STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345303	A. BUILDING: _____ B. WING _____	12/9/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 159	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and resident and staff interviews the facility failed to provide cognitively intact residents with a quarterly personal funds statement for 2 of 4 sampled residents reviewed for personal funds (Residents #46 and #81).

The findings included:

1. Review of the medical record revealed Resident #46 was admitted on 10/29/09. The quarterly Minimum Data Set (MDS) dated 09/23/16 revealed Resident #46 had severely impaired cognition, unclear speech, and was able to understand others.

During an interview on 12/05/16 at 3:00 PM Resident #46 stated the facility did not let her know how much

The above isolated deficiencies pose no actual harm to the residents

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money was in her personal funds account and did not provide her with a quarterly personal funds statement.

An interview with the Business Office Manager on 12/08/16 at 4:02 PM revealed personal funds account statements were sent out quarterly to the resident if they were able to make decisions and if not the quarterly statement was mailed to the resident's Power of Attorney (POA). Resident #46's patient trust statement for 07/01/16 through 09/30/16 was reviewed during the interview and the Business Office Manager noted Resident #46's statement went to a family member who served as her POA.

A follow up interview was conducted with Resident #46 on 12/08/16 at 4:45 PM. Resident #46 spoke clearly and was alert and oriented. Resident #46 stated she had never received a quarterly personal funds statement and thought she should get one.

During a follow up interview on 12/09/16 at 10:35 AM the Business Office Manager stated the quarterly funds statement was sent to the person who signed the resident's patient trust fund agreement. The Business Office Manager indicated there was not a trust fund agreement in Resident #46's file and she would complete a new one with Resident #46. The Business Office Manager further stated Resident #46 was competent and capable and she planned to ask Resident #46 if she wanted the quarterly personal funds statement delivered to her or her POA.

An interview was conducted with the Administrator on 12/09/16 at 12:02 PM. The Administrator stated she would expect residents to receive a copy of their quarterly personal funds statement if they wanted one. The Administrator further stated Resident #46's cognition was good but she sometimes had trouble finding the right word. During a follow up interview on 12/09/16 at 12:29 PM the Administrator indicated the current system was for the person who signed the resident's patient trust fund agreement to receive the quarterly personal funds statement.

2. Review of the medical record revealed Resident #81 was admitted on 09/02/09. The quarterly Minimum Data Set (MDS) dated 09/20/16 revealed Resident #81 was cognitively intact and able to make her needs known.

During an interview on 12/05/16 at 4:09 PM Resident #81 stated the facility did not let her know how much money was in her personal funds account and did not provide her with a quarterly personal funds statement.

An interview with the Business Office Manager on 12/08/16 at 4:02 PM revealed personal funds account statements were sent out quarterly to the resident if they were able to make decisions and if not the quarterly statement was mailed to the resident's Power of Attorney (POA). Resident #81's patient trust statement for 07/01/16 through 09/30/16 was reviewed during the interview and the Business Office Manager noted Resident #81's statement went to a family member who served as her POA.

During a follow up interview on 12/09/16 at 10:35 AM the Business Office Manager stated the quarterly funds statement was sent to the person who signed the resident's patient trust fund agreement. Review of Resident #81's patient trust fund agreement dated 10/05/09 revealed it was signed by her POA.

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A follow up interview was conducted with Resident #81 on 12/09/16 at 11:33 AM. Resident #81 stated she had never had a copy of her quarterly personal funds statement delivered to her but had recently gone to the business office and requested and received a copy.

An interview was conducted with the Administrator on 12/09/16 at 12:02 PM. The Administrator stated she would expect residents to receive a copy of their quarterly personal funds statement if they wanted one. During a follow up interview on 12/09/16 at 12:29 PM the Administrator indicated the current system was for the person who signed the resident's patient trust fund agreement to receive the quarterly personal funds statement.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, the facility failed to permit 1 of 3 sampled residents reviewed for discharge planning to remain in the facility for long term care (Resident #40).	F 201	The facility will continue to permit each resident to remain the facility and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the residents needs cannot be met in the	1/11/17

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

Electronically Signed | 12/30/2016

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F 201	Continued From page 1 The findings included: Resident #40 was admitted to the facility on 09/26/16 to a dually certified bed which meant payment could be by Medicare or Medicaid. Her diagnoses included cardiac issues, chronic renal insufficiency, congestive heart failure, pulmonary edema, hypertension, likely dementia syndrome, chronic respiratory failure and chronic kidney disease stage 3. The admission Minimum Data Set (MDS) dated 10/06/16 coded Resident #40 with moderately impaired cognition, having no mood or behaviors, and requiring extensive care with most activities of daily living skills except eating. She received oxygen therapy, occupational therapy and physical therapy. The MDS noted the resident and family participated in the goal setting and per the resident, her overall goal for discharge was unknown or uncertain. The MDS noted an active discharge plan to the community was in process. The cognition Care Area Assessment dated 10/07/16 noted a referral was to be made for palliative care. A care plan was developed 10/07/16 for the potential for discharge to lesser care. The goal was for Resident #40 to be prepared for tentative discharge back home. Interventions listed were based on the resident returning home. Social Service notes dated 10/07/16 written by Social Worker (SW) #1 stated the resident had previous lived in a house alone, participated in the decision for placement and stated she was in the facility for rehabilitation.	F 201	facility. Resident #40 no longer resides in the facility. No negative outcome was identified relating to this observation. Resident #40's HCPOA spoke with facility Social Worker on 1/6/17 and declined the offer of transferring back to the facility for LTC. Current residents in dually certified beds have the potential to be affected. Current residents in dually certified beds (or their responsible parties) were interviewed and no requests for changes to current care planned discharge goals were identified. All new admissions in dually certified beds (or their responsible parties) will be interviewed to determine discharge goals. The interdisciplinary team will be updated and any changes to the discharge goal will be reflected in the medical record. Social Worker #1, Social Worker #2, and the Rehabilitation Coordinator will be inserviced by the Administrator on the facility's policy for discharge planning. The interdisciplinary team will be inserviced by the Administrator on the facility's policy for discharge planning. The governing body/designee Regional Operations Manger, and Regional Quality Assurance Manager, with the assistance of the Regional Long Term Care Ombudsman shall conduct a root cause analysis regarding the facility's history of	

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F 201	Continued From page 2 The psychosocial assessment dated 10/07/16 written by SW #1 stated the resident understood what was being said to her, but did not comprehend what was happening to her. The resident was noted with long and short term memory impairments and was not capable of making decisions regarding daily life and care. Discharge plans were uncertain at this time. Review of Care Conference Minutes dated 10/13/16 noted this was the initial care conference. The notes stated that Resident #40 was invited but declined to attend. The Responsible Party (RP)/Power of Attorney was included by phone. The note stated the resident's current status and history were discussed along with her status at home prior to her hospitalization. The discharge plan was discussed and the RP reported that Resident #40 could not return home due to safety and living alone. The RP was requesting long term care and was informed of the "waitlist" here. Referrals will be made for long term care at other facilities. The RP reported she had started the Medicaid application and was in the process of completing it. The interdisciplinary team would start the long term care referral and continue to coordinate with the RP in the transfer process. The notes did not specify any special requests made by the RP that would prevent the resident from remaining in the facility. Review of the Notice of Medicare Non-Coverage letter revealed the RP was notified by phone on 10/20/16 that Medicare covered days would end 10/24/16. Resident #40 was discharged to another long term care facility in the vicinity on 10/27/16. The	F 201	cessation of Medicare benefits and communication of discharges since January 1, 2016. The root cause analysis shall specify the systemic changes needed to foster sustained compliance rather than cyclic compliance with the requirements of participation. The facility shall specify in writing who will be responsible and accountable for the provision of compliance with resident discharges. A copy of the root cause analysis was emailed to Assistant Section Chief on 1/10/17. The governing body/designee, Regional Operations Manager and, Regional Quality Assurance Manager, shall submit a written report of the systemic changes initiated in the facility to foster a culture of quality and safety with a particular focus on resident centered care. Reports shall be provided thereafter to the state monthly for six months. A QA monitoring tool will be utilized to ensure ongoing compliance by Social Workers. Social Workers will interview all new admissions in dually certified beds or their responsible parties weekly x 6 months to ensure that resident/responsible party discharge goals are being honored. Variances will be corrected at the time of the interviews and additional education provided when indicated. Interview results will be reported to the	

