STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345415	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE REHABILITATION AND LIVING CTR	1010 LAKEVIEW DRIVE PINEVILLE, NC 28134

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F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to honor food choices for 1 of 3 sampled residents (Resident #67). The findings included: Review of Resident #67's quarterly Minimum Data Set dated 03/27/17 revealed an assessment of intact cognition. Review of Resident #67's dietary slip on the breakfast meal of 05/31/17 revealed Resident #67 was not to be served fried foods, fruit cocktail, green beans, okra, peaches, squash, strawberries, zucchini and tomatoes. Interview with Resident #67 on 05/31/17 at 8:59 AM revealed his meals frequently contained tomatoes which he did not like. Resident #67	F 242	Resident # 67 food likes and dislikes were updated as of 6/5/17. All other resident□s food likes and dislikes were updated by the Dietary Manager or the Registered Dietician as of 6/6/17 and tray card is updated to reflect choices. 100% of Dietary staff have been re-educated by the Dietary Manager regarding the need to honor food preferences as of 6/19/17. All newly hired Dietary staff will be educated at the time of hire on the importance of resident choices with regard to food choices. The Dietary Manager will audit 5 trays per week for accuracy to include food	6/19/17

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

Electronically Signed | 06/19/2017

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F 242	Continued From page 1 pointed to two tomato slices on a napkin. Resident #67 explained the tomatoes came from a sandwich served on 05/30/17. Resident #67 explained he complained to the kitchen staff "4 or 5 months ago" but tomatoes continued to be served. Resident #67 reported the continued serving of tomatoes indicated the facility did not care. Observation of Resident #67's lunch meal, delivered by Nurse Aide (NA) #1, on 06/01/17 at 12:51 PM revealed Resident #67 received a sandwich. The sandwich contained 2 tomato slices. Resident #67 explained he ordered sandwiches frequently since he did not usually like the main entrée. Resident #67 removed the tomato slices and threw them into the trash can. Interview with NA #1 on 06/01/17 at 12:58 PM revealed she did not notice the tomato slices on the sandwich. NA #1 explained the kitchen staff were responsible for honoring Resident #67's food choices. Observation of Resident #67's supper meal on 06/01/17 at 6:26 PM revealed Resident #67 received strawberries. Resident #67 reported he did not like strawberries and pointed to the dietary slip which listed a strawberry dislike. Interview with the dietary manager (DM) on 06/02/17 at 9:38 AM revealed he did not recall if Resident #67 reported the frequent serving of tomatoes. The DM explained the cook should follow the direction on Resident #67's dietary slip and not serve tomatoes and strawberries. Interview with the interim Director of Nursing (DON) on 06/02/17 at 9:49 AM revealed she	F 242	preferences honored with report on his findings weekly to the administrator x one month The Dietary Manager will report these findings to the QA&A committee quarterly x one year. The QA&A committee will evaluate the effectiveness of the plan and make changes to the plan as needed.	

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F 242	Continued From page 2 expected nursing staff to read the diet slip and not deliver meals which contained a dislike.	F 242		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279		6/19/17

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F 279	Continued From page 3 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to develop a comprehensive care plan which included specific and individualized approaches for 1 of 4 sampled residents at risk for weight loss (Resident #49). The findings included: Resident #49 was admitted to the facility on 04/04/06 with diagnoses which included dementia and osteoarthritis. Review of Resident #49's annual Minimum Data	F 279	The nutritional care plan for resident # 49 was evaluated and updated as of 6/5/17 to reflect current interventions All care plans for residents at nutritional risk were reviewed by the Registered Dietician and interventions were evaluated and updated by 6/6/17. The Dietary Manager or Registered Dietician will initiate a care plan for any resident who has been deemed to be at nutritional risk including new admissions.	

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F 279	Continued From page 4 Set (MDS) dated 12/16/16 revealed an assessment of severely impaired cognition. The MDS indicated Resident #49 ate independently after set up, received a mechanically altered diet with no significant weight loss or gain. Review of Resident #67's Nutritional Status Care Area Assessment (CAA) dated 12/28/16 revealed the registered dietician (RD) documented Resident #49's weight of 82 pounds on 12/13/16 reflected a weight loss of 5.7% in the past 6 months with a BMI (Body Mass Index) below normal range at 15.5. (BMI is a measure of body fat based on weight and height; under 18.5 is considered underweight as defined by the National Institute of Health.) The RD documented Resident #49 received a frozen nutritional supplement which provided an additional 580 kilocalories and 18 grams of protein twice daily. The CAA indicated a gradual weight gain was desirable. Review of a RD's note dated 12/28/16 revealed Resident #49's weight, intake and acceptance of supplement should be monitored. Review of Resident #49's care plan dated 12/28/16 revealed a goal of weight maintenance. Interventions included delivery of diet with weight and intake monitoring. There was no documentation of nutritional supplements. Review of Resident #49's dietary slip revealed direction to serve a grilled cheese sandwich and frozen nutritional supplement with lunch and dinner meals. Observation on 06/01/17 from 1:01 PM to 1:27 PM revealed Resident #49's lunch meal did not	F 279	The Dietary Manager or Registered Dietician will update the care plan each time a goal or intervention has changed with new goal or updated interventions. The Dietary Manager was re-educated regarding the importance of an individualized and up-dated care plan for residents at nutritional risk on 6/14/17 by the Nurse Manager. The MDS Coordinator will audit five care plans for residents at nutritional risk per week for correct and relevant interventions x one month with report to the QA&A committee monthly x one month, then five care plans per month with report to the QA&A committee quarterly x 4 quarters. The QA&A committee will evaluate the effectiveness of the plan and make changes as indicated.	

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F 279	Continued From page 5	F 279		

contain a frozen nutritional supplement. Resident #49 consumed 100% of a grilled cheese sandwich.

Interview with Nurse Aide (NA) #3 on 06/01/17 at 1:31 PM revealed Resident #49 ate grilled cheese sandwiches frequently. NA #3 explained she was assigned monitoring of the main dining room and did not notice if Resident #49 received a frozen nutritional supplement.

