STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/GASTO	969 COX ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly K Blackmon

TITLE: NHA

(X6) DATE: 6/6/14

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.

DHHR NC Received JUN 11 2014 by: PSM

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to comprehensively assess the area of falls to include the description of the problem, the causes and contributing factors and risk factors related to falls, for 2 of 3 sampled residents. (Resident # 1 and #8). The findings included: 1. Resident #1 was admitted to the facility on 02/21/14. His diagnoses included lumbago, atrial fibrillation, muscle atrophy, chronic airway obstruction, congestive heart failure and symbolic dysfunction. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 02/22/14 at 12:15 AM, Resident #1 was found on the floor, out of bed. He stated he slid out of bed. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 02/28/14 at 6:00 PM, Resident #1 was noted laying on the floor face down at the foot of the bed. He stated he was trying to get up to get into his wheelchair. First aid was given for 5 skin tears including to his right arm, wrist, upper arm and left outer wrist. The admission Minimum Data Set (MDS) dated 02/28/14 coded him with a score of 10 (out of 15) on the Brief Interview for Mental Status (BIMS) which indicated he had moderately impaired cognition. He was also coded as requiring extensive assistance for bed mobility, transfers,	F 272	Resident's #1 and #8 comprehensively assessed to ensure Care Area Assessment updated related to falls. All residents have the potential to be affected. Audit completed by MDS Coordinator to identify current residents having a fall from 5/1/14 forward to ensure that all falls are comprehensively assessed to accurately reflect the falls description of the problem, causes and contributing factors and risk factors.	6/11/14

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F 272	Continued From page 2 toileting and dressing. He was nonambulatory during this assessment and had one fall with no major injury since admission. The Care Area Assessment (CAA) dated 03/06/14 consisted of a checklist indicating he had a fall on 02/28/14, difficulty maintained a standing position, impaired balance, gait problems, used antidepressants and took diuretics. Under the area of analysis of findings, the documentation stated "Triggered due to recent fall poor balance and psychotropic medications. Fall risk score of 12 at admission, resident has pad alarm at all times." The plan was to develop a care plan. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Reviews in the medical record revealed Resident #1 continued to fall as follows: *03/06/14 at 10:55 PM from bed; *03/14/14 at 7:40 PM from bed; and *03/18/14 at 2:30 PM slid from his wheelchair in front of the therapist A significant change MDS dated 03/31/14 coded him with a BIMS 10, requiring extensive assistance with bed mobility, toileting and limited assistance with transfers. He was noted with poor balance. Falls were noted in the previous 6 months. The subsequent CAA for falls dated 04/04/14 stated "Refer to CAA Dated 3/6/14. No changes noted in (Resident #1) other than he is no longer on hospice caseload." Neither the admission CAA or the significant change CAA addressed the reasons or trends of this resident's repeated falls specifically from bed and during the night.	F 272	Review of requirements of regarding comprehensively assessing falls completed with MDS Coordinator by Director of Nursing. Monitoring tool implemented to ensure falls are comprehensively assessed to reflect description of the problem, causes and contributing factors and risk factors. DON to complete monitoring tool to include at least 3 residents, 3 times a week for 2 weeks then once a week for 2 weeks, then once a month for 3 months. Results of Monitoring Tool will be incorporated in monthly Quality Assurance and Performance Improvement program to evaluate for compliance and effectiveness monthly x 3 months.	

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F 272	Continued From page 3 Resident #1 continued to fall per the review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Reviews as follows: *04/12/14 at 2:00 PM fall from bed; *04/20/14 at 2:10 AM from bed; *04/29/14 at 3:40 AM found on floor face down beside bed; *04/30/14 at 4:45 AM fall from wheelchair in the hallway; *05/13/14 at 3:30 AM, found lying on floor and he stated he did not want to lay in his bed; and *05/14/14 at unknown time during 3rd shift, was sitting on side of bed and wanted to be assisted with repositioning. Before the nurse could obtain assistance, nurse aide found resident lying on fall mat on floor. Incident was not witnessed. Interview with the MDS Coordinator on 05/14/14 at 2:16 PM revealed the software used by the facility for the CAA gave the options for the checklist, i.e. unsteady gait. She stated that the CAA should include the reason the area triggered, whether the resident was going to be long or short term, any risk factors and if a care plan would be developed. If a care plan was not going to be developed, then the CAA should indicate the reason. MDS Coordinator stated that she could add the dates of the falls but could not add additional information or description except under the analysis of findings. She also stated she had received training regarding MDS and CAA from the state agency.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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F 279	Continued From page 4 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop an individual plan of care which included all interventions to address falls for 2 of 3 sampled residents. (Resident #1 and #8). The findings included: The Fall Management program revised August 2012 indicated a Falling Star Program would be placed on newly admitted residents and residents identified at risk. The Falling Star was a visual identifier/reminder program for staff to recognize and be aware of residents at risk for falls. A falling star symbol would be placed over the bed, on assistive devices and or identification band.	F 279		

