STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 01/17/2019

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F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview the facility failed to follow their Abuse Prevention Policy by failing to investigate and report to the State Survey Agency allegations of misappropriation of resident narcotic medications by a nurse for 3 of 3 sampled residents (Resident #2, #3, #4) reviewed for misappropriation of property. The findings included: Review of a facility document titled, Abuse Prevention Policy and Procedure dated 04/19/18 read in part, "The facility shall not condone any acts of resident mistreatment, neglect, verbal, sexual, physical and/or mental abuse, corporal punishment, involuntary seclusion or misappropriation of resident property by any facility staff member, other resident, consultants, volunteers, staff of other agencies, family member, legal guardians, friends or other individuals." "Any allegation of abuse is reported immediately to the State agency and to all other	F 607	The facility failed to follow the Abuse Prevention Policy by failing to investigate and report to the State Survey Agency allegations of misappropriation of residents narcotics medications by nurse for (Residents #2, #3, #4)reviewed for misappropriation of property. The initial allegation of misappropriation of resident property was reported on 1/17/2019 and the five day follow up was conducted and completed on 1/23/19 by the Administrator, and the nurse was suspended for three days pending the out-come of the investigation. Resident #2, #3,#4 were interviewed by the Interim Director of Nursing on 1/20/19 and found no negative outcome. An audit of the last 2 months of staffing concerns was completed to determine if others failed to be investigated and reported to the State by the Regional Nurse on 2/7/19 and no other concerns	2/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/2019

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F 607	Continued From page 1 agencies as required per state and federal guidelines." "Any complaint, allegation, observation or suspicion of resident abuse, mistreatment, or neglect, whether physical, verbal, mental, or sexual, involuntary or voluntary, is to be thoroughly reported, investigated and documented in a uniform manner." 1a. Resident #2 was readmitted to the facility on 07/26/18 with diagnoses that included chronic pain and osteoarthritis. Review of a physician's order dated 07/30/18 read, oxycodone (narcotic pain medication)/acetaminophen 5/325 milligrams (mg) by mouth every 8 hours as needed. Review of Resident #2's quarterly Minimum Data Set (MDS) dated 08/09/18 indicated that he was cognitively intact for daily decision making. Review of a physician's order dated 10/27/18 read, Tramadol 50 mg by mouth twice a day. Review of Resident #2's Medication Administration Record (MAR) dated 12/01/18 through 12/31/18 revealed that the oxycodone/acetaminophen 5/325 mg had been administered 28 times all by Nurse #2. Review of Resident #2 's-controlled drug record from 12/01/18 through 12/31/18 revealed that the oxycodone/acetaminophen 5/325 mg had been signed out for 36 times all by Nurse #2. An interview was conducted with Resident #2 on 01/16/19 at 3:34 PM. Resident #2 stated that his	F 607	identified. Nine (9) out of fourty-two (42) residents receiving narcotics have the potential to be affected by the alleged deficient practice. Seven (7) cognitive of the nine were interviewed by the Interim Director of nursing on 2/5/19 and no other concerns were identified. The Administrator received re-education regarding the abuse Prevention Policy investigating and reporting to the State allegations of misappropriation of residents' narcotics/ property immediately by the Regional Nurse on 2/7/19. All staff were re-educated on 2/8/19 by HR Director and Administrator on Abuse and Prevention Policy investigating and Reporting to the State. In addition,the Abuse and Prevention Policy and procedure education will be included in subsequent new-hire orientation. The Administrator and Director of Nursing will continue audits for alleged reports of misappropriation of narcotic/property for the next three (3) months to ensure any allegation of abuse is reported immediately to the State and all other agencies as required per State and Federal guidelines. Results of these audits will be reported at the Quality Assurance Performance Improvement meeting monthly by the Administrator. Any issues or trends	