Interview with the dietary manager (DM) on 06/02/17 at 9:31 AM revealed Resident #49 should receive a frozen nutritional supplement with the lunch and supper meals. The DM explained the grilled cheese sandwich was added after a meeting with Resident #49's family member. The DM reported development of the care plan was shared with the registered dietician. The DM reported the interventions of the frozen nutritional supplements and grilled cheese should be listed on the care plan.

Interview with the interim Director of Nursing (DON) on 06/02/17 at 9:50 AM revealed she expected Resident #49's care plan interventions for weight loss to be specific and individualized.

Interview with MDS nurse #1 on 06/02/17 at 2:03 PM revealed either the DM or RD developed nutritional care plans for residents.

Telephone interview with the RD on 06/02/17 at 2:20 PM revealed Resident #49's care plan should include the interventions of the frozen nutritional supplement and grilled cheese. The RD explained she assisted the DM with care plan development.

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F 309	Continued From page 6	F 309		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		6/19/17

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F 309	Continued From page 7 Based on observation, resident/staff/pharmacist/nurse practitioner interviews and medical record review the facility failed to administer pain medication to 1 of 3 sampled residents reviewed for pain. (Resident #96) The findings included: Resident #96 was admitted to the facility 07/31/16 with diagnoses which included hemiplegia affecting right dominant side, muscle spasms and right shoulder repair. The quarterly Minimum Data Set dated 05/04/17 assessed Resident #96 with mild cognitive impairment and taking scheduled pain medication. The current care plan for Resident #96 included a problem area initiated 06/01/17 noting, Resident #96 has limited physical mobility related to stroke, weakness. Approaches to this problem area included physical therapy, occupational therapy referrals as ordered. Physician/nurse practitioner progress notes in the medical record of Resident #96 included the following: 04/27/17-The physician assessed Resident #96 and noted a history of right shoulder repair. The physician noted Resident #96 reported pain in his right shoulder with discomfort with palpation of the right shoulder as well as decreased range of motion. The physician noted it seemed consistent with impingement syndrome (rotator cuff pinched between the humerus and the scapula.) The physician noted Resident #96 had weakness of his right lower extremity and joint	F 309	Resident #96's tramadol was obtained and resident was medicated per physician's order as of 5/31/17 with resident stating "The pain is gone". An audit of all pain medications was completed as of 5/31/17 to ensure that all prescribed pain medications were available. An Audit of 100% of residents was completed by the West Unit Nursing Coordinator, the East Unit Nursing Coordinator, the Nurse Manager and the Second Shift Supervisor to ensure that pain management was effective as of 5/31/17. 100% of scheduled nurses were re-educated as of 6/19/17 by the Pharmacy Manager related to the importance of the following: Pain assessments Availability of pain medications System for reordering pain medications Steps to take when medications are not available, such as Pixis machine, back up pharmacy Steps to take when the Pixis machine is not in working order or the medication is not in the Pixis, utilization of back up pharmacy Nurses that were unavailable for re-education will not allowed to pass medications or work at facility until the education is completed. All newly hired nurses will be educated	

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F 309	Continued From page 8 contracture of the right upper extremity. The physician assessed Resident #96 as able to voice/express concerns though there was evidence of cognitive impairment. Due to the right shoulder pain on 04/27/17 the physician ordered Lidoderm patch and an X-ray of the right shoulder. 05/30/17-The nurse practitioner assessed Resident #96 for right shoulder pain. The nurse practitioner noted Resident #96 was seen for evaluation of pain to the right side; noting he had issues with osteoarthritis of the right joint and generalized discomfort to the right side since his stroke. The nurse practitioner assessed Resident #96 as alert and oriented X 2. Review of current physician orders in the medical record of Resident #96 noted the following medications were ordered: -Tramadol HCL 50 milligrams every 8 hours for moderate to moderately severe pain. Tramadol was scheduled to be given at 12:00 AM, 8:00 AM and 4:00 PM. -Baclofen 5 milligrams as needed twice a day for muscle spasticity. -Lidoderm patch right shoulder every day,12 hours on, 12 hours off. In addition, Resident #96 had physician orders for occupational therapy to evaluate and treat from 01/31/17-04/05/17. Review of the X-ray results from 04/28/17 for Resident #96 noted a humeral prosthesis, mild degenerative joint disease of the right shoulder; otherwise, no fracture, separation or dislocation was seen. Review of occupational therapy documentation in the medical record of Resident #96 noted the	F 309	regarding the following at the time of hire. Pain assessments Availability of pain medications System for reordering pain medications Steps to take when medications are not available, such as Pixis machine, back up pharmacy Steps to take when the Pixis machine is not in working order or the medication was not in the Pixis, utilization of back up pharmacy The Director of Nursing, West Unit Nursing Coordinator,the East Unit Nursing Coordinator or the Second Shift Supervisor will report on new pain medication orders daily and validate that the medications are available during the facilities morning meeting. The Director of Nursing or the East Unit Nursing Coordinator or the West Unit Nursing Coordinator or the Second Shift Nursing supervisor will audit 5 residents per week to ensure the availability of pain medications including new admissions as well as the effectiveness of the pain management regime. These audits will be performed weekly x one month with report to the QA&A committee monthly x 1 year. The QA&A committee will evaluate these findings to determine the effectiveness of the plan and make changes as needed.	