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

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F 279	Continued From page 5 1. Resident #1 was admitted to the facility on 02/21/14. His diagnoses included lumbago, atrial fibrillation, muscle atrophy, chronic airway obstruction, congestive heart failure and symbolic dysfunction. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 02/22/14 at 12:15 AM, Resident #1 was found on the floor, out of bed. He stated he slid out of bed. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 02/28/14 at 6:00 PM, Resident #1 was noted laying on the floor face down at the foot of the bed. He stated he was trying to get up to get into his wheelchair. First aid was given for 5 skin tears including to his right arm, wrist, upper arm and left outer wrist. The admission Minimum Data Set (MDS) dated 02/28/14 coded him with a score of 10 (out of 15) on the Brief Interview for Mental Status (BIMS) which indicated he had moderately impaired cognition. He was also coded as requiring extensive assistance for bed mobility, transfers, toileting and dressing. He was nonambulatory during this assessment and had one fall with no major injury since admission. Review of physician orders revealed on 03/01/14 an order was for a pad alarm to his wheelchair when out of bed due to decreased safety awareness. The Care Area Assessment (CAA) dated 03/06/14 consisted of a checklist indicating he had a fall on 02/28/14, difficulty maintained a	F 279	Care Plans relating to falls for resident's #1 and #8 were updated. All residents have the potential to be affected. Audit completed by MDS Coordinator to identify current residents having a fall from 5/1/14 forward to ensure Care Plans are individualized and include current interventions. Review of requirements regarding development of individualized plan of care, which include interventions for falls completed with MDS Coordinator by Director of Nursing. Monitoring tool implemented to ensure compliance relating to individualized Care Plans/interventions regarding falls.	6/11/14

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F 279	Continued From page 6 standing position, impaired balance, gait problems, used antidepressants and took diuretics. Under the area of analysis of findings, the documentation stated "Triggered due to recent fall poor balance and psychotropic medications. Fall risk score of 12 at admission, resident has pad alarm at all times." The plan was to develop a care plan. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Reviews in the medical record revealed Resident #1 continued to fall as follows: *03/06/14 at 10:55 PM from bed, observed on right side of bed on floor. He sustained 4 skin tears below the right knee and left outer leg. Review of the care plans revealed a care plan was developed on 03/11/14 for Resident #1 being at risk for falls related to new admission, balance problems standing and walking, and psychotropics (this was on a generic form that used a checklist). The goal was for Resident #1 to be free of fall related injury through the next review in 90 days. A checklist was also used for approaches which included encourage the resident to ask for assist, ensure proper foot wear, referrals to therapy, orient resident to environment, call light in reach, observed for potential patterns of falls to identify possible causes, offer toilet frequently, place frequently used items in reach and observe for potential medication related causes. This care plan failed to include the falling star program or the physician's order for a pad alarm. Interview with the MDS coordinator on 05/13/14 at 4:20 PM revealed the pressure alarm order should have been written for the bed and the	F 279	DON to complete monitoring tool to include at least 3 residents, 3 times a week for 2 weeks then once a week for 2 weeks, then once a month for 3 months. Results of Monitoring Tool will be incorporated in monthly Quality Assurance and Performance Improvement program to evaluate for compliance and effectiveness monthly x 3 months.	

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F 279	Continued From page 7 wheelchair. She further stated he was also placed on the falling star program. She stated the MDS nurse who completed the MDS was responsible for the development of the care plan. She had signed as the nurse completing the initial MDS. She stated the Assistant Director of Nursing (ADON) updated the care plans with individual falls and interventions. Follow up interview on 05/14/14 at 10:43 AM revealed her assistant failed to include the falling star program and the chair and bed alarms. Interview with the ADON on 05/14/14 at 10:22 AM revealed she received the incident reports about the falls and updated the care plans with the additional dates of falls. She further stated that interventions were usually already listed. No explanation for the missing care plan interventions of the alarms or falling star program was offered.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		

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F 280	Continued From page 8 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise the plan of care for 1 of 3 residents reviewed for falls. Resident #1's care plan was not updated to reflect current interventions. The findings included: The Fall Management program revised August 2012 indicated a Falling Star Program would be placed on newly admitted residents and residents identified at risk. The Falling Star was a visual identifier/reminder program for staff to recognize and be aware of residents at risk for falls. A falling star symbol would be placed over the bed, on assistive devices and or identification band. 1. Resident #1 was admitted to the facility on 02/21/14. His diagnoses included lumbago, atrial fibrillation, muscle atrophy, chronic airway obstruction, congestive heart failure and symbolic dysfunction. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Reviews revealed Resident #1 fell from bed on 02/22/14 at 12:15 AM and on 02/28/14 at 6:00 PM sustaining skin tears. The admission Minimum Data Set (MDS) dated	F 280	Care Plan relating to falls for resident's #1 was updated to reflect current interventions on 5/14/14. All resident's have the potential to be affected. Audit completed by MDS Coordinator to identify current residents having a fall from 5/1/14 forward to ensure Care Plans are reviewed and revised with each fall. Review of requirements regarding review and revision of Care Plans completed with MDS Coordinator by Director of Nursing. Monitoring tool implemented to ensure Care Plans are reviewed and revised regarding falls.	6/11/14

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F 280	Continued From page 9 02/28/14 coded him with a score of 10 (out of 15) on the Brief Interview for Mental Status (BIMS) which indicated he had moderately impaired cognition. He was also coded as requiring extensive assistance for bed mobility, transfers, toileting and dressing. He was nonambulatory during this assessment and had one fall with no major injury since admission. Review of physician orders revealed on 03/01/14 an order was for a pad alarm to his wheelchair when out of bed due to decreased safety awareness. The Care Area Assessment (CAA) dated 03/06/14 consisted of a checklist indicating he had a fall on 02/28/14, difficulty maintained a standing position, impaired balance, gait problems, used antidepressants and took diuretics. Under the area of analysis of findings, the documentation stated "Triggered due to recent fall poor balance and psychotropic medications. Fall risk score of 12 at admission, resident has pad alarm at all times." The plan was to develop a care plan. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Reviews in the medical record revealed Resident #1 continued to fall as follows: *03/06/14 at 10:55 PM from bed, observed on right side of bed on floor. He sustained 4 skin tears below the right knee and left outer leg. MDS coordinator stated during interview on 05/13/14 at 4:20 PM the plan was then to have the resident's medications reviewed. This was added on the care plan. Review of the care plans revealed a care plan	F 280	DON to complete monitoring tool relating to care plan updates and revisions to include at at least 3 residents 3 times a week for 2 weeks then once a week for 2 weeks, then once a month for 3 months. Results of Monitoring Tool will be incorporated in monthly Quality Assurance and Performance Improvement program to evaluate for compliance and effectiveness monthly for 3 months.	