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F 201	Continued From page 3 transfer sheet listed the reason for transfer as "Per Family Request". A phone interview was conducted on 12/07/16 at 12:30 PM with the RP. The RP stated that Resident #40 was very sick in the hospital but the hospital thought rehabilitation would be beneficial to Resident #40. RP selected this facility because she wanted a facility that would and could provide long term care after rehabilitation was completed because she did not want to have to move the resident to another facility following the end of therapy. Within 2 weeks of admission, the Social Worker (SW) #2 and rehabilitation coordinator asked the RP about her long term goals for Resident #40. She told them her goal from day one was for the resident to stay in the facility. They told her at that time there was no bed and she could be placed on the waiting list. RP stated Resident #40 had been in the facility previously in March 2016 and had been on the waiting list for long term care at that time. The RP questioned this and was told Resident #40 was in a Medicare rehab bed and if she was not out of the bed by a specific date, she would have to pay privately. The RP stated she complained, stated she was in a bed already and she could not take the resident home due to dementia. RP stated that she did not care if the resident was moved to a different room, even semiprivate as long as she stayed in the same facility. The facility gave the RP a list of other facilities in the area and she selected one of those. She stated that she would have selected another facility for rehabilitation if she knew this facility would not keep her after the resident completed rehabilitation. On 12/08/2016 at 10:26 AM an interview was conducted with SW #1 and SW #2. They stated	F 201	Administrator weekly for the next 6 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. An additional QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Long Term Care Ombudsman. The Regional Long Term Care Ombudsman will randomly interview new admissions in dually certified beds or their responsible parties bi-weekly to ensure that resident/responsible party discharge goals are being honored. Variances will be corrected at the time of the interviews and additional education provided when indicated. Continued compliance will be monitored through random resident/responsible party interviews by the Regional Operations Manager/designee, and results of interviews will be reported to the facility's Quality Assurance Program. The Social Worker will bring results/information to QA Committee for compliance monitoring for 6 months or until resolved and additional education/training will be provided for issues identified.	

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F 201	Continued From page 4 that discharge planning was discussed within 1 to 2 weeks of admission when a resident was admitted for rehabilitation. If a resident chose to stay long term, which happened often per the social workers, then they tried to accommodate the stay. They stated they encouraged residents to move to the long term care side so that there would be more consistency with roommates. They stated there was a wait list for the long term care side kept by the marketing staff (who was on medical leave) but that all beds were dually certified for Medicare and Medicaid and once a resident was in house they could stay. Specific to Resident #40, the social workers stated the RP wanted to remain in a private room and they could not accommodate that request. SW #1 stated they did not document the request for a private room by the RP. SW #2 stated that a private room was not covered under Medicaid and the RP did not want to pay the difference in the room rate. Interview with the Rehabilitation Coordinator on 12/09/16 at 9:28 AM revealed she could not recall any details about Resident #40's plans on leaving or staying. She could not recall why the resident did not remain at this facility.	F 201		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 221		1/6/17

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F 221	Continued From page 5 Based on observations, record review and staff interviews, the facility failed to maintain 1 of 1 sampled resident who utilized a self releasing seat belt free of restraints. Resident #141 had no medical diagnosis or medical justification for the seat belt which she was unable to release. The findings included: Resident #141 was admitted to the facility on 06/14/14. Her diagnoses included Alzheimer's Disease, dementia, anxiety disorder, major depressive disorder, spinal stenosis, and history of healed fracture. A significant change Minimum Data Set (MDS) dated 04/04/16 coded Resident #141 as having unclear speech, sometimes being understood, usually understanding, having severely impaired cognition, having no mood issues, no behaviors, requiring extensive assistance of 2 persons for bed mobility, transfers and being nonambulatory. She was noted to need staff assistance to balance self during transitions, having had 2 or more falls with non-major injury and having no restraints in place. The Care Area Assessment (CAA) for cognition dated 04/18/16 described Resident #141 as displaying inattention, disorganized thinking, easily distracted, out of touch with reality, having difficulty following what is said to her, and having severely impaired cognition. The CAA continued stating she had a seat belt in her wheelchair per family request. The CAA for falls dated 04/16/16 noted she had severely impaired cognition and a history of frequent falls. This CAA also stated she had a	F 221	The facility will continue to ensure that each resident is free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the residents' medical symptoms. Resident #141 no longer utilizes a self releasing seatbelt. No negative outcome was identified relating to this observation. Current residents with devices in place have the potential to be affected. Current residents with devices in place were reviewed to ensure that each device was required to treat the resident's medical symptoms. In addition, all new admissions will be assessed prior to initiating any device to ensure the device is required to treat the residents' medical symptoms. Unit Manager #1, NA #1, NA #2, and Nurse #1 will be inserviced by the ADON on the facility's policy for utilizing devices with the potential to be restraints. All nurses and nursing assistants will be inserviced by the ADON on the facility's policy for utilizing devices with the potential to be restraints. A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON. The ADON will observe all residents with devices having the potential to be restraints 3 times a week x 4 weeks then weekly x 4 weeks then randomly x 1 month to ensure that devices, if identified	

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F 221	Continued From page 6 self releasing seat belt while in the wheelchair which she frequently released. The most recent MDS, a quarterly dated 09/17/16, coded Resident #141 as severely impaired cognition, being nonambulatory and requiring extensive assistance with all activities of daily living skills. She was coded as having had 2 or more falls without injury since the last review and had no restraints in use. The most recent quarterly Pre-Restraint Intervention Evaluation dated 09/21/16 was completed by the Unit Manager #1. This evaluation stated Resident #141 had poor safety awareness, was unable to independently stand/transfer/ambulate, was unable to maintain body alignment, was alert and oriented to person, and was unable to follow directions. This form noted that Resident #141 had fall and poor balance or trunk control but that this was not a change in her condition. Under the evaluation section of this form, it was noted a self releasing seat belt in the wheelchair was chosen to promote safety. The form noted the resident could easily remove the device independently and consistently and it was used as an enabler. The care plan, originally developed 04/13/16 and last updated 09/22/16, identified the problem/conclusion was for the use of a self releasing seat belt while in the wheelchair which she was able to release independently. The goal was for Resident #141 to use the least restrictive device through the next review due 12/21/16. Interventions included to document the need to reassess the device, apply self releasing belt as ordered and to document effectiveness of device.	F 221	as a restraint, are being used to treat medical symptoms. Variances will be corrected at the time of the interview and additional education provided when indicated. Observation results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations of residents and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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Physician Orders per the December 2016 cumulative orders included: a self releasing seat belt to be used in the wheelchair to prevent self harm as needed per family request and to release the seat belt every 2 hours and as needed when out of bed. The physician order did not identify the medical necessity for the seat belt.

Review of the medical record revealed no documented diagnoses or medical necessity for the seat belt restraint.

On 12/07/16 at 8:28 AM, Resident #141 was observed in the dining room sitting at a table in her wheelchair. She had a seat belt with a button release buckle in place. Attempts to engage Resident #141 in conversation were unsuccessful as the resident offered no verbal or physical response. In the presence of NA #1 and NA #2, Resident #141 was asked several times to remove and unbuckle her seat belt. She made no attempt to reach for the seat belt or buckle. Then NA #1 and NA #2 were asked if Resident #141 could release the seat belt. Both stated yes. Then when asked if Resident #141 could do it on command, both stated no that she just fidgets with the buckle until the buckle came undone.

On 12/07/16 at 8:45 AM, the Unit Manager (UM) was observed talking with Resident #141 who was in her wheelchair opposite the nursing station. The UM was observed asking Resident #141 to take off her seat belt. When Resident #141 made no attempt to reach for the belt after several requests, the UM then placed the resident's hand on the buckle and again asked the resident to unfasten the seat belt. When the resident did not unfasten the seat belt, then the

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UM asked Resident #141 to use both hands to release the button. Resident #141 did not release the seat belt on her own. UM stated the seat belt was reviewed quarterly.

A follow up interview was conducted on 12/07/16 with NA #2 who stated it had been awhile since Resident #141 could release the seat belt consistently on command. NA# 2 stated he was unsure how long it had been since Resident #141 was able to release the seat belt. He further stated that he informed the nursing staff when she did release the belt but not when she could not.

Nurse #1 stated during interview on 12/07/16 at 9:46 AM that she worked on the hall about once a week with Resident #141. Nurse #1 stated the resident used the seat belt for awhile and used to be able to release it but not now. She was unable to say how long she was aware that the resident could not release it. Nurse #1 stated she had a history at home of wanting to lay on the floor due to back issues and Resident #141 would release the belt so she could place herself on the floor. Nurse #1 also stated that at times she just fiddled with the seat belt buckle until it came unfastened.