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F 607	Continued From page 2 pain level was not bad at all and that he took something every morning and every night for pain but nothing else. Resident #2 stated that if he needed anything extra for pain he could request it but stated he had not requested any extra pain medication in months. He added that he was legally blind and could not see the pills that were being administered to him and that the staff were crushing his medication and putting them in applesauce. b. Resident #3 was admitted to the facility on 01/04/17 with diagnoses of spinal stenosis and pain. Review of a physician's order dated 08/23/18 read, Oxycontin (narcotic pain medication) 15 milligrams (mg) by mouth twice a day. Review of the quarterly Minimum Data set (MDS) dated 10/15/18 revealed that Resident #3 was cognitively intact for daily decision making. Review of Resident #3's Medication Administration Record (MAR) revealed that the oxycontin 15 mg had been administered twice a day as prescribed. Review of Resident #3's-controlled drug record for 12/03/18 through 12/31/18 indicated that the oxycontin had been administered 28 times and 7 of those times were by Nurse #2. An interview was conducted with Resident #3 on 01/17/18 at 10:50 AM. Resident #3 denied any issues with his medication or receiving them from the staff. Resident #3 stated that he had mild pain in his left leg daily and took scheduled pain medication daily that took care of that pain. He	F 607	identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and Administrator are responsible for implementing and maintaining the acceptable plan of correction.	

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added that the scheduled pain medication was enough, and he never had to request any additional pain medication.

c. Resident #4 was admitted to the facility on 11/21/13 with diagnoses that included vascular dementia and pain.

Review of a physician's order dated 04/20/17 read, hydrocodone (narcotic pain medication)/acetaminophen 5/325 milligrams (mg) by mouth every 6 hours as needed for pain.

Review of Resident #4's quarterly Minimum Data Set (MDS) dated 08/06/18 revealed that she was moderately impaired for daily decision making.

Review of Resident #4's Medication Administration Record (MAR) dated 12/01/18 through 12/31/18 revealed that the hydrocodone/acetaminophen 5/325 mg had been administered 30 times all by Nurse #2.

Review of Resident #4's-controlled drug record for 12/01/18 through 12/31/18 revealed that the hydrocodone/acetaminophen 5/325 mg had been administered 30 times all by Nurse #2.

On 1/17/19 a review of resident #4's January 2019 MAR revealed from 01/01/19 through 01/14/19 she had received the hydrocodone/acetaminophen 21 times with 20 of them being administered by Nurse #2.

Review of Resident #4's-controlled drug record for 01/01/19 through 01/31/19 revealed that the hydrocodone/acetaminophen 5/325 mg had been administered 17 times and 16 of them were by Nurse #2.

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An interview was conducted with Resident #4 on 01/16/19 at 4:55 PM. Resident #4 stated that she rarely had any pain and when she did it was usually just a headache. She added that she would ask for some Tylenol on the occasions when she had a headache but stated other than that she did not have any pain. Resident #4 stated she never requested anything except the Tylenol for her pain which helped ease her headache pain. Resident #4 stated that the nurses would bring her medication crushed up in applesauce, so she could not verify what all was in the applesauce.

An interview was conducted with Nurse #2 on 01/16/19 at 4:05 PM. Nurse #2 stated that she had been employed by the facility for a couple of months and worked the 100 unit and 200 unit (where Resident #2, #3, and #4 resided). She indicated that Resident #2, #3, and #4 had either scheduled narcotic pain medication or as needed narcotic pain medication. She stated that during her medication pass she asked each resident if they were hurting and if they were, she would ask them where they were hurting and if they could rate their pain on a numeric pain scale. Nurse #2 stated if the resident had something scheduled or if the resident could have their as needed narcotic pain medication she would administer the narcotic pain medication and then document it on the back of the Medication Administration Record (MAR) and sign the narcotic book. Nurse #2 stated that approximately one hour later she would return to the resident and ask them if the narcotic pain medication was effective and each time the residents reported it was effective. Nurse #2 stated that had administered each medication that she had signed out for and denied that she

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had misappropriated Resident #2, #3, and #4's narcotic pain medication. She offered no explanation to the numerous administrations of the narcotic pain medication to Resident #2, #3, and #4 given by herself except that the resident either verbalized or exhibited signs of pain.