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F 280	Continued From page 10 was developed on 03/11/14 for Resident #1 being at risk for falls related to new admission, balance problems standing and walking, and psychotropics (this was on a generic form that used a checklist). The goal was for Resident #1 to be free of fall related injury through the next review in 90 days. A checklist was also used for approaches which included encourage the resident to ask for assist, ensure proper foot wear, referrals to therapy, orient resident to environment, call light in reach, observed for potential patterns of falls to identify possible causes, offer toilet frequently, place frequently used items in reach and observe for potential medication related causes. This care plan failed to include the falling star program or the physician's order for a pad alarm. Interview with the MDS coordinator on 05/13/14 at 4:20 PM revealed the pressure alarm order should have been written for the bed and the wheelchair. She further stated he was also placed on the falling star program. She stated the MDS nurse who completed the MDS was responsible for the development of the care plan. She had signed as the nurse completing the initial MDS. She stated the Assistant Director of Nursing (ADON) updated the care plans with individual falls and interventions. Follow up interview on 05/14/14 at 10:43 AM revealed her assistant failed to include the falling star program and the chair and bed alarms. Interview with the ADON on 05/14/14 at 10:22 AM revealed she received the incident reports about the falls and updated the care plans with the additional dates of falls. She further stated that interventions were usually already listed and anyone can update the care plan. No explanation	F 280		

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F 280	Continued From page 11 for the lack of updating the falling star program or alarms was given. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Reviews in the medical record revealed Resident #1 continued to fall as follows: *03/14/14 at 7:40 PM from bed was observed on the floor. He sustained a skin tear to his left wrist. MDS coordinator stated on 05/13/14 at 4:20 PM the intervention was to add the wedge mattress. This was added with the date of the fall to the care plan. Follow up interview with the MDS coordinator on 05/13/14 at 4:40 PM revealed there was no wedge mattress on the bed and a clip type alarm was in use. On 05/14/14 at 10:43 AM, the MDS coordinator stated she confirmed with the DON who was on vacation that the wedge mattress was removed on 03/17/14 as the resident did not like it and a bariatric bed was moved in it's place. *03/18/14 at 2:30 PM slid from his wheelchair in front of the therapist. He sustained a small laceration to the left side of his head and a skin tear to his left elbow. A significant change MDS dated 03/31/14 coded him with a BIMS 10, requiring extensive assistance with bed mobility, toileting and limited assistance with transfers. He was noted with poor balance. Falls were noted in the previous 6 months. The subsequent CAA for falls dated 04/04/14 stated "Refer to CAA Dated 3/6/14. No changes noted in (Resident #1) other than he is no longer on hospice caseload." The care plan was still not updated to include the falling star program, the chair alarm or the bed alarm. In addition the wedge mattress was still listed as an intervention on the care plan.	F 280		

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F 280	Continued From page 12 Resident #1 continued to fall per the review of the Communication Form and Progress Note and the Interdisciplinary Post fall Reviews as follows: *04/12/14 at 2:00 PM fall from bed, found lying on floor. He sustained a skin tear to the left upper arm measuring 1.5 cm x 1.3 cm. *04/20/14 at 2:10 AM from bed, observed sitting on floor. He sustained skin tears to bilateral knees. *04/29/14 at 3:40 AM found on floor face down beside bed. Noted with a lump on the right side of his forehead. *04/30/14 at 4:45 AM fall from wheelchair in the hallway. Resident #1 stated he did it on purpose. On 04/30/14 the care plan was updated with the addition of positive reinforcement for no falls/behaviors and referred to the behavior care plan. The behavior care plan stated that the enforcement was to remind the resident he could have a soda at the end of every week if he exhibited no behaviors. MDS coordinator stated on 05/14/14 at 4:20 PM that at the time of this intervention, he was on a fluid restriction diet and this restriction had since been discontinued. Resident #1 was observed on 05/12/14 at 1:03 PM in a wheelchair, barefoot with oxygen on the back of his wheelchair. His face was bruised around both eyes, nose, right cheek and forehead. He had a hematoma on his forehead. There was a clip alarm attached to his side rail but he did not have an alarm on his wheelchair. His bed was stripped of sheets and the mattress was observed not to have a concave or wedged edge. On 05/12/14 at 2:06 PM, Resident #1 was in an activity with the tab alarm attached to his wheelchair and in place with nonskid socks on his	F 280		

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F 280	Continued From page 13	F 280		

feet. Nurse Aide (NA) #1 stated on 05/12/14 at 4:33 PM, Resident #1 has an alarm when in bed, but he gets up on his own. On 05/13/14 at 8:20 AM he was observed in his wheelchair with a tab alarm in place. On 05/13/14 at 9:56 AM, he was observed in bed, the bed was in lowest position, the tab alarm was attached to his shirt and the alarm box was under his shoulder not attached to the siderail. A mat was on the floor on the door side of the bed. NA #2 stated at this time he had just walked over to put himself to bed and his alarm sounded. She further stated he can and has removed the tab alarm at times. The tab alarm remained in place as he laid in bed on 05/13/14 at 10:25 AM.

Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed Resident #1 fell:
*05/13/14 at 3:30 AM, found lying on floor and he stated he did not want to lay in his bed. There was no documentation of any alarm in use. The summary of the interdisciplinary team noted the resident exercised his right-a choice to lie on the floor evidenced by his statement. At 4:20 PM on 05/13/14, MDS coordinator stated she was unaware of this fall.

On 05/14/14 at 10:22 AM, ADON stated she normally received the incident reports about any falls and she interviewed the resident if able and staff to determine what happened. She subsequently updated the care plan with the date of the new fall. She normally did not add any new interventions. She stated she did not always ask if the alarm was on and functioning as she assumed it would be and/or the documentation in the record would reflect if the alarm was on, was not, or if it was not working. ADON stated that

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F 280	Continued From page 14 according to her knowledge, Resident #1 should have a wedge cushion in place but was not sure who checks to make sure planned interventions were implemented. She stated "We all do" but could not say who ultimately was responsible for ensuring care plan interventions were in place. ADON stated no intervention was put into place following the 05/13/14 fall as it was his choice to lay on the floor. A new physician's telephone order was written on 05/14/14 at 6:00 AM as a clarification for an alarming device to bed and wheelchair due to resident decreased safety awareness. The MDS Coordinator was interviewed about this order on 05/14/14 at 10:43 AM. She related originally a pad alarm was planned but somewhere down the line, it was switched to a tab alarm. She could not say why or who made the decision or the switch from a pad alarm to a tab alarm. She further stated the use of any alarm is okay, depending on the resident's mood. On 05/14/14, the care plan still did not include the interventions of the falling star program, any chair or bed alarms (or any type of alarm), or the intervention of a mat on the floor. The use of a wedge mattress was still noted as appropriate on the care plan.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to identify trends, evaluate causes, implement interventions and/or modify interventions to address repeated falls for 2 of 3 sampled residents. (Resident #1 and #8). The findings included: 1. Resident #1 was admitted to the facility on 02/21/14. His diagnoses included lumbago, atrial fibrillation, muscle atrophy, chronic airway obstruction, congestive heart failure and symbolic dysfunction. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 02/22/14 at 12:15 AM, Resident #1 was found on the floor, out of bed. He stated he slid out of bed. He sustained no injuries. Interview with the MDS Coordinator on 05/13/14 at 4:20 PM revealed since Resident #1 was a newly admitted resident and this was his first fall, staff encouraged him to call for assistance and encouraged the use of gripper socks. MDS coordinator also stated he was screened and picked up for occupational and physical therapies. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 02/28/14 at 6:00 PM, Resident #1 was noted laying on the floor face down at the foot of the bed. He stated he was	F 323	Analysis of falls conducted for resident's #1 and #8 to identify trends, evaluate causes, implement and/or modify interventions to address falls. All resident's with repeat falls have the potential to be affected. DON/Unit Coordinator will audit current resident's identified as having repeat falls from 5/1/14 forward to ensure trends are identified, evaluation of causes, and to implement and/or modify interventions. Review of requirements provided to Inter Disciplinary Team completed by DON.	6/11/14

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F 323	Continued From page 16 trying to get up to get into his wheelchair. First aid was given for 5 skin tears including to his right arm, wrist, upper arm and left outer wrist. He did have gripper socks on and was receiving therapy. Interview with the MDS Coordinator on 05/13/14 at 4:20 PM revealed a physician's order was obtained for an alarm on 03/01/14. Review of the physician order dated 03/01/14 noted at 8 AM an order for a pad alarm to the wheelchair when out of bed due to decreased safety awareness. MDS Coordinator confirmed the falls were from bed and stated that she thought the order was supposed to be for the pad alarm to be placed in the wheelchair and the bed. The admission Minimum Data Set (MDS) dated 02/28/14 coded him with a score of 10 (out of 15) on the Brief Interview for Mental Status (BIMS) which indicated he had moderately impaired cognition. He was also coded as requiring extensive assistance for bed mobility, transfers, toileting and dressing. He was nonambulatory during this assessment which coded only one fall with no major injury since admission. The Care Area Assessment (CAA) dated 03/06/14 consisted of a checklist indicating he had a fall on 02/28/14, difficulty maintaining a standing position, impaired balance, gait problems, used antidepressants and took diuretics. Under the area of analysis of findings, the documentation stated "Triggered due to recent fall poor balance and psychotropic medications. Fall risk score of 12 at admission, resident has pad alarm at all times." The CAA indicated a care plan would be developed. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall	F 323	Monitoring tool implemented to ensure analysis of falls identify trends, evaluate causes, implement and/or modify interventions to address repeat falls. DON to complete monitoring tool to include at least 3 residents, 3 times a week for 2 weeks, once a week for 2 weeks, then once a month for 3 months. Results of Monitoring Tool will be incorporated in monthly Quality Assurance and Performance Improvement program to evaluate for compliance and effectiveness monthly for 3 months.	

