccine on 10/31/2019. There was no evidence of education provided to Resident #2 or her representatives.</p> <p>Nurse #1 was interviewed on 1/8/2020 at 2:36 PM and she reported she and the nurse managers managed the influenza immunization for the facility. Nurse #1 reported the resident, or the family members signed a consent form for the immunization, but the facility had not provided them with a vaccine information statement education and she was not aware the education was required to be provided to the resident or representative.</p> <p>The Director of Nursing (DON) was interviewed on 1/8/2020 at 2:40 PM and she reported that influenza immunization education was provided to residents or their representative on admission to</p>	F 883	<p>information sheet at that time. Resident's #2, #22, #25, #36, and #37 were included in this omission. The updated information will be given to these individuals though they had already been given the inoculation. This was completed by 2/7/2020.</p> <p>The director of nursing in-serviced the Social Worker and the Admissions/Marketing Director on January 28, 2020 on ensuring the updated flu vaccination information sheet is provided for all residents who requests the flu vaccine and for new admissions requesting the flu vaccine.</p> <p>2) The facility had its annual flu vaccine campaign for all existing residents in October 2019 where consents where provided to all residents and/or their responsible parties. Those residents will be offered copies of the updated flu vaccine information sheet.</p> <p>Newly admitted residents will have the information sheet provided per their consent form.</p> <p>3) There are no systemic changes however the consent form has been modified to denote if the resident and/or responsible party requests the information sheet and will be used effective 1/30/2020 and ongoing.</p> <p>4) The facility social worker will audit the consent forms weekly for one month, monthly for three months, and then</p>		

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F 883	<p>Continued From page 26</p> <p>the facility, but not annually. The DON reported she was not aware that the influenza immunization education should be provided annually.</p> <p>The Administrator was interviewed on 1/8/2020 at 3:48 PM and he reported it was his expectation that residents and/or their representatives were provided with influenza immunization education annually.</p> <p>2. Resident #22 was admitted to the facility on 2/3/2018 with diagnoses to include congestive heart failure and hypertension.</p> <p>A review of Resident #22 ' s medical chart revealed a signed consent for the influenza immunization and administration of the vaccine on 10/31/2019. There was no evidence of education provided to Resident #22 or her representatives.</p> <p>Nurse #1 was interviewed on 1/8/2020 at 2:36 PM and she reported she and the nurse managers managed the influenza immunization for the facility. Nurse #1 reported the resident, or the family members signed a consent form for the immunization, but the facility had not provided them with a vaccine information statement education and she was not aware the education was required to be provided to the resident or representative.</p> <p>The Director of Nursing (DON) was interviewed on 1/8/2020 at 2:40 PM and she reported that influenza immunization education was provided to residents or their representative on admission to the facility, but not annually. The DON reported she was not aware that the influenza</p>	F 883	<p>quarterly thereafter to ensure that if the resident and/or responsible party is requesting the flu vaccine information sheet they are provided a copy. Results of these audits will be reviewed during the facility QAPI meetings and corrective actions taken as needed.</p> <p>The administrator is responsible for overall compliance.</p>		

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F 883	<p>Continued From page 27</p> <p>immunization education should be provided annually.</p> <p>The Administrator was interviewed on 1/8/2020 at 3:48 PM and he reported it was his expectation that residents and/or their representatives were provided with influenza immunization education annually.</p> <p>3. Resident #25 was admitted to the facility on 6/1/2017 with diagnoses to include dementia and functional quadriplegia.</p> <p>A review of Resident #25 ' s medical chart revealed a signed consent for the influenza immunization and administration of the vaccine on 10/31/2019. There was no evidence of education provided to Resident #25 or her representatives.</p> <p>Nurse #1 was interviewed on 1/8/2020 at 2:36 PM and she reported she and the nurse managers managed the influenza immunization for the facility. Nurse #1 reported the resident, or the family members signed a consent form for the immunization, but the facility had not provided them with a vaccine information statement education and she was not aware the education was required to be provided to the resident or representative.</p> <p>The Director of Nursing (DON) was interviewed on 1/8/2020 at 2:40 PM and she reported that influenza immunization education was provided to residents or their representative on admission to the facility, but not annually. The DON reported she was not aware that the influenza immunization education should be provided annually.</p>	F 883			

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F 883	<p>Continued From page 28</p> <p>The Administrator was interviewed on 1/8/2020 at 3:48 PM and he reported it was his expectation that residents and/or their representatives were provided with influenza immunization education annually.</p> <p>4. Resident #36 was admitted to the facility on 1/31/2018 with diagnoses to include dementia and chronic kidney disease.</p> <p>A review of Resident #36 ' s medical chart revealed a signed consent for the influenza immunization and administration of the vaccine on 10/31/2019. There was no evidence of education provided to Resident #36 or his representatives.</p> <p>Nurse #1 was interviewed on 1/8/2020 at 2:36 PM and she reported she and the nurse managers managed the influenza immunization for the facility. Nurse #1 reported the resident, or the family members signed a consent form for the immunization, but the facility had not provided them with a vaccine information statement education and she was not aware the education was required to be provided to the resident or representative.</p> <p>The Director of Nursing (DON) was interviewed on 1/8/2020 at 2:40 PM and she reported that influenza immunization education was provided to residents or their representative on admission to the facility, but not annually. The DON reported she was not aware that the influenza immunization education should be provided annually.</p> <p>The Administrator was interviewed on 1/8/2020 at</p>	F 883			

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F 883	<p>Continued From page 29</p> <p>3:48 PM and he reported it was his expectation that residents and/or their representatives were provided with influenza immunization education annually.</p> <p>5. Resident #37 was admitted to the facility on 5/5/2017 with diagnoses to include anemia and heart failure.</p> <p>A review of Resident #37 ' s medical chart revealed a signed consent for the influenza immunization and administration of the vaccine on 10/31/2019. There was no evidence of education provided to Resident #37 or her representatives.</p> <p>Nurse #1 was interviewed on 1/8/2020 at 2:36 PM and she reported she and the nurse managers managed the influenza immunization for the facility. Nurse #1 reported the resident, or the family members signed a consent form for the immunization, but the facility had not provided them with a vaccine information statement education and she was not aware the education was required to be provided to the resident or representative.</p> <p>The Director of Nursing (DON) was interviewed on 1/8/2020 at 2:40 PM and she reported that influenza immunization education was provided to residents or their representative on admission to the facility, but not annually. The DON reported she was not aware that the influenza immunization education should be provided annually.</p> <p>The Administrator was interviewed on 1/8/2020 at 3:48 PM and he reported it was his expectation that residents and/or their representatives were</p>	F 883			

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F 883	Continued From page 30 provided with influenza immunization education annually.	F 883			