A follow up interview was conducted with NA #1 on 12/07/16 at 10:09 AM. NA #1 stated that it had been about a month since Resident #141 could release her seat belt and stated she had declined and had not been feeding herself as much as she previously did. NA #1 further stated that she informed the nurses whenever the resident released the seat belt and NA reapplied it. NA #1 could not recall if she informed the nurses when she noticed Resident #141 was unable to release her seat belt.

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F 221	Continued From page 9 On 12/09/16 at 12:01 PM interview with UM revealed that every quarter she reassessed the seat belt to ensure it was not a restraint. UM stated it was an enabler if the resident was able to unfasten the seat belt. UM stated at the last evaluation in September 2016, Resident #141 was able to release the seat belt when asked to do so. UM conducted that assessment quarterly or whenever there was a significant change. She further stated that the nurses and nurse aides were not expected to ask the resident to unfasten the seat belt but should report to the nurses if they found she could no longer release the belt on her own. UM stated Resident #141 would have been reevaluated for the seat belt later this month as she was due to another MDS assessment and had not had any significant changes to warrant an earlier evaluation. UM also stated the self releasing seat belt was initiated because she crawled onto the floor to lie on the floor, which was her habit at home to relieve back pain. UM stated the family wanted the use of a restraint and the seat belt was the least restrictive device as she was able to release the belt on her own. The facility subsequently placed a floor mat next to the bed to accommodate her desire to lie on the floor about a year ago. UM stated that she had since stopped lying on the floor as often as she did and the seat belt was to remind her she needed assistance. The Director of Nursing stated at 12/09/16 at 1:22 PM that Resident #141 was doing what she normally did which was to release the buckle when she wanted. DON further stated that the resident would have been reevaluated this month but there had been no reason to reevaluate the	F 221		

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F 221	Continued From page 10 seat belt as a restraint before this week as she had been seen releasing it at will on a regular basis.	F 221		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair a loose drain cover in a resident shower, remove a broken towel rack rod from a resident bathroom floor, and replace one side of a sliding mirror on a medicine cabinet in a resident bathroom. In addition, the facility failed to replace a baseboard in a resident room, repair and remove uncovered, unused brackets on the bathroom wall beside the commode and failed to replace torn and cracked arm rests for two resident wheelchairs on 3 of 4 halls (Halls 200, 300 and 400 and Residents #81 and #102). The findings included: 1. Observations of the shared bathroom in room 204 throughout the survey revealed the following: · 12/05/16 at 11:30 AM revealed the shower drain cover to be loose with half of the drain hole exposed. · 12/06/16 at 9:30 AM revealed the shower drain cover to be loose with half of the drain hole exposed. · 12/08/16 at 9:15 AM revealed the shower drain cover to be loose with half of the drain hole	F 253	The facility will continue to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The shower drain cover in the shared bathroom in room 204 was repaired. The sliding mirror on the medicine cabinet in the bathroom in room 404 was repaired. The baseboard by bed A in room 406 was replaced. The metal bracket on the toilet paper holder in the bathroom of room 402 was repaired. Resident #102's wheelchair arm rests were replaced. Resident #81's wheelchair arm rests were replaced and the right arm rest was tightened. No negative outcomes were identified relating to these observations. Current residents have the potential to be affected. All shower drain covers were inspected and no further need for repairs were identified. All metal towel rack rods were inspected and no further need for repairs were identified. All baseboards	1/6/17

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F 253	Continued From page 11 exposed. An interview was conducted on 12/09/16 at 10:16 AM with the Administrator and Maintenance Director. The Administrator stated the facility had recently hired a new Director of Maintenance and he was still in the process of learning the maintenance schedules and the building needs. She stated each hall had work orders that all staff could fill out and leave in a book for repairs needed and the Maintenance Director checked those each day and prioritized the requests to be completed. The Maintenance Director stated he checked the work requests every day and kept a log as well. The Administrator further stated each Department Head was assigned environmental rounds and should be reporting needed repairs to the Maintenance Director. The Administrator and the Maintenance Director were accompanied to the shared bathroom in room 204 and agreed the shower drain cover was loose and needed to be repaired. The Maintenance Director stated he had not received a work order for the loose shower drain in room 204 and was not aware it was loose. He further stated the repairs would be completed as soon as possible. 2. Observations of the bathroom in room 310 throughout the survey revealed the following: · 12/05/16 at 3:58 PM metal towel rack rod lying in the floor against the wall under the toilet paper dispenser. · 12/06/16 at 12:04 PM metal towel rack rod lying in the floor against the wall under the toilet paper dispenser. · 12/08/16 9:22 AM metal towel rack rod lying in the floor against the wall under the toilet paper dispenser. · 12/09/16 10:00 AM metal towel rack rod lying	F 253	were inspected and no further need for repairs were identified. All wheelchair arm rests were inspected and no further need for repairs were identified. The Maintenance Director and Department Heads will be inserviced by the Administrator on the facility's policy for environmental rounds and the facility work order system. All staff will be inserviced by the Administrator on the facility's policy for environmental rounds and the facility work order system. A QA monitoring tool will be utilized to ensure ongoing compliance by the Administrator/Maintenance Director. The Administrator/Maintenance Director will randomly inspect 3 rooms and 3 wheelchairs 5 times a week x 4 weeks then weekly x 4 weeks then randomly x 1 month to ensure that maintenance and housekeeping concerns are reported and repaired in a timely manner. Variances will be corrected at the time of the inspection and additional education provided when indicated. Inspection results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random room and wheelchair inspection and through the facility's	

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F 253	Continued From page 12 in the floor against the wall under the toilet paper dispenser. An interview was conducted on 12/09/16 at 10:16 AM with the Administrator and Maintenance Director. The Administrator stated the facility had recently hired a new Director of Maintenance and he was still in the process of learning the maintenance schedules and the building needs. She stated each hall had work orders that all staff could fill out and leave in a book for repairs needed and the Maintenance Director checked those each day and prioritized the requests to be completed. The Maintenance Director stated he checked the work requests every day and kept a log as well. The Administrator further stated each Department Head was assigned environmental rounds and should be reporting needed repairs to the Maintenance Director. The Administrator and the Maintenance Director were accompanied to the bathroom in room 310 and agreed the towel rack rod should not be lying in the floor. The Maintenance Director stated he was not aware the towel rack was broken in room 310 and had not received a work order to repair it. He further stated the repairs would be completed as soon as possible. 3. Observations made of the medicine cabinet in the shared bathroom for room 404 throughout the survey revealed the following: · 12/07/16 at 10:01 AM revealed one side of the sliding mirror on the medicine cabinet was missing. · 12/08/16 at 9:28 AM revealed one side of the sliding mirror on the medicine cabinet was missing. · 12/09/16 at 10:05 AM revealed one side of the sliding mirror on the medicine cabinet was	F 253	Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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missing.

An interview was conducted on 12/09/16 at 10:16 AM with the Administrator and Maintenance Director. The Administrator stated the facility had recently hired a new Director of Maintenance and he was still in the process of learning the maintenance schedules and the building needs. She stated each hall had work orders that all staff could fill out and leave in a book for repairs needed and the Maintenance Director checked those each day and prioritized the requests to be completed. The Maintenance Director stated he checked the work requests every day and kept a log as well. The Administrator further stated each Department Head was assigned environmental rounds and should be reporting needed repairs to the Maintenance Director. The Administrator and the Maintenance Director were accompanied to the shared bathroom in room 404 and agreed one side of the sliding mirror was missing on the medicine cabinet and needed to be replaced. The Maintenance Director stated he had not received a work order for the missing mirror and he was not aware of the problem until today. He further stated the repairs would be completed as soon as possible.

4. Observations made of room 406 throughout the survey revealed the following:
· 12/07/16 at 9:55 AM revealed baseboard missing by bed A.
· 12/08/16 at 9:30 AM revealed baseboard missing by bed A.
· 12/09/16 at 10:07 AM revealed baseboard missing by bed A.

An interview was conducted on 12/09/16 at 10:16 AM with the Administrator and Maintenance

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Director. The Administrator stated the facility had recently hired a new Director of Maintenance and he was still in the process of learning the maintenance schedules and the building needs. She stated each hall had work orders that all staff could fill out and leave in a book for repairs needed and the Maintenance Director checked those each day and prioritized the requests to be completed. The Maintenance Director stated he checked the work requests every day and kept a log as well. The Administrator further stated each Department Head was assigned environmental rounds and should be reporting needed repairs to the Maintenance Director. The Administrator and the Maintenance Director were accompanied to room 406 and agreed the baseboard by bed A was missing and needed to be replaced. The Maintenance Director stated he was not aware the baseboard in room 406 was missing and he had not received a work order to repair it. He further stated the repairs would be completed as soon as possible.