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F 309	Continued From page 9 following: 01/31/17-Resident #96 was screened by the occupational therapist (OT) and noted with complaints of pain in his right shoulder which was rated as an 8 on a scale of 1-10 (with 10 being severe pain). The OT noted Resident #96 stated he had the pain for an extended period of time and the OT felt it was due to impaired strength and range of motion related to the stroke. The OT noted the pain impaired Resident #96's ability to perform mobility tasks and skilled therapy was necessary to improve functional abilities. Goals set by the OT included: -Resident #96 will report decreased pain in right shoulder with a goal for no pain at rest in order to perform transfers. At the end of therapy on 04/05/17 the OT noted progress as follows: -At the start of therapy on 01/31/17 Resident #96 reported his right shoulder pain as severe. At the end of therapy Resident #96 reported his right shoulder pain as a 4 on a scale of 1-10 (with 10 being severe pain.) On 05/31/17 at 9:11 AM Resident #96 was observed laying in bed. Resident #96 stated he was in a lot of pain and stated he had not received his morning dose of Tramadol. In addition, Resident #96 stated he missed his Tramadol the day prior and was told they were out of Tramadol. Review of the May 2017 Medication Administration Record (MAR) for Resident #96 noted the 8:00 AM dose of Tramadol had not been documented as given that morning. The 4:00 PM dose of Tramadol on 05/30/17 was documented as "not given" by Nurse #5 due to "medication not available." The 12:00 AM dose	F 309		

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F 309	Continued From page 10 on 05/31/17 was documented as administered to Resident #96 by Nurse # 6. On 05/31/17 at 9:26 AM Nurse #3 (assigned to work with Resident #96 on 05/31/17 from 7:00 AM-3:00 PM) stated she had not given morning medications yet to Resident #96. Nurse #3 was asked specifically about the availability of the Tramadol for Resident #96. Nurse #3 opened the locked narcotic box and stated there was no Tramadol available to give to Resident #96. Nurse #3 stated she would ask another staff nurse to obtain a Tramadol for Resident #96 from the Pyxis MedStation (an automated medication dispensing system). On 05/31/17 at 10:15 AM Nurse #4 (the unit supervisor) stated the Pyxis MedStation was not operating and, as a result, Tramadol was not readily accessible to administer to Resident #96. Nurse #4 stated because Tramadol was a narcotic it required a written prescription for re-ordering. Nurse #4 stated each nurse was responsible for checking when a residents narcotic medication was "getting low" so the physician or nurse practitioner could be notified and a prescription written. Nurse #4 stated if the medication wasn't available staff should obtain it from the Pyxis MedStation. Nurse #4 stated she did not know how long the Pyxis MedStation had not been working. The Nurse Practitioner (NP) was present at the time of the interview and recalled she had just assessed Resident #96 for continued need of the Tramadol and written a prescription. The NP looked at her notes and verified she had seen Resident #96 on 05/30/17 and wrote the prescription for the Tramadol. The NP stated she would have expected the Tramadol to be delivered from the pharmacy on 05/30/17	F 309		

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F 309	Continued From page 11 for administration to Resident #96. On 05/31/17 at 10:40 AM the Controlled Drug Record for the Tramadol for Resident #96 was requested from Nurse #3. At the time of the request the NP was overheard talking to Nurse #3 about her (the NP's) assessment of Resident #96's pain that morning and the NP recommended giving the Baclofen for muscle spasms until the Tramadol arrived at the facility for administration. Review of the Controlled Drug Record for Resident #96 on 05/31/17 at 10:43 AM noted the last dose of Tramadol was documented and signed as given on 05/30/17 at 9:00 AM. On 05/31/17 at 10:45 AM a phone interview was done with Nurse #6. Nurse #6 reported she had worked with Resident #96 on 05/30/17 from 11:00 PM until 05/31/17 at 7:00 AM. Nurse #6 stated she recalled giving several residents Tramadol during her shift but couldn't recall any specifics regarding Resident #96. Nurse #6 stated if she gave Tramadol to Resident #96 she would have recorded it on the Controlled Drug Record. Nurse #6 stated she would not have borrowed the Tramadol for Resident #96 because they would never borrow a narcotic. Nurse #6 was informed the last dose of Tramadol signed out for Resident #96 was 05/30/17 at 9:00 AM. Nurse #6 reported she was having a lot of computer issues during her shift and stated there was a possibility she signed off for the medication but did not give it. On 05/31/17 at 10:59 AM Resident #96 stated he still had not received the Tramadol and he felt like his arm was pulling and his pain was a 10 on a scale of 1-10 (with 10 being severe pain.) On	F 309		

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F 309	Continued From page 12 05/31/17 at 12:00 PM Resident #96 reported he still had not received his Tramadol. On 05/31/17 at 12:13 PM Nurse #3 stated she had not given Resident #96 the 8:00 AM dose of Tramadol or the Baclofen (as suggested by the NP at 10:40 AM). Nurse #3 stated it was her understanding from the NP that Resident #96 wasn't in pain but had muscle tightness. Nurse #3 offered to go to the room of Resident #96 to verify this. Nurse #3 entered the room of Resident #96 and asked him if he was going to get out of bed to eat lunch. Resident #96 stated he was hurting too much to get out of bed or eat and was waiting for his medication. Nurse #3 stated to Resident #96 that the NP had assessed him that morning and he was having muscle tightness, not pain. Resident #96 responded, no, I am hurting. Nurse #3 asked Resident #96 what his pain level was and Resident #96 replied "10". Nurse #3 returned to her medication cart and produced a paper where she documented the report from the NP (at approximately 10:40 AM) which noted no pain, muscle tightness and given Baclofen. Nurse #3 was asked if she had given the Baclofen to Resident #96 and she reported no, she was planning on doing that. On 05/31/17 at 12:15 PM the interim Director of Nursing was asked if the Pyxis MedStation was operating and she reported it "went up" at 11:24 AM. The interim Director of Nursing was asked if the Tramadol had been taken out of the Pyxis for administration to Resident #96 and she responded, not yet. On 05/31/17 at approximately 12:20 PM Nurse #3 reported she gave Resident #96 the (8:00 AM scheduled) Tramadol.	F 309		