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F 323	Continued From page 17 Reviews in the medical record revealed Resident #1 continued to fall as follows: *03/06/14 at 10:55 PM from bed, observed on right side of bed on floor. He sustained 4 skin tears below the right knee and left outer leg. He was not wearing footwear. The forms did not mention if an alarm was on and/or sounding. There was no nursing note dated 03/06/14. MDS coordinator stated during interview on 05/13/14 at 4:20 PM the plan was then to have the resident's medications reviewed. She stated this was done either by the Director of Nursing (DON) or the pharmacist. Review of the record revealed the pharmacist had reviewed the medications earlier in the day on 03/06/14 and made no recommendation or mention of falls. The record did not include any medication review by the DON. Per MDS coordinator on 05/14/14 at 10:43 AM, the physician reviewed the medications and made no changes. Physician progress notes revealed Resident #1 was seen by the physician on 03/09/14. Review of the care plans revealed a care plan was developed on 03/11/14 for Resident #1 being at risk for falls related to new admission, balance problems standing and walking, and psychotropics (this was on a generic form that used a checklist). The goal was for Resident #1 to be free of fall related injury through the next review in 90 days. A checklist was also used for approaches which included: encourage the resident to ask for assist, ensure proper foot wear, referrals to therapy, orient resident to environment, call light in reach, observed for potential patterns of falls to identify possible causes, offer toilet frequently, place frequently used items in reach and observe for potential medication related causes. This care plan failed	F 323		

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F 323	Continued From page 18 to include the falling star program or alarms to either the bed or the wheelchair. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review in the medical record revealed Resident #1 continued to fall as follows: *03/14/14 at 7:40 PM from bed was observed on the floor. He sustained a skin tear to his left wrist. Documentation did not mention the use or functioning of any alarms. MDS coordinator stated during interview on 05/13/14 at 4:20 PM the next intervention was a wedge mattress, which was added to the care plan on 03/14/14 along with the continuation of therapy. On 05/13/14 at 4:40 PM, MDS coordinator confirmed Resident #1 had no wedge mattress in place on his bed and a tab (clip) alarm. Upon follow up interview on 05/14/14 at 10:43 AM, she contacted the DON, who was on vacation, and reported the wedge mattress was placed on the bed on 03/17/14 but switched to a bariatric bed on 03/17/14 when the resident was not happy with the wedge mattress. The intervention of a wedge mattress remained on the care plan at this time. *03/18/14 at 2:30 PM slid from his wheelchair in front of the therapist. He sustained a small laceration to the left side of his head and a skin tear to his left elbow. MDS coordinator stated during interview on 05/13/14 at 4:20 PM there was no additional interventions since he fell in the presence of the therapist. A significant change MDS dated 03/31/14 coded him with a BIMS 10, requiring extensive assistance with bed mobility, toileting and limited assistance with transfers. He was noted with poor balance. Falls were noted in the previous 6 months. The subsequent CAA for falls dated	F 323		

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F 323	Continued From page 19 04/04/14 stated "Refer to CAA Dated 3/6/14. No changes noted in (Resident #1) other than he is no longer on hospice caseload." There was no evaluation or identification of trends or patterns regarding Resident #1's falls from bed. Resident #1 continued to fall per the review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review as follows: *04/12/14 at 2:00 PM fall from bed, found lying on floor. He sustained a skin tear to the left upper arm measuring 1.5 cm x 1.3 cm. There was no documentation as to whether the alarm was on and or functioning. During interview on 05/13/14 at 4:20 PM, the MDS coordinator stated the resident was educated on safety awareness by the therapist. When asked about the use of the alarm, she stated she could not say if the alarm was on and sounding but that she did not think the alarm would prevent a fall only alert staff that Resident #1 had fallen. *04/20/14 at 2:10 AM from bed, observed sitting on floor. He sustained skin tears to bilateral knees. The information did not indicate any use of any alarms. MDS Coordinator again stated during interview on 05/13/14 at 4:20 PM, the resident was educated by therapy. Physical therapy notes indicated the resident was educated "on safety" on 04/19/14 and there was no mention of education during therapy on 04/21/14. *04/29/14 at 3:40 AM found on floor face down beside bed. Noted with a lump on the right side of his forehead. No documentation of alarms in use was noted in the record. *04/30/14 at 4:45 AM unwitnessed fall from wheelchair in the hallway. Resident #1 stated he did it on purpose. There was no evidence that an alarm was sounding. During interview with the	F 323		

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F 323	Continued From page 20 MDS coordinator on 05/14/14 at 4:20 PM, she stated the falls for 04/29/14 and 04/30/14 were addressed together via education from therapy. Physical therapy notes dated 04/30/14 stated "discussed with patient at length about safety and fall prevebntion and asking for help esp. (especially) for all and in and out of bed or wheelchair activities, about pressing call button. " The note continues to state the resident stated he knew to do that and he probably jusforgot as he didn't know what he was trying to do. MDS coordinator further stated that since the resident told 3 staff members he fell on purpose on 04/30/14, a behavior plan would be developed. According to the MDS coordinator, because he was on a fluid restricted diet at that time, an agreement was made that if he did not fall, refuse care, refuse his CPAP machine at night, he could have a soda in place of liquids on his tray. The care plan was updated to include "positive reinforcement for no falls/behaviors" and the behavior care plan included the intervention to remind him he could have a diet coke at the end of every week for positive behavior. Nursing notes dated 05/07/14 at 12:15 PM revealed this behavior approach was not effective. Resident #1 was observed on 05/12/14 at 1:03 PM in a wheelchair, barefoot with oxygen on the back of his wheelchair. His face was bruised around both eyes, nose, right cheek and forehead. He had a hematoma on his forehead. When asked what happened, Resident #1 first said he was chasing parked cars, then he laughed and said he had fallen. There was a clip alarm attached to his side rail but he did not have an alarm on his wheelchair. His bed was stripped of sheets and the mattress was observed not to have a concave or wedged edge. On 05/12/14 at	F 323		