5. Observations made of room 402 throughout the survey revealed the following:
· 12/07/16 at 10:03 AM revealed one metal bracket removed from the toilet paper holder with sharp edges exposed.
· 12/08/16 at 9:35 AM revealed one metal bracket removed from the toilet paper holder with sharp edges exposed.
· 12/09/16 at 10:22 AM revealed one metal bracket removed from the toilet paper holder with sharp edges exposed.

An interview was conducted on 12/09/16 at 10:22 AM with the Administrator and Maintenance Director. The Administrator stated the facility had recently hired a new Director of Maintenance and

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he was still in the process of learning the maintenance schedules and the building needs. She stated each hall had work orders that all staff could fill out and leave in a book for repairs needed and the Maintenance Director checked those each day and prioritized the requests to be completed. The Maintenance Director stated he checked the work requests every day and kept a log as well. The Administrator further stated each Department Head was assigned environmental rounds and should be reporting needed repairs to the Maintenance Director. The Administrator and the Maintenance Director were accompanied to room 402 and agreed the sharp, exposed bracket needed to be removed. The Maintenance Director stated he had not received a work order to repair/remove the exposed bracket in room 402 ' s bathroom. He further stated the repairs would be completed as soon as possible.

6. Observations of Resident #102's wheelchair chair throughout the survey revealed the following:

· 12/05/16 at 6:04 PM revealed Resident #102's wheelchair armrests to be cracked on both sides.

· 12/06/16 at 12:03 PM revealed Resident #102's wheelchair arm rests to be cracked on both sides.

· 12/07/16 at 9:50 AM revealed Resident #102's wheelchair arm rests to be cracked on both sides.

· 12/08/16 at 9:22 AM revealed Resident #102's wheelchair arm rests to be cracked on both sides.

· 12/09/16 at 10:30 AM revealed Resident #102's wheelchair arm rests to be cracked on both sides.

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F 253	Continued From page 16 An interview was conducted on 12/09/16 at 10:30 AM with the Administrator and Maintenance Director. The Administrator stated the facility had recently hired a new Director of Maintenance and he was still in the process of learning the maintenance schedules and the building needs. She stated each hall had work orders that all staff could fill out and leave in a book for repairs needed and the Maintenance Director checked those each day and prioritized the requests to be completed. The Maintenance Director stated he checked the work requests every day and kept a log as well. The Administrator further stated each Department Head was assigned environmental rounds and should be reporting needed repairs to the Maintenance Director. The Administrator and the Maintenance Director were accompanied to observe Resident #102's wheelchair arm rests and agreed they were cracked and needed to be replaced. The Maintenance Director stated he was not aware of the cracked arm rests on Resident #102's wheelchair and had not received a work order for them. He further stated the repairs would be completed as soon as possible. 7. Observations made of Resident #81's wheelchair armrests throughout the survey revealed the following: · 12/07/16 at 9:55 AM revealed Resident #81's wheelchair armrests to be cracked on both sides and the right side arm rest was loose. · 12/08/16 at 10:15 AM revealed Resident #81's wheelchair armrests to be cracked on both sides and the right side arm rest was loose. · 12/09/16 at 10:35 AM revealed Resident #81's wheelchair armrests to be cracked on both sides and the right side arm rest was loose. An interview was conducted on 12/09/16 at 10:35	F 253		

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F 253	Continued From page 17 AM with the Administrator and Maintenance Director. The Administrator stated the facility had recently hired a new Director of Maintenance and he was still in the process of learning the maintenance schedules and the building needs. She stated each hall had work orders that all staff could fill out and leave in a book for repairs needed and the Maintenance Director checked those each day and prioritized the requests to be completed. The Maintenance Director stated he checked the work requests every day and kept a log as well. The Administrator further stated each Department Head was assigned environmental rounds and should be reporting needed repairs to the Maintenance Director. The Administrator and the Maintenance Director were accompanied to observe Resident #81's wheelchair armrests and agreed they were cracked and the right arm rest was loose and needed to be replaced. The Maintenance Director stated he was not aware of the cracked armrests on Resident #81's wheelchair and had not received a work order for them. He further stated the repairs would be completed as soon as possible.	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility staff failed to follow the care plan interventions for 2 of 17 sampled	F 282	The facility will continue to provide and arrange services by qualified persons in accordance with each resident's written	1/6/17

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F 282	Continued From page 18 residents reviewed for care plans. Resident #67's care plan was not followed related to the number of staff needed during a sit to stand lift transfer and the number of full side rails to be used. Resident #154's care plan was not followed regarding the number of full side rails to be used on his bed. The findings included: 1. Resident #67 was admitted to the facility on 01/24/15. Her diagnoses included coronary artery disease, hypertension, anticoagulant use, chronic kidney disease, and venous embolism. The most recent Care Area Assessment (CAA) dated 12/15/15 relating to falls stated that she was alert and oriented with some impaired memory and required weight bearing assistance with transfers and mobility. She required a wheelchair for ambulation and used a sit to stand lift with transfers. The CAA also stated she used the right side rail up while in bed to assist with bed mobility. The care guide in the closet, for reference by staff for resident specific care, was noted last revised 08/10/16 and included the use of a sit to stand lift. There was no specification as to the number of staff to be involved with the sit to stand lift transfer. This guide also noted she used one side rail on the right side of the bed. The most recent Minimum Data Set, a quarterly dated 09/08/16 coded her with moderately impaired cognition, having no mood concerns or behaviors. She was coded as requiring extensive assistance of 2 persons for bed mobility, transfers toileting and dressing. She was coded as being	F 282	plan of care. Residents #67 and #154 were assessed to ensure that services related to assistance with transfers and siderail usage were being provided by qualified persons in accordance with each resident's plan of care. No negative outcome was identified relating to this observation. Current residents that require sit to stand lift transfers and/or require the use of siderails have the potential to be affected. Current residents that require sit to stand lift transfers were reviewed to ensure that assistance with transfers was being provided by qualified persons in accordance with each resident's plan of care. Current residents that require the use of siderails were reviewed to ensure that siderails were being used in accordance with each resident's plan of care. No negative observations were identified. The Unit Manager, the MDS Nurse, NA #3, NA#4, NA#5 and NA#9 will be inserviced by the ADON on the facility's policy for providing assistance with sit to stand lift transfers and siderail usage in accordance with each resident's plan of care. All nursing assistants will be inserviced by the ADON on the facility's policy for providing assistance with sit to stand lift transfers and siderail usage in accordance with each resident's plan of	

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nonambulatory and needed staff assistance to stabilize herself during transitions. She had no falls since previous review.

The care plan for falls most recently reviewed on 09/12/16 addressed Resident #67's risk for falls due to impaired mobility. The goal was for her to be free of falls. Interventions included she was to be transferred with a 2 person assist using a mechanical lift for transfers and the right side rail was to be up while in bed to assist with bed mobility.

On 12/05/2016 at 4:53 PM, Resident #67 was observed in bed with both full siderails in the upright position.

On 12/07/16 at 3:14 PM, Resident #67 was observed being transferred to the commode by Nurse Aide (NA) #3. NA #3 obtained the sit to stand lift. She stated she was a little rusty using the lift. Resident #67 directed NA #3 as to where to place the lift in the bathroom. NA #3 proceeded to attach the sit to stand lift straps appropriately and used the sit to stand lift to place Resident #67 on the commode. NA #3 had no other staff with her. Then at 3:40 PM, NA #3 stated she needed to get help to transfer Resident #67 with the sit to stand lift. When asked about the first transfer being performed by her alone, NA #3 stated she could not find help originally and transferred Resident #67 herself. She stated she was going to get another staff member to help her transfer Resident #67 back from the commode. NA #4 then assisted with the transfer from the commode to the bed using the sit to stand lift. After the resident was transferred to the bed, NA #3 placed the left full side rail up. The right full side rail was already in the upright

care.

A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON. NA #3, NA #4, NA#5, and NA #9 will be observed weekly x 4 weeks to ensure that they are providing assistance with sit to stand lift transfers and using siderails in accordance with each resident's plan of care. All other NA's will be observed x 1 to ensure that they are providing assistance with sit to stand lift transfers and using siderails in accordance with each resident's plan of care. The ADON will randomly observe all residents requiring sit to stand lift transfers weekly x 4 weeks then randomly x 2 months to ensure that assistance with sit to stand lift transfers and siderail usage is provided in accordance with each resident's plan of care. Variances will be corrected at the time of the observation and additional education provided when indicated.