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F 309	Continued From page 13 On 05/31/17 at 12:30 PM the administrator stated she was aware Resident #96 had missed several doses of Tramadol and agreed it was a concern. The administrator stated they were going to audit all narcotics for residents to ensure medication was available to be given to residents as ordered. On 05/31/17 at 12:45 PM a phone interview was done with the NP. The NP stated she assessed Resident #96 on 05/30/17 prior to writing the prescription for the Tramadol. The NP stated she felt the Tramadol was warranted for Resident #96. The NP stated she did assess Resident #96 that morning (around 10:40 AM) and asked him to describe his pain. The NP stated Resident #96 reported his right arm felt "tight." The NP stated she felt the right bicep of Resident #96 as well as his right calf and noted his muscles were tight. The NP stated she massaged the right bicep and right calf of Resident #96 and Resident #96 reported a little relief from pain. The NP stated she told Resident #96 she would have Nurse #3 give him the Baclofen until the Tramadol arrived to see if it would relieve his muscle pain. The NP stated she discussed this with Nurse #3 and told her to give the Baclofen while awaiting the Tramadol. The NP stated she would have expected the Baclofen to be given within 30 minutes of their discussion. On 05/31/17 at 2:20 PM in a follow-up interview Nurse #3 stated she got "caught up in a lot of things" that morning which was why the Baclofen was not given to Resident #96 from 10:40 AM until brought to her attention at 12:13 PM. Nurse #3 stated she later went back and checked on Resident #96 after he received the Tramadol and Baclofen and he reported his pain had gone from a "10" to a "1".	F 309		

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F 309	Continued From page 14 On 06/01/17 at 11:35 AM in a phone interview Nurse #5 verified she worked with Resident #96 on 05/30/17 from 3:00 PM-11:00 PM. Nurse #5 stated she recalled the Tramadol was not available to be given to Resident #96. Nurse #5 stated she asked another nurse with access rights to the Pyxis MedStation to obtain a Tramadol for Resident #96. Nurse #5 stated this nurse told her the Pyxis MedStation wasn't working which was why she charted the 4:00 dose of Tramadol wasn't available on the MAR of Resident #96 on 05/30/17. On 06/01/17 at 1:25 PM the OT that treated Resident #96 from 01/31/17-04/05/17 was interviewed. The OT reported when she screened Resident #96 on 01/31/17 he complained of right shoulder pain. The OT stated she felt the pain was related to his stroke and immobility of his right side. The OT stated Resident #96 understood the 1-10 pain scale and was able to report his pain using this scale. The OT explained that though Resident #96 could not always give the exact date she felt he answered questions appropriately, including whether he was in pain. The OT stated at the beginning of therapy on 01/31/17 Resident #96 described his pain level as severe. The OT stated various modalities were used to treat the pain of Resident #96 which included heat packs, exercise and electrical stimulation. The OT stated at the end of treatment on 04/05/17 Resident #96 described his pain as a 4 out of 10. The OT stated she knew nursing staff were providing pain medication and there were no OT recommendations for pain management at the end of his therapy on 04/05/17. The OT stated Resident #96 was discharged from therapy on	F 309		

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04/05/17 with the goal for no pain in the right shoulder at rest not met due to Resident's #96's report of a 4 out of 10 pain level.

On 06/02/17 at 1:25 PM the consultant pharmacist stated his expectation was for residents to receive medications as ordered by the physician, especially medications for pain management. The consultant pharmacist stated he wasn't aware of any issues with medications not being available to be administered to residents at the facility. When asked specifically about Tramadol the consultant pharmacist stated because it was a narcotic it was a little more involved in the ordering process as well as obtaining from the Pyxis MedStation.

On 06/02/17 at 1:33 PM a pharmacist at the dispensing pharmacy pulled up the records of Resident #96 and noted the 05/30/17 prescription for Tramadol for Resident #96 had not been Fax'd to the pharmacy until 05/31/17 at 9:34 AM. The pharmacist stated the prescription had been filled the morning of 05/31/17 and sent to the facility on the 12:30 PM delivery.

On 06/02/17 from 3:15 PM-4:00 PM the interim Director of Nursing (DON) was interviewed about the availability of Tramadol for Resident #96. The interim DON stated the facility had a form called the Narcotic Tuesday form which staff utilized to document any residents in need of a prescription for narcotic refill. The interim DON stated all nurses were responsible for looking at the quantity of medications left for residents and either informing the physician or nurse practitioner or documenting on the Narcotic Tuesday sheet any resident needs for narcotic refills. The interim DON stated typically nurses

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F 309	Continued From page 16 would physically report the need to the physician or nurse practitioner if they were present in the building. The interim DON stated the nurses would document needs on the Narcotic Tuesday sheet if the physician or nurse practitioner were not in the building for them to address when they were present. The interim DON stated there were no set parameters for staff to go by (like a certain number of medications remaining), just when the need was seen. The interim DON explained the name of the sheet (Narcotic Tuesday) had nothing to do when the need for a prescription would be written. The interim DON verified it appeared Resident #96 went from 9:00 AM on 05/30/17 until 12:20 PM on 05/31/17 without Tramadol. The interim DON stated it appeared Resident #96 missed the 4:00 PM dose on 05/30/17, the 12:00 AM dose on 05/31/17 and the 8:00 AM dose on 05/31/17 was over four hours late. The interim DON could not explain why the prescription for Tramadol had not been Fax'd to the pharmacy until it was brought to the facility's attention. The interim DON stated she did not know who Fax'd the prescription to the pharmacy on 05/31/17 at 9:34 AM. The interim DON stated if the medication was not available nursing staff should access the medication from the Pyxis MedStation. The interim DON stated she did not know the Pyxis was down the evening of 05/30/17 and wasn't aware it was down the morning of 05/31/17 until Nurse #4 attempted to access it for the Tramadol for Resident #96. The interim DON stated they currently did not have a second shift nursing supervisor but she was available 24 hours and could have been called on 05/30/17. The interim DON stated the pharmacy was available 24/7 for Pyxis support. The interim DON stated if a medication was not available she expected staff to access the Pyxis MedStation.	F 309		