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F 323	Continued From page 21 2:06 PM, Resident #1 was in an activity with the tab alarm attached to his wheelchair and in place with nonskid socks on his feet. Nurse Aide (NA) #1 stated on 05/12/14 at 4:33 PM, Resident #1 has an alarm when in bed, but he gets up on his own. The alarm sounds all the time. On 05/13/14 at 8:20 AM he was observed in his wheelchair with a tab alarm in place. On 05/13/14 at 9:56 AM, he was observed in bed, the bed was in lowest position, the tab alarm was attached to his shirt and the alarm box was under his shoulder not attached to the siderail. A mat was on the floor on the door side of the bed. NA #2 stated at this time he had just walked over to put himself to bed and his alarm sounded. She further stated he can and has removed the tab alarm at times. The tab alarm remained in place as he laid in bed on 05/13/14 at 10:25 AM. An interview was conducted on 05/13/13 at 10:56 AM with the psychiatric nurse practitioner. He stated he has been seeing Resident #1 for depression and staff reports of behaviors and throwing himself on the floor. The nurse practitioner stated Resident #1 was not a great historian. On 05/13/14 at 11:49 he remained in bed with a tab alarm in place and mat on the floor. On 05/13/14 at 12:16 PM, Nurse #2 stated Resident #1 always wore a tab alarm which alarmed very often. She described him a being noncompliant with care, refusing oxygen, noncompliant with his CPAP machine, ambulating, etc. She stated the behavior plan with changing fluids to soda did not work. He was no longer on a fluid restriction. Interview with the Physical Therapist on 05/13/14 at 2:58 PM revealed therapy worked with	F 323		

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F 323	Continued From page 22 Resident #1 on strengthening, balance and transfers. He was discharged with being able to walk with a walker and supervision. She described Resident #1 as having very poor safety awareness, often forgetting to lock the brakes on his wheelchair or hold his walker. He was discharged to restorative nursing to maintain abilities and strength. Interview with the Occupational Therapist on 05/13/14 at 3:40 PM revealed Resident #1's wheelchair was adjusted with the back wheels lower than the front so he was tilted back more. She also stated therapy got him a bariatric bed. She related his memory was poor form day to day. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed Resident #1 fell: *05/13/14 at 3:30 AM, found lying on floor and he stated he did not want to lay in his bed. There was no documentation of any alarm in use. The summary of the interdisciplinary team noted the resident exercised his right-a choice to lie on the floor evidenced by his statement. At 4:20 PM on 05/13/14, MDS coordinator stated she was unaware of this fall. A phone interview with NA #3 who worked third shift with Resident #1 was conducted on 05/14/14 at 5:45 AM. NA #3 this night, Resident #1 had both a pad alarm and tab alarm in bed, which was new as he normally just had a tab alarm. She stated at night, he had his bed at the lowest position and a mat on the floor. She stated the alarm sounds, however, Resident #1 had been known to remove the tab alarm.	F 323		

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F 323	Continued From page 23 On 05/14/14 at 10:22 AM, ADON stated she normally received the incident reports about any falls and she interviewed the resident if able and staff to determine what happened. She subsequently updated the care plan with the date of the new fall. She normally did not add any new interventions. She stated she did not always ask if the alarm was on and functioning as she assumed it would be and/or the documentation in the record would reflect if the alarm was on, was not, or if it was not working. ADON stated that according to her knowledge, Resident #1 should have a wedge cushion in place but was not sure who checks to make sure planned interventions were implemented. She stated "We all do" but could not say who ultimately was responsible for ensuring care plan interventions were in place. ADON stated no intervention was put into place following the 05/13/14 fall as it was his choice to lay on the floor. A new physician's telephone order written on 05/14/14 at 6:00 AM for "order clarification: Alarming device to bed and wc (wheelchair) d/t resident (symbol for decreased) safety awareness." The MDS Coordinator was interviewed about this order on 05/14/14 at 10:43 AM. She related originally a pad alarm was planned but somewhere down the line, it was switched to a tab alarm. She could not say why or who made the decision or the switch from a pad alarm to a tab alarm. She further stated the use of any alarm is okay, depending on the resident's mood. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review Resident #1 fell: *05/14/14 at unknown time during 3rd shift, was	F 323		

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F 323	Continued From page 24 sitting on side of bed and wanted to be assisted with repositioning. Before the nurse could obtain assistance, nurse aide found resident lying on fall mat on floor. Incident was not witnessed. On 05/14/14 at 2:34 PM, The Assistant Director of Nursing (ADON) stated she was unaware of a fall on 05/14/14 during third shift. Interview with Nurse #2 on 05/14/14 at 2:35 PM revealed she received notice in report that Resident #1 fell during the night. The night shift nurse obtained an order for a urinalysis and psychiatric evaluation. On 05/14/14 at 3:10 PM, the Administrator stated she was aware of the fall on 05/14/14. 2. Resident #8 was admitted to the facility on 10/15/13. His diagnoses included unsteady gait, and closed vertebral fracture. The admission Minimum Data Set (MDS) dated 11/04/13 indicated Resident #8 had a score of 0 (out of 15) on the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment and unable to make his needs known. He was coded as requiring extensive assistance for bed mobility, transfers, dressing, toileting, and history of falls. He was nonambulatory during the assessment which indicated a wheelchair as his required mobility device. The Care Area Assessment (CAA) dated 11/04/13 consisted of a checklist indicating Resident #8 had difficulty maintaining a standing position, impaired balance during transitions, and gait problems, and used antipsychotics. Under the area of analysis of findings, the documentation stated "Recurrent falls secondary to unsteady gait, T11 and T12 compression fracture secondary to fall." The CAA indicated a care plan would be developed related to the indicated factors.	F 323		