Observation results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.

Continued compliance will be monitored through random observations of residents and through the facility's Quality Assurance Program.

Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.

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position.

Upon further interview with NA #3 on 12/07/16 at 3:51 PM, NA #3, who stated she worked in the facility for approximately 2 months, stated she forgot to get assistance with the sit to stand lift the first time. NA #4 stated at this time that Resident #67 insisted that both side rails be upright so he "ignored" the care guide related to side rail usage because he knew what the resident wanted.

Interview with the Unit Manager (UM) on 12/08/16 at 2:54 PM revealed that the number of persons needed for a sit to stand lift should be noted on the care guide in the closet. On 12/08/16 at 3:09 PM the care guide was reviewed with the UM who then stated that the expectation was for 2 persons to always be involved when using any mechanical lift. She further stated that this expectation was reviewed in orientation. Regarding the side rails, UM stated that she should only have one full side rail up. If the resident insisted on both, the UM expected staff to inform her so that they could look at alternatives such as two half rails. Until today when NA #5 mentioned it to the UM, she was unaware that the resident was insisting on 2 side rails and that staff were putting up two full siderails.

On 12/08/2016 at 3:00 PM, Resident #67 stated that 2 staff were not always present when she was transferred with the sit to stand lift. She also stated that she insisted on both full side rails being up when she was in bed.
2. Resident #154 was admitted to the facility with diagnoses of diabetes, and chronic respiratory failure.

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Review of the quarterly Minimum Data Set (MDS) dated 12/23/16 revealed Resident #154 was cognitively intact and needed extensive assistance with bed mobility and transfers.

Review of the care plan dated 11/04/16 revealed Resident #154 required supervision to total assistance with activities of daily living (ADL) related to a spinal cord injury with recent pneumonia. The goal was for Resident #154 to assist with ADL task completion within limitations of health status through the next review. The interventions included one full side rail up when in bed for increased independence in bed mobility.

Review of the facility Pre Restraint Evaluation dated 11/18/16 revealed one full side rail up as an enabler.

Review of the physician order's dated 11/30/16 revealed Resident #154 to have 1 full side rail up when in bed as an enabler.

Observations made throughout the survey revealed the following:
· 12/07/16 at 8:22 AM Resident #154 lying in bed with two full side rails up.
· 12/07/16 at 3:11 PM Resident #154 lying in bed with two full side rails up.
· 12/08/16 at 11:45 AM Resident #154 lying in bed with two full side rails up.
· 12/09/16 at 9:45 AM Resident #154 lying in bed with two full side rails up.

An interview conducted on 12/07/16 at 3:12 PM with Nurse Aide #9 revealed Resident #154 always had two full side rails up for enablers. He stated Resident #154 asked to have both side

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F 282	Continued From page 22 rails up. An interview conducted on 12/07/16 at 3:17 PM with Resident #154 revealed he wanted two full side rails up while in bed to help with bed mobility. An interview conducted on 12/08/16 at 3:09 PM with the MDS Nurse revealed she wrote the care plan for Resident #154 and was not aware he was using two full side rails while in bed. She stated the care plan and physician order were for one full side rail to be used and the care plan should be followed. The MDS Nurse further stated since Resident #154's preference was for two full side rails she would re-evaluate him and update the care plan.	F 282		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		1/6/17

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F 322	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to clarify physician's orders for water flushes before and after medication administration and document water flushes on the medication administration record for 1 of 1 sampled resident with a gastrostomy feeding tube (Resident #234). The findings included: Review of a facility policy for "Medication Administration Via Enteral Feeding Tube" dated 11/02 read in part: "A physician's order is required for the administration of any medication via feeding tube. The physician's order must specify the medication, dose, route, and frequency as well as the volume of water to be administered with the medication." Review of the medical record revealed Resident #234 was admitted on 11/23/16 with diagnoses including cerebrovascular accident (CVA). Review of the admission Minimum Data Set (MDS) dated 11/30/16 revealed Resident #234 had severely impaired cognition and did not speak. The admission MDS noted Resident #234 had a feeding tube. Review of Resident #234's physician's orders and Medication Administration Records (MARs) from 11/23/16 through 12/07/16 revealed there were no orders for or documentation of water flushes before and after medications were administered.	F 322	The facility will continue to ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Resident #234 no longer resides at the facility. No negative outcome was identified relating to this observation. Current residents that have naso-gastric or gastrostomy tubes have the potential to be affected. Current residents that have naso-gastric or gastrostomy tubes were reviewed to ensure that physician orders for water flushes before and after medication administration were present. NO negative observations identified. Nurse #2 will be inserviced by the ADON on the facility's policy for obtaining physician's orders for administering water flushes before and after medication administration for those residents with naso-gastric or gastrostomy tubes. A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager. The Unit Manager will review all physician orders 5x per week x 3 months to ensure that residents with	

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F 322	Continued From page 24 Observations of medication pass on 12/07/16 at 12:21 PM revealed Nurse #2 dispensed a Baclofen (used to treat muscle spasms) 10 mg (milligram) tablet into a medicine cup and at 12:28 PM dispensed a Metoprolol (used to treat hypertension) 25 mg tablet into a separate medicine cup. The medications were both crushed at the medication cart and returned to the medicine cups. Nurse #2 was followed to Resident #234's bedside with the medications and was observed verifying the feeding tube placement. Nurse #2 attached a 60 cc (cubic centimeter) syringe to the feeding tube and administered a 120 cc water flush prior to administering the medications. Nurse #2 then administered an additional 120 cc water flush after the medications. During an interview on 12/07/16 at 3:07 PM Nurse #2 confirmed he had administered a 120 cc water flush before and after Resident #234's medications during the 12:00 PM medication pass that day but did not have a physician's order on the December 2016 MAR for the water flushes with medications. Nurse #2 added he had contacted the Registered Dietitian after medication pass and obtained and order for 30 cc water flushes before and after medication administration. An interview with the Director of Nursing (DON) on 12/07/16 at 3:25 PM revealed she expected nurses to administer water flushes with medications per the facility's policy. The DON reviewed Resident #234's electronic physician's orders and confirmed there were no orders which specified the amount of water to be administered before and after medications. Nurse #2 was	F 322	naso-gastric or gastrostomy tubes have physician orders for water flushes before and after medication administration. The Unit Manager will review all new admissions with naso-gastric or gastrostomy tubes to ensure that physician orders for water flushes before and after medication administration are present. Variances will be corrected at the time of the review and additional education provided when indicated. Review results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random reviews and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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present during the interview and stated he got confused and had administered the water flushes ordered for before and after Resident #234's bolus tube feedings.

A follow up interview was conducted with the DON on 12/08/16 at 8:41 AM. The facility's policy for "Medication Administration Via Enteral Feeding Tube" was reviewed at that time and the DON noted the policy did not specify the amount of water to be used for flushes before and after medications were administered. The DON explained the physician typically ordered the water flushes until the RD completed her assessment and made recommendations. The DON stated residents with feeding tubes typically had orders for all of the water flushes entered on their MARs. The DON further stated she did not know what had happened with Resident #234 but thought it was an oversight on their part. The interview further revealed the DON expected the nurses to administer a 30 cc water flush before and after medication administration which was a basic standard of practice.

An interview with the RD on 12/08/16 at 9:49 AM revealed the facility notified her when a resident was admitted with a feeding tube. The RD stated she focused on the type of formula, calories, and water flushes with the tube feeding when she completed an assessment. The RD further stated she had just increased Resident #234's water flushes with his tube feedings earlier in the week because laboratory tests indicated he needed more water. The RD indicated she asked how many medications residents were taking but did not typically get involved with the water flush orders with medication administration. The interview further revealed Nurse #2 had

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F 322	Continued From page 26 contacted her yesterday regarding Resident #234's water flush orders and she told him to administer a 30 cc water flush before and after medications. During an interview on 12/08/16 at 12:06 PM the Nurse Practitioner (NP) stated if a resident with a gastrostomy feeding tube was admitted with water flush orders he usually continued the orders and had the RD evaluate the resident. The NP did not recall what flush orders Resident #234 had with his medications. The NP noted he had consulted with the RD several times regarding Resident #234 and she had increased his water flushes again this week because laboratory tests results indicated he was "dry". The NP further stated he was not concerned with the additional fluids Resident #234 received during the 12:00 PM medication pass yesterday.	F 322		
F 323 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to use 2 staff members during a sit to stand lift transfer to ensure the safety for 1 of 5 residents sampled and observed using mechanical lifts for transfers	F 323	The facility will continue to ensure that the residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	1/6/17