An interview was conducted with Nurse #4 on 01/16/19 at 5:45 PM. Nurse #4 stated that she had shared with the Administrator on 11/28/18 and again on 12/10/18 that she had concerns with Nurse #2. Nurse #4 stated that Nurse #2 was administering a high quantity of narcotic pain medication to Resident #2 and #3 who normally did not have any pain and it was only when Nurse #2 was working. Nurse #4 stated that on 11/28/18 she and Nurse #1 copied orders, MARs, and narcotic sheets for Resident #2, #3, and #4 and slid them under the Administrator doors but never heard anything from her, so she approached the Administrator on 12/10/18 and verbally voiced her concerns. She stated that the Administered acknowledged her concerns but did not indicate what she was going to do with her concerns and had not asked her any additional questions since she reported to her.

An interview was conducted with Nurse #1 on 01/17/19 at 8:43 AM. Nurse #1 stated that on 11/28/18 and again on 12/07/18 she had informed the Administrator at the facility that she had concerns with Nurse #2. Nurse #1 stated that she informed the Administrator that she believed Nurse #2 was misappropriating Resident #2, #3, and #4's narcotic medications due to the excessive number of narcotics she was administering to these residents. Nurse #1 stated that Resident #2, #3, and #4 were not requesting or getting the narcotics except for when Nurse #2

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was working. Nurse #1 stated that she and Nurse #4 had copied orders, MARs, and narcotic sheets and placed them in an envelope and slid them under the Administrator's door on 11/28/18. Nurse #1 stated that she heard nothing from the Administrator so on 12/07/18 she verbally informed her of her concerns with Nurse #2 and was informed by the Administrator that she would have the corporate nurse investigate the situation or have the Director of Nursing (DON) investigate it whenever the facility hired a DON. Nurse #1 stated that she had never witnessed Nurse #2 misappropriate Resident #2, #3, or #4 narcotics.

An interview was conducted with the Administrator on 01/17/19 at 9:39 AM. The Administrator stated that she had no reportable events that needed to be reported to the State Survey Agency since she came to the facility on 11/27/18.

An interview was conducted with Nurse #3 on 01/17/19 at 11:43 AM. Nurse #3 stated that on 11/28/18 she had gone to the Administrator and voiced some concerns with narcotic pain medications for Resident #3 that were administered by Nurse #2. Nurse #2 stated the Administrator asked her to make copies of the order, narcotic sheet, and MAR and put them in an envelope and slide them under her office door. Nurse #3 stated she did as asked by the Administrator but heard nothing from her, so on 12/07/18 Nurse #3 again verbally shared her concerns with the Administer about Nurse #2 potentially misappropriating narcotic pain medication from Resident #2, #3, and #4. She stated that to her knowledge there was no follow up to her concerns she had voiced to the Administrator.

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An interview was conducted with the Interim DON on 01/17/19 at 12:30 PM. The interim DON stated that she had been at the facility since late December 2018 and since her arrival she had heard no concerns about Nurse #2 or the potential misappropriation of resident's narcotics. The interim DON stated that she had been made aware of a medication error that involved Nurse #2 but that was it. She added that if the staff had concerns about misappropriation of resident medication that the staff should report it to the Administrator or herself and they would immediately investigate their concerns. She stated that the investigation would include resident and staff interviews and record review. The interim DON stated that if Nurse #2 was giving a high quantity of narcotic pain medication that would be a sign of misappropriation of resident medication and we would immediately report it to the State Survey agency and began our investigation.

A follow up interview was conducted with the Administrator on 01/17/19 at 1:45 PM. The Administrator stated that Nurse #1 had come to her on 12/07/18 and shared with her concerns that Nurse #2 was misappropriating Resident #2, #3, and #4 narcotic pain medication. She stated that she asked Nurse #1 to please makes copies of things to better explain her concern's, but she had never received that information. The Administrator stated that she was not a nurse and at that time she asked the former DON to investigate the matter but "apparently that fell to the wayside." The Administrator went on to say, "if I don't have the necessary people in place to take care of that then I have to make sure the information is correct before I report it." She

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F 607	Continued From page 8 further stated that she should have immediately reported the concern to the State Survey Agency and then turned it over to the DON for investigation and then provided the follow up as the abuse coordinator and reported it to the State Survey agency as required.	F 607		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636		2/8/19

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F 636	Continued From page 9 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete an annual comprehensive Minimum Data Set (MDS) 12 months from the previous annual comprehensive MDS for 1 of 4 residents reviewed (Resident #4). The findings included: Resident #4 admitted to the facility on 11/21/13	F 636	The facility failed to complete and annual comprehensive Minimum Data Set (MDS) 12 months from the previous annual for resident #4. The annual comprehensive for resident #4 was completed on 1/22/19 and submitted 2/6/19 by the interim Director of Nursing. Residents in the facility have the potential	