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F 323	Continued From page 25 Review of the care plans revealed a care plan was developed on 11/04/13 for Resident #8 being at risk for falls related to new admission, mental status, history of previous falls, balance problem/standing and walking, cerebral vascular accident (old), and psychotropics. The goal for Resident #8 was to be free of fall related injury through next review in 90 days. Care plan approaches included: encourage resident to ask for assist, ensure proper footwear, referrals to therapy, orient resident to room/environment, call light within reach, observe for potential patterns of falls to identify possible causes, offer/assist to toilet frequently, place frequently used items within reach, and observe for potential medication related causes. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 01/05/14 at 9:30 PM, Resident #8 was found on the floor in front of his wheelchair. He stated he slid from his wheelchair and landed on his buttocks. He complained of no pain and sustained no injuries. The MDS Coordinator was interviewed on 05/13/14 at 4:19 PM regarding Resident #8's unwitnessed fall on 01/05/14. She stated Resident #8 was referred and screened for occupational and physical therapies. Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 02/07/14 at 7:38 PM, Resident #8 was found on the floor in the doorway of his room and his wheelchair was nearby. He sustained no injuries. He did have shoes on and was screened by occupational therapy (OT). The MDS Coordinator was interviewed on 05/13/14 at 4:19 PM regarding Resident #8's unwitnessed fall on 02/07/14. She stated Resident #8 was placed on OT caseload to	F 323		

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F 323	Continued From page 26	F 323		

be screened. The OT Rehab Notes dated 02/19/14 revealed occupational screening performed and no skilled OT services was warranted at the time. The Occupational Therapist was interviewed on 05/13/14 at 3:22 PM. She stated Resident #8 did not meet OT services criteria at the screening date of 02/19/14. She further stated he was educated and encouraged to call staff for assistance.
Review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 02/25/14 at 3:20 PM, Resident #8 was found on the floor in his doorway by another resident's family member. He sustained no injuries. The MDS Coordinator was interviewed on 05/13/14 at 4:19 PM regarding Resident #8's unwitnessed fall on 02/25/14. She indicated Resident #8 was screened by occupational and physical therapies. He was placed on their caseload and remained on their caseload until 03/21/14.
Further review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review revealed on 03/28/14 at 5:15 PM, Resident #8 was observed lying on the floor. He sustained a bruise to his right hand and left 2nd finger and laceration to the back of the head on the right side; area was cleaned with normal saline and steri-stripes was applied. The MDS Coordinator was interviewed on 05/13/14 at 4:19 PM regarding Resident #8's unwitnessed fall on 03/28/14. She stated Resident #8 was not screened by occupational or physical therapies and was started on the frequent toileting program. Resident #8 continued to fall per the review of the Communication Form and Progress Note and the Interdisciplinary Post Fall Review as follows:
On 04/06/14 at 6:50 PM fall from a standing position, found lying on the floor and assisted to a

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F 323	Continued From page 27 sitting position. He sustained 2 abrasions; one on the mid back area on the left side and one on the lower back on the left side. The MDS Coordinator was interviewed on 05/13/14 at 4:19 PM regarding Resident #8's fall on 04/06/14. She stated Resident #8 was placed on the skilled rehab caseload and he was placed in the "SunCatchers" program which meets at 7PM each evening for diversional activities for residents considered "frequent fallers." On 04/14/14 at 6:45 PM fall from wheelchair, found sitting on buttocks in the floor. He sustained no injuries and staff assisted him back to his wheelchair. The MDS Coordinator was interviewed on 05/13/14 at 4:19 PM regarding Resident #8's unwitnessed fall on 04/14/14. She stated Resident #8 was on the occupational therapy case load and OT changed the cushion in his wheelchair. Review of the OT treatment notes dated 04/16/14 indicated a "two posture works" cushion was placed in his wheelchair to decrease fall risk, the cushion prevented Resident #8 from propelling self while in wheelchair and cushion was removed; the standard wheelchair cushion was placed to prevent skin breakdown. Review of the Doctor's Progress Notes dated 04/15/14 revealed discussion regarding resident's fall on 04/14/14. Physician suggested, resident may benefit from a safety-release belt. Review of Physician's Order dated 04/17/14 revealed Physical Therapy to evaluate resident for seat-belt alarm. The Physical Therapist was interviewed on 05/13/14 at 3:32 PM. She stated she received an order a few months ago for Resident #8 to be evaluated and he was so weak, unable to balance, and his cognition was such a challenge; he was discharged from physical therapy services. She further stated no other measures were implemented to prevent falls for	F 323		

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F 323	Continued From page 28 Resident #8 at this time. On 04/21/14 at 7:00 PM resident was in his wheelchair in the dining room when he started walking and fell on his back. He sustained no injuries. The MDS Coordinator was interviewed on 05/13/14 at 4:19 PM. She stated Resident #8 was on OT caseload and the use of a self-release Velcro alarm belt was placed on 04/21/14. Review of the physician's orders dated 04/22/14 revealed for OT to assess for self-release seat belt when in wheelchair related to unsteady gait and history of falls. Resident #8 was observed on 05/13/14 at 12:12 PM in a wheelchair, with a Velcro lap belt with an alarm in place. Resident #8 was unable to communicate with comprehensible words. On 05/14/14 at 1:27 PM Nursing Assistant (NA) #4 was interviewed. She stated Resident #8 recently had a self-release seat belt with an alarm was placed in his wheelchair. She indicated she was unaware Resident #8 was on the fall risk or scheduled toileting programs. She further indicated she was unaware of any additional supervision needed for Resident #8. On 05/14/14 at 1:36 PM Nurse #2 was interviewed. She stated she did feel the scheduled toileting program was beneficial for Resident #8 due to his cognitive impairment and his inability inform anyone he needed to go to the toilet. She indicated she expected Resident #8 to be toileted every 2 hours. She further indicated she expected the NA's to place the seat belt with the alarm around Resident #8 when he was up in his wheelchair and check the alarm for proper functioning. On 05/14/14 at 1:51 PM the Assistant Director of Nursing (ADON) was interviewed. She stated she received the incident reports related to any falls. She indicated she interviewed the resident; if the	F 323		