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F 323	Continued From page 27 (Resident #67). The findings included: Resident #67 was admitted to the facility on 01/24/15. Her diagnoses included coronary artery disease, hypertension, anticoagulant use, chronic kidney disease, and venous embolism. The annual Care Area Assessment dated 12/15/16 relating to falls stated that she was alert and oriented with some impaired memory and required weight bearing assistance with transfers and mobility. She required a wheelchair for ambulation and used a sit to stand lift with transfers. The care guide in the closet, for reference by staff for resident specific care, was noted last revised 08/10/16 and included the use of a sit to stand lift. There was no specification as to the number of staff to be involved with the sit to stand lift transfer. The most recent Minimum Data Set, a quarterly dated 09/08/16 coded her with moderately impaired cognition, having no mood concerns or behaviors, and requiring extensive assistance of 2 persons for bed mobility, transfers toileting and dressing. She was coded as being nonambulatory and needed staff assistance to stabilize herself during transitions. She had no falls since previous review. The care plan for falls established 12/11/15 and most recently reviewed on 09/12/16 addressed Resident #67's risk for falls due to impaired mobility. The goal was for her to be free of falls. Interventions included she was to be transferred	F 323	prevent accidents. Resident #67 will continue to receive two person assist for sit to stand lift transfers. No negative outcome was identified relating to this observation. Current residents that require sit to stand lift transfers have the potential to be affected.Current residents that require sit to stand lift transfers will continue to receive assistance with transfers in accordance with each resident's plan of care. The Unit Manger, NA #3, and NA #4 will be inserviced by the ADON on the facility's policy for providing assistance with sit to stand lift transfers in accordance with each resident's plan of care. A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON. NA#3 and NA#4 will be observed weekly x 4 weeks to ensure that they are providing assistance with sit to stand lift transfers in accordance with each resident's plan of care. All other NAs will be observed x 1 to ensure that they are providing assistance with sit to stand lift transfers in accordance with each resident's plan of care. The ADON will randomly observe all residents requiring sit to stand lift transfers weekly x 4 weeks then randomly x 2 months to ensure that assistance with sit to stand lift transfers is provided in accordance with each resident's plan of care. Variances will be corrected at the time of the observation and additional	

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F 323	Continued From page 28 with a 2 person assist using a mechanical lift for transfers. On 12/07/16 at 3:14 PM, Resident #67 was observed being transferred to the commode by Nurse Aide (NA) #3. NA #3 obtained the sit to stand lift. She stated she was a little rusty using the lift. Resident #67 directed NA #3 as to where to place the lift in the bathroom. NA #3 proceeded to attach the sit to stand lift straps appropriately and used the sit to stand lift to place Resident #67 on the commode. NA #3 had no other staff with her. Then at 3:40 PM, NA #3 stated she needed to get help to transfer Resident #67 with the sit to stand lift. When asked about the first transfer she did alone, NA #3 stated she could not find help originally and transferred Resident #67 herself. She stated she was going to get another staff member to help her transfer Resident #67 back from the commode. NA #4 then assisted with the transfer from the commode to the bed using the sit to stand lift. Upon further interview with NA #3 on 12/07/16 at 3:51 PM, NA #3, who stated she worked in the facility for approximately 2 months, stated she forgot to get assistance with the sit to stand lift the first time. Interview with the Unit Manager (UM) on 12/08/16 at 2:54 PM revealed that the number of persons needed for a sit to stand lift should be noted on the care guide in the closet. On 12/08/16 at 3:09 PM the care guide was reviewed with the UM who then stated that the policy is for 2 persons to always be involved when using any mechanical lift. She further stated that policy was reviewed in orientation. On 12/08/2016 at 3:00 PM, Resident #67 stated	F 323	education provided when indicated. Observation results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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F 323	Continued From page 29 that 2 staff were not always present when she was transferred with the sit to stand lift.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain an ice scoop holder and ice dispensing chute in a sanitary condition and failed to seal an open bag of frozen okra stored in the walk in freezer. The findings included: 1. During the initial tour of the facility kitchen on 12/05/16 at 9:35 AM a clear ice scoop holder was observed located on a shelf, adjacent to the ice machine. The clear ice scoop holder had a clear, cupped insert which fit into the exterior holder. A metal scoop was observed stored inside the clear, cupped insert with the base of the scoop touching water residue within the bottom of the insert. A clear gelatinous film was observed on the interior portion of the cupped insert. The ice scoop was removed and, when touched, a slimy feel was felt in the water residue on the interior	F 371	The facility will continue to ensure that food is stored, prepared, distributed and served under sanitary conditions. The ice scoop holder in the kitchen was cleaned immediately upon observation. The bag of sliced okra in the walk-in freezer in the kitchen was discarded immediately upon observation. The automated ice and water dispensing machine in the congregate dining/living room was cleaned immediately upon observation. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. All facility ice scoop holders were inspected. The kitchen cleaning schedule has been updated to include ice scoop holders. All items in the walk-in	1/6/17

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F 371	Continued From page 30 portion of the cupped insert. The Food Service Director (FSD) was present at the time of the observation and also felt the interior portion of the cupped insert and agreed, it was problematic. The FSD stated he expected the evening aide to clean the ice scoop holder every evening. The FSD provided the cleaning schedule which listed all cleaning responsibilities of the evening aide and noted the cleaning of the ice scoop holder had inadvertently been left off the schedule. On 12/09/16 at 12:57 PM the Administrator stated she expected the ice scoop holder in the facility kitchen to be kept clean. 2. During the initial tour of the facility kitchen on 12/05/16 at 9:35 AM a bag of sliced okra was observed in the walk in freezer. The bag was open to air and stored on shelving, ready for use. The Food Service Director was present at the time of the observation and stated he expected bags of food in the walk in freezer to be sealed after they were opened to preserve the integrity of the food product. The Food Service Director stated he was not sure which staff member had left the okra open to air in the walk in freezer. On 12/09/16 at 12:57 PM the Administrator stated she expected food stored in the walk in freezer to be sealed to maintain the integrity of the product. 3. On 12/05/16 at 10:12 AM an automated ice and water dispensing machine was observed on a counter, in a congregate dining/living room within the facility. A clear plastic chute with a white plastic inner sleeve was observed on the dispensing ice portion of the machine. Black spotted matter was observed on the interior portion of the ice chute (which the ice passed through when dispensed). On 12/05/16 at 12:00 PM staff were observed using the ice dispenser	F 371	freezer in the kitchen were inspected. All automated ice and water dispensing machines were inspected. No negative observations were identified. The Food Service Director will be inserviced by the Administrator on the facility's policies for cleaning ice scoop holders and storing leftover frozen foods in the walk-in freezer. The Maintenance Director will be inserviced by the Administrator on the facility's policy for cleaning automated ice and water dispensing machines. All dietary staff will be inserviced by the Food Service Director on the facility's policies for cleaning ice scoop holders and storing leftover frozen foods in the walk-in freezer. A QA monitoring tool will be utilized to ensure ongoing compliance by the Food Service Director. The Food Service Director will review the kitchen cleaning schedule and observe the kitchen ice scoop holders 5 times a week x 4 weeks then weekly x 1 month then randomly x 1 month to ensure that ice scoop holders are clean. The Food Service Director will randomly observe the walk-in freezer in the kitchen 5 times a week x 4 weeks then weekly x 4 weeks then randomly x 1 month to ensure that all items in the freezer are properly stored. A QA monitoring tool will be utilized to ensure ongoing compliance by the Administrator. The Administrator will	