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F 309	Continued From page 17 The interim DON stated if the Pyxis MedStation was down she expected a supervisor or herself to be notified. The interim DON stated the back-up pharmacy was also available until approximately 9:00 PM. The interim DON stated staff should not borrow narcotics. The interim DON was told of the approximate 1 1/2 hour delay in giving Baclofen to Resident #96 on 05/31/17 (while awaiting the Tramadol) and the DON stated she would have expected it to be given sooner. On 06/02/17 at 4:15 PM the administrator stated she expected medications to be available and given as ordered by the physician. The administrator stated there was a system failure that resulted in Tramadol not being given to Resident #96 as ordered.	F 309		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 325		6/19/17

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F 325	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, staff and nurse practitioner interviews, and record review, the facility failed to provide a nutritional supplement for 1 of 4 sampled residents at risk for weight loss (Resident #49). The findings included: Resident #49 was admitted to the facility on 04/04/06 with diagnoses which included dementia and osteoarthritis. Review of physician's orders dated 12/12/16 revealed Resident #49 should receive a frozen nutritional supplement twice daily with the lunch and dinner meals. Review of Resident #49's annual Minimum Data Set (MDS) dated 12/16/16 revealed an assessment of severely impaired cognition. The MDS indicated Resident #49 ate independently after set up and received a mechanically altered diet with no significant weight loss or gain. Review of Resident #67's Nutritional Status Care Area Assessment (CAA) dated 12/28/16 revealed the registered dietician (RD) documented Resident #49's weight of 82 pounds on 12/13/16 reflected a weight loss of 5.7% in the past 6 months with a BMI (Body Mass Index) below normal range at 15.5. (BMI is a measure of body fat based on weight and height; under 18.5 is considered underweight as defined by the National Institute of Health.) The RD documented Resident #49 received a frozen nutritional supplement which provided an additional 580 kilocalories and 18 grams of	F 325	Resident # 49 was given the ordered supplement as of 6/2/17. An audit of all residents with ordered nutritional supplements was completed by the Registered Dietician as of 6/6/17 to ensure that they are receiving nutritional supplements per physician's order. The Dietary Manager will review new supplement orders daily to ensure that they are reflected on the MAR or tray card and report on new supplements, including new admissions during the facility morning meeting. All Dietary and Nursing staff were re-educated regarding the importance of providing nutritional supplements as ordered as of 6/19/17. Dietary and Nursing staff who were unavailable for the re-education will not be allowed to work until the education is complete. Newly hired Dietary and Nursing staff will be educated regarding the importance of receiving nutritional supplements at the time of hire. The DON, The West Unit Nursing Coordinator or the East Unit Nursing Coordinator will audit 5 residents per week on the administration of nutritional supplements x one month with report to the administrator weekly.	

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F 325	Continued From page 19 protein twice daily. The CAA indicated a gradual weight gain was desirable. Review of a RD's note dated 12/28/16 revealed Resident #49's weight, intake and acceptance of supplement should be monitored. Review of Resident #49's care plan dated 12/28/16 revealed a goal of weight maintenance. Interventions included delivery of diet with weight and intake monitoring. Review of Resident #49's quarterly MDS dated 02/20/17 revealed an assessment of severely impaired cognition. The MDS indicated Resident #49 ate independently after set-up with no significant weight loss. Review of Resident #49's weight measurements revealed the following: 83 pounds (lbs.) on 01/04/17, 83 lbs. on 02/03/17, 81 lbs. on 03/07/17, 04/08/17 and on 05/05/17. Review of Resident #49's electronic Medication Administration Record (eMAR) revealed documentation of frozen nutritional acceptance at the lunch and dinner meals from 05/30/17 to 06/01/17. Observation on 05/30/17 from 1:05 PM to 1:40 PM revealed Resident #49's lunch meal did not contain a frozen nutritional supplement. Resident #49's dietary slip on the meal tray indicated a frozen nutritional supplement should be served with the lunch meal. Resident #49 consumed 75% of the lunch meal. At 1:41 PM, Resident #49 left the dining room without receipt of a frozen nutritional supplement.	F 325	The DON will report monthly on the results of these audits once per month x one month, once per quarter x 11 months. The QA&A committee will evaluate the findings of these audits and evaluate the effectiveness of the plan and make changes as indicated.	

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F 325	Continued From page 20 Observation on 06/01/17 from 1:01 PM to 1:27 PM revealed Resident #49's lunch meal did not contain a frozen nutritional supplement. Resident #49's dietary slip on the meal tray indicated a frozen nutritional supplement should be served with the lunch meal. Resident #49 consumed 50 % of the lunch meal. At 1:30 PM, Resident #49 left the dining room without receipt of a frozen nutritional supplement. Interview with Nurse Aide (NA) #3 on 06/01/17 at 1:31 PM revealed the dietary department provided frozen nutritional supplements on the meal trays. NA #3 explained she was assigned monitoring of the main dining room and did not notice if Resident #49 received a frozen nutritional supplement. Interview with Nurse #2 on 06/01/17 at 4:21 PM revealed she relied on nursing staff assigned to the dining room to report consumption of meals and frozen nutritional supplements. Nurse #2 could not recall if Resident #49 received or consumed a frozen nutritional supplement. Nurse #2 explained she did not routinely monitor meals taken in the main dining room. Nurse #2 reported she documented acceptance of the frozen nutritional supplement on the eMAR but did not verify receipt of the supplement. Observation on 06/01/17 at 6:24 PM revealed Resident #49's dinner meal did not contain a frozen nutritional supplement. Resident #49's dietary slip on the meal tray indicated a frozen nutritional sweet supplement should be served with the dinner meal. Interview on 06/02/17 at 8:46 AM with NA # 2 revealed Resident #49 was her assigned resident	F 325		