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F 323	Continued From page 29 resident was interviewable, and interviewed the staff to determine what happened. She further stated she updated the care plan with the date of the new fall and she normally did not add any new interventions and was not sure who checks to make sure the planned interventions were implemented. She stated "We all do" but was unaware of who was ultimately responsible for ensuring care plan interventions were in place. In addition, she further stated she had no knowledge of any additional supervision and/or any additional interventions that was put into place for Resident #8 regarding his numerous unwitnessed falls. On 05/14/14 at 2:04 PM the Administrator was interviewed. She stated she expected the ADON to update the care plans related to falls. She was unable to provide any information to identify patterns or possible causes and/or lack of interventions regarding Resident #8's falls as indicated in his plan of care.	F 323		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		

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F 514	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to document the administration of medications on the Medication Administration Record (MAR) for 5 of 11 sampled residents (Resident #4, Resident #9, Resident #10, Resident #11, and Resident #12). The findings included: Resident #4 was admitted on 12/16/13 and was discharged on 12/24/13. She was admitted with diagnoses to include heart failure, renal failure, and diabetes among others. Review of her 14 day Minimum Data Set (MDS) revealed she was cognitively intact, and required limited assistance with most activities of daily living. A review of Resident #4's MAR of 12/18/13 and 12/19/13 indicated Novolog Insulin 25units ordered to be given daily before meals, was not initialed as given on the MAR. The 4:30 PM dose on 12/18/13, and the 6:30 AM and 11:30 AM doses on 12/19/13 were left unsigned. There was no documentation in the medical record that indicated why these medications were not initialed, and no reasons were given on the back of the MAR for the omissions. Further review of the medication variance logs revealed no indication of a medication variance for Resident #4 on these dates. An interview was conducted with the MDS nurse at 2:30 PM on 05/13/14. She acknowledged issues with missing documentation was a problem, and indicated anytime a medication was not given, the reason for the omission should be documented on the medical record. An interview was conducted with the Facility Nurse Consultant #1 at 3:50 PM on 05/13 14. She presented paperwork that indicated Resident	F 514	Omissions addressed for resident's #4, #9, #10, #11 and #12. All resident's identified as having the potential to be affected. Staff Development Coordinator in-serviced Licensed and Medication Aides regarding Medication Administration specifically relating to omissions. Monitoring tool implemented to ensure medication administration compliance relating to omissions. Monitoring tool to be completed by Unit Coordinator 3 times a week for 2 weeks, once a week for 2 weeks, then monthly for 3 months. Results of Monitoring Tool will be incorporated in monthly Quality Assurance and Performance Improvement program to evaluate for compliance and effectiveness monthly for 3 months.	6/11/14

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F 514	Continued From page 31 #4 was at the dialysis center from 5:30 AM until after 3:00 PM on 12/19/13. She stated this would be the reason Resident #4 missed the two insulin doses, but acknowledged the reason for the omissions should be documented on the MAR. An interview was conducted with Nurse #1 at 9:45 AM on 05/14/14. She stated she recalled giving Resident #4 her insulin on 12/18/13. Nurse #1 revealed she checked Resident #4's fingerstick blood sugar and gave her the Novolog insulin injection, but forgot to sign the MAR. An interview was conducted with the Administrator at 11:15 AM on 05/14/14. She stated the facility acknowledged an issue with documentation of medication administration. She revealed Unit Managers were responsible for daily reviews of the MAR's and identifying medications that had not been initialed. The Administrator indicated staff were notified of the omissions and they were corrected. On 05/14/14 at 2:30 PM a review of random MAR's was selected from the 400 Hall. These included the MAR's of Resident #9, Resident #10, Resident #11, and Resident #12. Resident #9's MAR revealed missing initials for Lopressor at 8:00 AM on 05/03/14, missing initials for Melatonin at 8:00 PM on 05/03/14, and missing initials for Med Pass 2.0 at 4:00 PM on 5/3/14. Resident #10 was missing initials for Prozac 40mg at 8:00 AM on 05/04/14, Mobic 15mg at 8:00 AM on 05/04/14, Vitamin B12 1000mcg. at 8:00 AM on 05/04/14, and Med Pass 2.0 at 12:00 PM on 05/09/14 among others. Residents #11 and #12 also presented MAR's with missing initials that would have documented the administration of the medication. Further review of the MAR revealed no documentation that indicated why the medication was not issued. On 05/14/14 at 3:00 PM an interview was	F 514		

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F 514	Continued From page 32 conducted with the Administrator. She was shown the MAR's that were randomly reviewed from the 400 Hall. The Administrator acknowledged it was her expectation that staff properly documented medication administration, as well as documenting the reason why a medication was omitted. Facility Nurse Consultant #2 revealed this was an issue the facility had identified and continued to work towards improving.	F 514		