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F 371	Continued From page 31 for beverages served to residents eating in the congregate dining room. On 12/06/16 at 9:13 AM and 12/07/16 at 12:07 PM the ice chute was observed in the same condition as seen on 12/05/16 at 10:12 AM. On 12/07/16 at 5:21 PM a nurse was observed using the ice dispenser to fill a pitcher of water for use during the medication administration. On 12/08/16 at 8:50 AM the Food Service Director stated his department did not clean or service the ice and water dispensing machine located in the congregate dining/living room. On 12/08/16 at 9:00 AM the Maintenance Director stated he began working at the facility about 3-4 weeks prior. The Maintenance Director stated he had a cleaning schedule which showed ice machines were cleaned quarterly, with the last cleaning noted as September 2016. The Maintenance Director stated he did not have any current work orders for the machine and, because he was new, was not aware of any specific cleaning he had to do for the machine outside of changing the filter and cleaning the coils. On 12/08/16 at 9:26 AM the Maintenance Director removed the front cover from the ice and water dispensing machine and the ice dispensing chute was inspected. Black and pink matter were observed on the inner surface of the white inner sleeve which was easily removed with light pressure. A brown substance was observed on the interior surface of the clear plastic chute which was easily removed with light pressure. The Maintenance Director was present when the matter was wiped from the white inner sleeve and clear chute and agreed, it was of concern. On 12/08/16 at 9:50 AM the Housekeeping Director stated her staff wiped the drain of the ice	F 371	observe all automated ice and water dispensing machines weekly x 4 weeks then randomly x 2 months to ensure that automated ice and water dispensing machines are clean. Variances will be corrected at the time of the observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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F 371	Continued From page 32 and water dispensing machine as well as the visible portion of the clear ice dispensing chute. The Housekeeping Director stated if her staff noticed any additional cleaning needs it would have been reported to the Maintenance Director for servicing. The Housekeeping Director stated she had not been aware of any cleaning needs involving the ice and water dispensing machine. On 12/09/16 at 12:57 PM the Administrator stated she was aware the former Maintenance Director signed off on the cleaning schedule noting that the ice machines had last been detailed in September but did not know if the detailing included the interior portion of the ice chute on the automatic ice and water dispensing machine. The Administrator stated if any staff member had noticed the matter on the interior portion of the ice chute she would have expected them to report it to the Maintenance Director for servicing.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interviews, and staff interviews, the facility failed to maintain 2 of 4 hydraulic lifts in working order. This affected 3 residents out of 5 residents observed being transferred via lifts (Residents #67, #159 and #1).	F 465	The facility will continue to ensure that the environment is safe, functional, sanitary, and comfortable for residents, staff, and the public. Residents #67, #159, and #1 had no negative outcome relating to this	1/6/17

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F 465	Continued From page 33 The findings included: 1. Resident #67 was admitted to the facility on 01/24/15. Her diagnoses included coronary artery disease, hypertension, anticoagulant use, chronic kidney disease, and venous embolism. Review of grievances filed by Resident #67 revealed on 11/19/15 she reported that staff were leaving her unattended on the toilet or shower with the lift to get batteries for the lift. Follow up documentation for this grievance revealed that her issue was not being left but that the lift battery had died three times on her when staff used it. The documented resolution was that Resident #67 would immediately report any concerns to the nurse when problems occur. The care guide in the closet, for reference by staff for resident specific care, was noted last revised 08/10/16 and included the use of a sit to stand lift. The most recent Minimum Data Set, a quarterly dated 09/08/16 coded her with moderately impaired cognition, having no mood concerns or behaviors, and requiring extensive assistance of 2 persons for bed mobility, transfers, toileting and dressing. She was coded as being nonambulatory and needed staff assistance to stabilize herself during transitions. On 12/05/16 at 4:18 PM, Resident #67 demanded the surveyor come into the bathroom to see what was happening to her. Resident #67 was observed sitting on the commode with a sling around her. She stated she was stuck on the commode because the lift did not work. Within a minute or two, staff came back to the room with a sit to stand lift, stating it was now fixed.	F 465	observation. Current residents that are transferred via mechanical lift have the potential to be affected. All mechanical lift batteries were inspected. Two batteries were replaced with new ones. Four additional batteries were ordered for backup use. Two additional charging stations were ordered for backup use. No further issues identified. NA#1, NA#2, NA#4, NA#7, and NA#8 will be inserviced by the Administrator on the facility's expectation that they will notify the Administrator or Maintenance Director immediately for needed repair/replacement of mechanical lift batteries. The Maintenance Director will be inserviced by the Administrator on the facility's expectation for the repair/replacement of mechanical lift batteries. All nursing assistants will be inserviced by the Administrator on the facility's expectation that they will notify the Administrator or Maintenance Director immediately for needed repair/replacement of mechanical lift batteries. A QA monitoring tool will be utilized to ensure ongoing compliance by the Maintenance Director. The Maintenance Director will observe all mechanical lift batteries 5x/week x 4 weeks, then weekly	

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F 465	Continued From page 34 On 12/05/16 at 4:53 PM, Resident #67 was interviewed. She stated that using the lift was a struggle because it did not work many times. She stated that 4 to 5 times, it has taken 3 battery changes to get the lift to work during the same transfer. She stated this date they changed the battery 3 times in order to get the lift to work. Observations of the supply room on the 300/400 side of the building on 12/07/16 at 10:57 AM revealed there were 2 chargers for the batteries for the lifts. Observations of the supply room on the 100/200 side of the building on 12/07/16 at 3:05 PM revealed there were 2 chargers for the batteries for the lifts. Interview with Nurse Aide #8 on 12/07/16 at 3:05 PM revealed that there were a total of 4 battery chargers in the building, 2 on each side of the building. The building had 2 sit to stand lifts and 2 total mechanical lifts, one of each type for each side of the building. There was a total of 8 batteries so that each lift would be equipped with a battery while the spare batteries were charging. The Maintenance Director and Administrator were interviewed on 12/09/16 at 10:05 AM. The Maintenance Director has only been working for 4 weeks. There were maintenance requests at each nursing station which staff filled out and he checked them daily and prioritized the work load. In addition, staff made daily rounds to report issues. An interview was conducted with the Administrator on 12/09/16 at 12:30 PM. She	F 465	x 4 weeks then randomly x 1 month to ensure that mechanical lift batteries are functioning properly. Variances will be corrected at the time of the observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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F 465	Continued From page 35	F 465		

stated that the facility had only one sit to stand lift and one total mechanical lift and they had purchased another set so that each side of the building would have access to the lifts. She stated they then purchased another charging station for the lifts and also as of this week ordered 4 more batteries and an additional 2 charging stations. The Administrator also stated that she discovered this week via her phone calls to the lift company that interchanging the batteries between the sit to stand lift and total mechanical lift reduced the life span of the battery. She stated that she discovered issues via the preceptor meetings and had heard of no issues with the lifts until this week..

Review of the invoices with the Administrator on 12/09/16 at 1:07 PM revealed the following purchases:
*10/18/16: 2 lift controllers- which were ordered because the lifts were working intermittently. She stated one controller was replaced this week.
*10/18/16: 1 cable and housing assembly; and
*12/08/16: 4 lift batteries and 2 charging units.
The Administrator stated they ordered the new batteries and chargers after Nurse Aide #2 reported problems with the lift this week.

2. Resident #1 was admitted to the facility on 09/12/08. His diagnoses included closed head injury, seizure disorder, depression, and encephalopathy.

His most recent Minimum Data Set, a quarterly dated 11/14/16, coded him as having unclear speech, rarely or never understanding, being nonambulatory and requiring total assistance of two persons for all activities of daily living skills.

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His care plan for activities of daily living skills last updated 11/25/16 stated he required the use of a mechanical lift by 2 persons.

On 12/07/16 at 10:43 AM, Nurse Aides (NA) #2 and #4 were observed transferring Resident #1 via a total mechanical lift. Once Resident #1 was positioned in the total mechanical lift, staff were unable to get the lift to raise up. Staff then had to disconnect Resident #1 from the lift and obtain another battery for the lift. At the second attempt, the lift worked and Resident #1 was transferred to the gerichair without incident.

Interview with the NAs directly following this observations revealed the batteries for the lifts were all the same size (interchangeable between the total lift and sit to stand lifts). NA #2 stated that he had just put a new battery in the lift this morning. He further stated that night shift was supposed to charge the batteries during the night but if the battery was not in the charger exactly right, the battery would not charge.

Observations of the supply room on the 300/400 side of the building on 12/07/16 at 10:57 AM revealed there were 2 chargers for the batteries for the lifts.

Observations of the supply room on the 100/200 side of the building on 12/07/16 at 3:05 PM revealed there were 2 chargers for the batteries for the lifts.

Interview with Nurse Aide #8 on 12/07/16 at 3:05 PM revealed that there were a total of 4 battery chargers in the building, 2 on each side of the building. The building had 2 sit to stand lifts and

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2 total mechanical lifts, one of each type for each side of the building. There was a total of 8 batteries so that each lift would be equipped with a battery while the spare batteries were charging.

The Maintenance Director and Administrator were interviewed on 12/09/16 at 10:05 AM. The Maintenance Director has only been working for 4 weeks. There were maintenance requests at each nursing station which staff filled out and he checked them daily and prioritized the work load. In addition, staff made daily rounds to report issues.

An interview was conducted with the Administrator on 12/09/16 at 12:30 PM. She stated that the facility had only one sit to stand lift and one total mechanical lift and they had purchased another set so that each side of the building would have access to the lifts. She stated they then purchased another charging station for the lifts and also as of this week ordered 4 more batteries and an additional 2 charging stations. The Administrator also stated that she discovered this week via phone call to the lift manufacturer that interchanging the batteries between the sit to stand lift and total mechanical lift reduced the life span of the battery. She stated that she discovered issues via the preceptor meetings and had heard of no issues with the lifts until this week..