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F 325	Continued From page 21 on 06/01/17. NA #2 reported she did not observe Resident #49 during lunch meal and relied on staff in the dining room to monitor receipt and consumption of meals. Interview with the dietary manager (DM) on 06/02/17 at 9:31 AM revealed Resident #49 should receive a frozen nutritional supplement with the lunch and supper meals. The DM explained staff should follow the guidance on the dietary slip and check compliance prior to meal delivery. Interview with the nurse practitioner on 06/02/17 at 9:47 AM revealed she expected Resident #49 to receive a frozen nutritional supplement twice daily as ordered. Interview with the interim Director of Nursing (DON) on 06/02/17 at 9:50 AM revealed she expected Resident #49 to receive the ordered frozen nutritional supplements. The interim DON reported she expected nursing staff to obtain the frozen nutritional supplement if omitted by the dietary department. A second interview with interim DON on 06/02/17 at 11:21 AM revealed Resident #49 weighed 82 lbs. on 06/02/17. Telephone interview with the registered dietician (RD) on 06/02/17 at 2:20 PM revealed Resident #49 should be offered a frozen nutritional supplement with the lunch and supper meals. The RD explained Resident #49's supplement consumption was an important intervention in weight maintenance and nutritional status.	F 325		
F 333	483.45(f)(2) RESIDENTS FREE OF	F 333		6/19/17

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F 333 SS=G	Continued From page 22 SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, resident/staff/pharmacist/nurse practitioner interviews and medical record review the facility failed to administer pain medication as ordered by the physician for 1 of 3 sampled residents reviewed for pain management. (Resident #96) The findings included: Resident #96 was admitted to the facility 07/31/16 with diagnoses which included hemiplegia affecting right dominant side, muscle spasms and right shoulder repair. The quarterly Minimum Data Set dated 05/04/17 assessed Resident #96 with mild cognitive impairment and taking scheduled pain medication. Physician/nurse practitioner progress notes in the medical record of Resident #96 included the following: 04/27/17-The physician assessed Resident #96 and noted a history of right shoulder repair. The physician noted Resident #96 reported pain in his right shoulder with discomfort with palpation of the right shoulder as well as decreased range of motion. The physician noted it seemed consistent with impingement syndrome (rotator	F 333	Resident #96's tramadol was obtained and resident was medicated per physician's order as of An audit of all residents with ordered pain medications was completed by the West Unit Nursing Coordinator, East Unit Nursing Coordinator and the Second Shift Supervisor as of 5/31/17 to ensure that all prescribed pain medications were available. All available nurses were re-educated related to the importance of the following: Pain assessments Availability of pain medications System for reordering pain medications Steps to take when medications are not available, such as Pixis machine, back up pharmacy Steps to take if the Pixis machine is not in working order or the medication is not in the Pixis, utilization of back up pharmacy Nurses that were unavailable for re-education will not be allowed to pass medications or work at facility until the education is completed.	

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F 333	Continued From page 23 cuff pinched between the humerus and the scapula.) Due to the right shoulder pain on 04/27/17 the physician ordered Lidoderm patch and an X-ray of the right shoulder. 05/30/17-The nurse practitioner assessed Resident #96 for right shoulder pain. The nurse practitioner noted Resident #96 was seen for evaluation of pain to the right side; noting he had issues with osteoarthritis of the right joint and generalized discomfort to the right side since his stroke. The nurse practitioner assessed Resident #96 as alert and oriented X 2. Review of current physician orders in the medical record of Resident #96 noted the following medications were ordered: -Tramadol HCL 50 milligrams every 8 hours for moderate to moderately severe pain. Tramadol was scheduled to be given at 12:00 AM, 8:00 AM and 4:00 PM. -Baclofen 5 milligrams as needed twice a day for muscle spasticity. -Lidoderm patch right shoulder every day,12 hours on, 12 hours off. Review of the X-ray results from 04/28/17 for Resident #96 noted a humeral prosthesis, mild degenerative joint disease of the right shoulder; otherwise, no fracture, separation or dislocation was seen. On 05/31/17 at 9:11 AM Resident #96 was observed laying in bed. Resident #96 stated he was in a lot of pain and stated he had not received his morning dose of Tramadol. In addition, Resident #96 stated he missed his Tramadol the day prior and was told they were out of Tramadol.	F 333	All newly hired nurses will be educated regarding the following at the time of hire. Pain assessments Availability of pain medications System for reordering pain medications Steps to take when medications are not available, such as Pixis machine, back up pharmacy Steps to take if the Pixis machine is not in working order or the medication is not in the Pixis, utilization of back up pharmacy The Director of Nursing or the East Unit Nursing Coordinator or the West Unit Nursing Coordinator or the Second Shift Nursing supervisor will audit 5 residents per week to ensure the availability of pain medications. These audits will be performed weekly x one month with report to the QA&A committee monthly x 1 year. The QA&A committee will evaluate these findings to determine the effectiveness of the plan and make changes as needed.	

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Review of the May 2017 Medication Administration Record (MAR) for Resident #96 noted the 8:00 AM dose of Tramadol had not been documented as given that morning. The 4:00 PM dose of Tramadol on 05/30/17 was documented as "not given" by Nurse #5 due to "medication not available." The 12:00 AM dose on 05/31/17 was documented as administered to Resident #96 by Nurse # 6.

On 05/31/17 at 9:26 AM Nurse #3 (assigned to work with Resident #96 on 05/31/17 from 7:00 AM-3:00 PM) stated she had not given morning medications yet to Resident #96. Nurse #3 was asked specifically about the availability of the Tramadol for Resident #96. Nurse #3 opened the locked narcotic box and stated there was no Tramadol available to give to Resident #96. Nurse #3 stated she would ask another staff nurse to obtain a Tramadol for Resident #96 from the Pyxis MedStation (an automated medication dispensing system).

On 05/31/17 at 10:15 AM Nurse #4 (the unit supervisor) stated the Pyxis MedStation was not operating and, as a result, Tramadol was not readily accessible to administer to Resident #96. Nurse #4 stated because Tramadol was a narcotic it required a written prescription for re-ordering. Nurse #4 stated each nurse was responsible for checking when a residents narcotic medication was "getting low" so the physician or nurse practitioner could be notified and a prescription written. Nurse #4 stated if the medication wasn't available staff should obtain it from the Pyxis MedStation. Nurse #4 stated she did not know how long the Pyxis MedStation had not been working. The Nurse Practitioner (NP) was present at the time of the interview and

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recalled she had just assessed Resident #96 for continued need of the Tramadol and written a prescription. The NP looked at her notes and verified she had seen Resident #96 on 05/30/17 and wrote the prescription for the Tramadol. The NP stated she would have expected the Tramadol to be delivered from the pharmacy on 05/30/17 for administration to Resident #96.

On 05/31/17 at 10:40 AM the Controlled Drug Record for the Tramadol for Resident #96 was requested from Nurse #3. At the time of the request the NP was overheard talking to Nurse #3 about her (the NP's) assessment of Resident #96's pain that morning and the NP recommended giving the Baclofen for muscle spasms until the Tramadol arrived at the facility for administration.

Review of the Controlled Drug Record for Resident #96 on 05/31/17 at 10:43 AM noted the last dose of Tramadol was documented and signed as given on 05/30/17 at 9:00 AM.

On 05/31/17 at 10:45 AM a phone interview was done with Nurse #6. Nurse #6 reported she had worked with Resident #96 on 05/30/17 from 11:00 PM until 05/31/17 at 7:00 AM. Nurse #6 stated she recalled giving several residents Tramadol during her shift but couldn't recall any specifics regarding Resident #96. Nurse #6 stated if she gave Tramadol to Resident #96 she would have recorded it on the Controlled Drug Record. Nurse #6 stated she would not have borrowed the Tramadol for Resident #96 because they would never borrow a narcotic. Nurse #6 was informed the last dose of Tramadol signed out for Resident #96 was 05/30/17 at 9:00 AM. Nurse #6 reported she was having a lot of computer issues during

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her shift and stated there was a possibility she signed off for the medication but did not give it.

On 05/31/17 at 10:59 AM Resident #96 stated he still had not received the Tramadol and he felt like his arm was pulling and his pain was a 10 on a scale of 1-10 (with 10 being severe pain.) On 05/31/17 at 12:00 PM Resident #96 reported he still had not received his Tramadol.

On 05/31/17 at 12:13 PM Nurse #3 stated she had not given Resident #96 the 8:00 AM dose of Tramadol or the Baclofen (as suggested by the NP at 10:40 AM). Nurse #3 stated it was her understanding from the NP that Resident #96 wasn't in pain but had muscle tightness. Nurse #3 offered to go to the room of Resident #96 to verify this. Nurse #3 entered the room of Resident #96 and asked him if he was going to get out of bed to eat lunch. Resident #96 stated he was hurting too much to get out of bed or eat and was waiting for his medication. Nurse #3 stated to Resident #96 that the NP had assessed him that morning and he was having muscle tightness, not pain. Resident #96 responded, no, I am hurting. Nurse #3 asked Resident #96 what his pain level was and Resident #96 replied "10". Nurse #3 returned to her medication cart and produced a paper where she documented the report from the NP (at approximately 10:40 AM) which noted no pain, muscle tightness and given Baclofen. Nurse #3 was asked if she had given the Baclofen to Resident #96 and she reported no, she was planning on doing that.

On 05/31/17 at 12:15 PM the interim Director of Nursing was asked if the Pyxis MedStation was operating and she reported it "went up" at 11:24 AM. The interim Director of Nursing was asked if

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the Tramadol had been taken out of the Pyxis for administration to Resident #96 and she responded, not yet. On 05/31/17 at approximately 12:20 PM Nurse #3 reported she gave Resident #96 the (8:00 AM scheduled) Tramadol.

On 05/31/17 at 12:30 PM the administrator stated she was aware Resident #96 had missed several doses of Tramadol and agreed it was a concern. The administrator stated they were going to audit all narcotics for residents to ensure medication was available to be given to residents as ordered.

On 05/31/17 at 12:45 PM a phone interview was done with the NP. The NP stated she assessed Resident #96 on 05/30/17 prior to writing the prescription for the Tramadol and felt the Tramadol was warranted for Resident #96. The NP stated she did assess Resident #96 that morning (around 10:40 AM) and asked him to describe his pain. The NP stated Resident #96 reported his right arm felt "tight" and she felt the right bicep of Resident #96 as well as his right calf and noted his muscles were tight. Because of the tightness, the NP reported she massaged the right bicep and right calf of Resident #96 and Resident #96 reported a little relief from pain. The NP stated she told Resident #96 she would have Nurse #3 give him the Baclofen until the Tramadol arrived to see if it would relieve his muscle pain. The NP stated she discussed this with Nurse #3 and told her to give the Baclofen while awaiting the Tramadol and she would have expected the Baclofen to be given within 30 minutes of their discussion.

On 05/31/17 at 2:20 PM in a follow-up interview Nurse #3 stated she got "caught up in a lot of

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things" that morning which was why the Baclofen was not given to Resident #96 from 10:40 AM until brought to her attention at 12:13 PM. Nurse #3 stated she later went back and checked on Resident #96 after he received the Tramadol and Baclofen and he reported his pain had gone from a "10" to a "1".

On 06/01/17 at 11:35 AM in a phone interview Nurse #5 verified she worked with Resident #96 on 05/30/17 from 3:00 PM-11:00 PM. Nurse #5 stated she recalled the Tramadol was not available to be given to Resident #96. Nurse #5 stated she asked another nurse with access rights to the Pyxis MedStation to obtain a Tramadol for Resident #96. Nurse #5 stated this nurse told her the Pyxis MedStation wasn't working which was why she charted the 4:00 dose of Tramadol wasn't available on the MAR of Resident #96 on 05/30/17.

On 06/02/17 at 1:25 PM the consultant pharmacist stated his expectation was for residents to receive medications as ordered by the physician, especially medications for pain management. The consultant pharmacist stated he wasn't aware of any issues with medications not being available to be administered to residents at the facility. When asked specifically about Tramadol the consultant pharmacist stated because it was a narcotic it was a little more involved in the ordering process as well as obtaining from the Pyxis MedStation.