Review of the invoices with the Administrator on 12/09/16 at 1:07 PM revealed the following purchases:
*10/18/16: 2 lift controllers- which were ordered because the lifts were working intermittently. She stated one controller was replaced this week.
*10/18/16: 1 cable and housing assembly; and

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*12/08/16: 4 lift batteries and 2 charging units. The Administrator stated they ordered the new batteries and chargers after Nurse Aide #2 reported problems with the lift this week.

3. Resident #159 was admitted to the facility on 09/10/15. Her diagnoses included seizure disorder, traumatic brain injury, and dysphagia.

Her most recent Minimum Data Set, a quarterly dated 11/22/16 coded her with rarely or never understanding, sometimes being understood and having severely impaired cognition. She required extensive assistance with 2 person for bed mobility and transfers.

An undated care guide in the closet noted she was to be transferred via total mechanical lift.

On 12/07/2016 11:23 AM observations were made of Nurse Aides (NA) #1 and #7 transferring Resident #159 with a total mechanical lift. Staff attached the lift pad to the lift and when they went to lift the resident, the mechanical lift did not move. Staff fiddled with the controls with no success. Staff then unattached the lift sling from the lift and staff had to obtain another battery. Once another battery was obtained, the resident was reconnected to the lift and the transfer into the bed was made. After the transfer, NAs #1 and #7 stated that daily they had trouble with the lift working. They stated sometimes it was the battery and sometimes it was the cord. They stated that sometimes when they reported the problems to maintenance, they would be surprised because the lift just started working without intervention.

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Observations of the supply room on the 300/400 side of the building on 12/07/16 at 10:57 AM revealed there were 2 chargers for the batteries for the lifts.

Observations of the supply room on the 100/200 side of the building on 12/07/16 at 3:05 PM revealed there were 2 chargers for the batteries for the lifts.

Interview with Nurse Aide #8 on 12/07/16 at 3:05 PM revealed that there were a total of 4 battery chargers in the building, 2 on each side of the building. The building had 2 sit to stand lifts and 2 total mechanical lifts, one of each type for each side of the building. There was a total of 8 batteries so that each lift would be equipped with a battery while the spare batteries were charging.

The Maintenance Director and Administrator were interviewed on 12/09/16 at 10:05 AM. The Maintenance Director has only been working for 4 weeks. There were maintenance requests at each nursing station which staff filled out and he checked them daily and prioritized the work load. In addition, staff made daily rounds to report issues.

An interview was conducted with the Administrator on 12/09/16 at 12:30 PM. She stated that the facility had only one sit to stand lift and one total mechanical lift and they purchased another set so that each side of the building would have access to the lifts. She stated they then purchased another charging station for the lifts and also as of this week ordered 4 more batteries and an additional 2 charging stations. The Administrator also stated that she discovered this week via phone call with the lift manufacturer

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F 465	Continued From page 40 that interchanging the batteries between the sit to stand lift and total lift reduced the life span of the battery. She stated that she discovered issues via the preceptor meetings and had heard of no issues with the lifts until this week.. Review of the invoices with the Administrator on 12/09/16 at 1:07 PM revealed the following purchases: *10/18/16: 2 lift controllers- which were ordered because the lifts were working intermittently. She stated one controller was replaced this week. *10/18/16: 1 cable and housing assembly; and *12/08/16: 4 lift batteries and 2 charging units. The Administrator stated they ordered the new batteries and chargers after Nurse Aide #2 reported problems with the lift this week.	F 465		

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F 000	INITIAL COMMENTS On 11/30/16 the Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section completed a complaint investigation at the facility which identified deficient practice without citation. After the 2567 report for the 11/30/16 complaint investigation was provided to the facility, administrative review revealed the deficient practice should have been cited related to an incomplete plan of correction provided by the faciliy. The exit date of this survey was extended to 12/09/16 to coincide with the exit date from the recent recertification survey. Event ID# ZPYY11.	F 000		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, nurse practitioner, and medical director interviews the facility failed to administer Oxycodone (narcotic pain reliever) as ordered for 1 of 3 residents reviewed for significant medication errors (Resident #2). Findings included: Resident #2 was admitted to the facility on 11/16/16 with diagnoses that included end stage renal disease and peripheral arterial disease. Review of the physician's orders for Resident #2 revealed an order dated 11/22/16 for Oxycodone liquid 20 milligram (mg)/milliliter (ml) 0.25 mg (5mg) 4 times a day scheduled and every 4 hours as needed for pain and dyspnea. Review of the medication administration record	F 333	The facility will continue to ensure that residents are free from any significant medication errors. Resident #2 no longer resides at the facility. No negative outcome was identified relating to this observation. Current residents with physician ordered liquid narcotics have the potential to be affected. Medication Administration Records and Pharmacy Medication Sheets for current residents with physician ordered liquid narcotics were audited and no further discrepancies were identified.	1/6/17

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

Electronically Signed | 12/05/2016

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F 333	Continued From page 1 revealed Resident #2 was scheduled to receive 0.25 cubic centimeters (cc) (5mg) of oxycodone at 9:00 AM, 12:00 PM, 4:00 PM, and 10:00 PM for pain. Review of the Pharmacy Medication Sheet (PMS) revealed Resident #2 received 2.5 cc (instead of 0.25 cc as ordered) of oxycodone on 11/22/16 at 9:25 PM administered by Nurse #1. Further review of the PMS revealed Resident #2 received 0.25 cc of oxycodone on 11/23/16 at 9:00 AM and 12:00 PM administered by Nurse #2. An interview was conducted with the Medical Director (MD) on 11/30/16 at 8:45 AM who revealed Resident #2's health was fragile due to end stage renal disease and heart disease. The MD explained when a medication dosage error occurred, he would expect for staff to notify him or the Nurse Practitioner (NP) of the error. The MD added if a resident displayed respiratory distress after a medication dosage error, he would instruct staff to send the resident to the hospital for evaluation but if the resident was lethargic (sleepy) he would instruct staff to monitor and report any abnormal vital signs or trouble breathing. The MD stated Resident #2 had displayed no signs of respiratory distress. Nurse #1 was unavailable for an interview. An interview was conducted with Nurse #2 on 11/30/16 at 11:10 AM who revealed she had discovered the medication dosage error from 11/22/16 after she had given Resident #2 the 12:00 PM scheduled dose of oxycodone and had immediately informed the Director of Nursing (DON) and NP. Nurse #2 added she had received orders from the NP to hold the next 2 scheduled doses of oxycodone for Resident #2 and to notify the NP of any change in his vitals. An interview was conducted with the NP on11/30/16 at 12:23 PM who confirmed he had	F 333	Nurse #1 and Nurse #2 will be inserviced by the DON on the facility's policy for administering liquid narcotics. All nurses will be inserviced by the DON on the facility's policy for administering liquid narcotics. A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager. The Unit Manager will randomly audit Pharmacy Medication Sheets for liquid narcotics 5 times a week x 2 weeks then 3 times a week x 2 weeks then weekly x 1 month then randomly x 1 month to ensure that liquid narcotics are being administered per physician orders. Variances will be corrected at the time of the audit and additional education provided when indicated. Audit results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits of Pharmacy Medication Sheets and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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been notified by Nurse #2 on 11/23/16 of the medication dosage error administered to Resident #2 on 11/22/16. The NP stated he had instructed Nurse #2 to hold the next two scheduled doses of oxycodone, monitor Resident #2 ' s vitals and respiration and to inform him of any changes. The NP explained "Resident #2 was not doing very well medically and was progressively going downhill due to comorbidities (presence of two or more chronic diseases) prior to the medication dosage error."

An interview was conducted on 11/30/16 at 3:56 PM with the DON who stated when a medication error was discovered she would expect for staff to notify her and the MD or NP. The DON confirmed she had been notified by Nurse #2 on 11/23/16 of the medication dosage error administered to Resident #2 on 11/22/16 and investigated the incident. The DON explained Nurse #1 had misread the dosage instructions on the label and had administered the incorrect dose of oxycodone to Resident #2 on 11/22/16 at 9:25 PM. The DON added the error had not been discovered until after Nurse #2 had administered the scheduled dose of oxycodone at 12:00 PM on 11/23/16. The DON discussed the medication error with the NP who felt there had been no lasting effects due to the medication dosage error other than Resident #2 being sleepy.