On 06/02/17 at 1:33 PM a pharmacist at the dispensing pharmacy pulled up the records of Resident #96 and noted the 05/30/17 prescription for Tramadol for Resident #96 had not been Fax'd to the pharmacy until 05/31/17 at 9:34 AM.

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F 333	Continued From page 29 The pharmacist stated the prescription had been filled the morning of 05/31/17 and sent to the facility on the 12:30 PM delivery. On 06/02/17 from 3:15 PM-4:00 PM the interim Director of Nursing (DON) was interviewed about the availability of Tramadol for Resident #96. The interim DON stated the facility had a form called the Narcotic Tuesday form which staff utilized to document any residents in need of a prescription for narcotic refill. The interim DON stated all nurses were responsible for looking at the quantity of medications left for residents and either informing the physician or nurse practitioner or documenting on the Narcotic Tuesday sheet any resident needs for narcotic refills. The interim DON indicated typically nurses would physically report the need to the physician or nurse practitioner if they were present in the building. The interim DON stated the nurses would document needs on the Narcotic Tuesday sheet if the physician or nurse practitioner were not in the building for them to address when they were present. The interim DON reported there were no set parameters for staff to go by (like a certain number of medications remaining), just when the need was seen. The interim DON explained the name of the sheet (Narcotic Tuesday) had nothing to do when the need for a prescription would be written. The interim DON verified it appeared Resident #96 went from 9:00 AM on 05/30/17 until 12:20 PM on 05/31/17 without Tramadol. The interim DON stated it appeared Resident #96 missed the 4:00 PM dose on 05/30/17, the 12:00 AM dose on 05/31/17 and the 8:00 AM dose on 05/31/17 was over four hours late. The interim DON could not explain why the prescription for Tramadol had not been Fax'd to the pharmacy until it was brought to the	F 333		

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F 333	Continued From page 30 facility's attention. The interim DON stated she did not know who Fax'd the prescription to the pharmacy on 05/31/17 at 9:34 AM. The interim DON stated if the medication was not available nursing staff should access the medication from the Pyxis MedStation. The interim DON reported she did not know the Pyxis was down the evening of 05/30/17 and wasn't aware it was down the morning of 05/31/17 until Nurse #4 attempted to access it for the Tramadol for Resident #96. The interim DON noted they currently did not have a second shift nursing supervisor but she was available 24 hours and could have been called on 05/30/17. The interim DON stated the pharmacy was available 24/7 for Pyxis support. The interim DON stated if a medication was not available she expected staff to access the Pyxis MedStation. The interim DON stated if the Pyxis MedStation was down she expected a supervisor or herself to be notified. In addition, the interim DON stated the back-up pharmacy was also available until approximately 9:00 PM. The interim DON stated staff should not borrow narcotics. The interim DON was told of the approximate 1 1/2 hour delay in giving Baclofen to Resident #96 on 05/31/17 (while awaiting the Tramadol) and the DON stated she would have expected it to be given sooner. On 06/02/17 at 4:15 PM the administrator stated she expected medications to be available and given as ordered by the physician. The administrator stated there was a system failure that resulted in Tramadol not being given to Resident #96 as ordered.	F 333		
F 500 SS=D	483.70(g)(1)(2)(i)(ii) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	F 500		6/19/17

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F 500	Continued From page 31 (g) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g) (2) of this section. (2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to obtain written agreements for services provided by two outside providers for 2 of 2 residents (Resident #52, Resident #19) receiving dialysis services. The residents received dialysis without a contract in place. Findings included: 1. A review of the list of residents who received dialysis and the dialysis centers where they received their dialysis was provided by the Director of Nursing (DON) revealed Resident #52 received dialysis at Dialysis Center #1.	F 500	Current contracts are in place for all active Dialysis residents as of 6/2/17 An audit of all contracts was completed as of 6/19/17 to ensure that the facility has contracts for all vendors. The Administrator was re-educated by the Regional Director of Operations as of 6/2/17 regarding the importance of having contracts with all outside vendors The Administrator will audit all new vendors as they are contracted with to	

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F 500	Continued From page 32 A review of Resident #52's Minimum Data Set (MDS) dated 05/16/2017 documented the resident was receiving dialysis. An interview on 06/02/2017 at 2:16 PM with the Registered Dietician revealed she communicated with the dialysis center dietician. She stated any diet orders from the dialysis center were received and entered by the nurses. 2. A review of the list of residents who received dialysis and the dialysis centers where they received their dialysis was provided by the Director of Nursing (DON) revealed Resident #19 received dialysis services at Dialysis Center #2. A review of Resident #19's MDS dated 04/26/2017 documented the resident was receiving dialysis. On 06/02/2017 at 10:45 AM an interview with the Administrator revealed the facility did not have dialysis contracts for either Dialysis Center #1 or Dialysis Center #2. An interview on 06/02/2017 at 2:16 PM with the Registered Dietician revealed she communicated with the dialysis center dietician. She stated orders were was received by the nursing staff and put in the computer. She stated she and the dialysis dietician had good communication regarding the residents receiving dialysis and their dietary needs. On 06/02/2017 at 4:32 PM an interview with the Administrator revealed it was her expectation that the facility would have current contracts in place	F 500	ensure that there is a signed contract with all outside vendors with report to the QA&A committee monthly x 1 year. The QA&A committee will evaluate the effectiveness of the plan and make changes as indicated.	

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F 500	Continued From page 33 with every outside vendor. She was new and not aware that they did not have copies of current contracts for Dialysis Centers #1 and #2. She contacted the dialysis centers and obtained dialysis contracts with dialysis Centers #1 and #2. A review 06/02/2017 of the contracts for Dialysis Center #1 and #2 with the facility indicated the facility had obtained a written agreement with Dialysis Centers #1 and #2 which included the dialysis facility's responsibilities, the nursing facilities responsibilities, the medical management of the residents, transportation and dialysis scheduling and communication between the dialysis center and the facility.	F 500		