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F 636	Continued From page 10 with diagnoses that included: vascular dementia, diabetes, schizoaffective disorder, bipolar disorder, and hypertension. Review of Resident #4's medical record revealed an annual comprehensive Minimum Data Set (MDS) dated 11/06/17. Further review of Resident #4's medical record revealed an annual comprehensive MDS dated 11/05/18 that had not yet been completed, making the assessment greater than 12 months from the previous annual comprehensive MDS and late. An interview was conducted with the Interim Director of Nursing (DON) on 01/17/19 at 12:30 PM. The Interim DON confirmed that the facility currently did not have a MDS Coordinator and she was helping to fill the spot as needed. The interim DON stated that they were relying on MDS coordinators from sister facilities to assist with completing MDS and could not explain why Resident #4's annual comprehensive MDS with an ARD date of 11/05/18 had not yet been completed. The Interim DON stated that she expected that all MDS assessment to be completed timely and accurately.	F 636	to be affected by the alleged deficient practice. An audit regarding completed MDS was done by the Interim Director of Nursing on 2/5/19 any concerns identified were addressed. A RN MDS Coordinator started employment January 24, 2019. The MDS Coordinator was educated by the Interim Director of Nursing on 2/4/19 regarding the survey results that the facility failed to complete an annual comprehensive MDS and that the facility must conduct a comprehensive assessment of a resident in accordance with specific timeframes. Monitoring: The Administrator and or Regional Nurse will audit the completion status of five (5)MDS per week x 4 then 2 per week x's 4 weeks. Data will be summarized and presented to the facility QA Committee meeting monthly x's two (2) months by the Administrator or MDS coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and director of nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 2/08/19	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	F 638		2/8/19

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F 638	Continued From page 11 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) within 92 days of the Assessment Reference Date (ARD) of the previous MDS assessment for 1 of 4 sampled residents (Resident # 2). The findings included: Resident #2 was readmitted to the facility 07/26/18 with diagnoses that included anemia, dementia, heart failure, and blindness. Review of Resident #2's medical record revealed a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/09/18. Resident #2's next MDS assessment was a quarterly MDS with an ARD of 11/05/18 that was not yet completed, making the assessment greater than 92 days from the previous quarterly MDS assessment and late. An interview was conducted with the Interim Director of Nursing (DON) on 01/17/19 at 12:30 PM. The Interim DON confirmed that the facility currently did not have a MDS Coordinator and she was helping to fill the spot as needed. The interim DON stated that they were relying on MDS coordinators from sister facilities to assist with completing MDS and could not explain why Resident #2's quarterly MDS with an ARD date of	F 638	The Facility completed the quarterly assessment for resident # 2 on 1/21/19 by the Regional MDS Coordinator. Residents in the facility have the potential to be affected by the alleged deficient practice. An audit for completed quarterly assessment was done by the Interim Director of Nursing on 1/5/19 any concerns identified were addressed. The RN MDS Coordinator started employment January 24, 2019. The MDS Coordinator was educated by the Interim Director of Nursing on 2/4/19 regarding the survey results that the facility failed to completed a quarterly assessment. MDS Coordinator educated that the facility must complete a timely quarterly assessment when due on residents and make necessary revisions to ensure accuracy and once completed transmit to CMS. The Administrator and or Regional Nurse will audit the completion of quarterly assessments, status of 5 MDS per week x 4 weeks then 2 per week x's 4 weeks. Data will be summarized and presented to the facility Quality Assurance Performance	

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F 638	Continued From page 12 11/05/18 had not yet been completed. The Interim DON stated that she expected that all MDS assessment to be completed timely and accurately.	F 638	Improvement meeting monthly x 2 months by the Administrator or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 2/8/19	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by	F 640		2/8/19

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F 640	Continued From page 13 CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit a completed discharge assessment for 1 of 1 discharged records sampled (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/04/17 with diagnoses that included heart disease. Review of the medical record revealed on	F 640	The Facility failed to transmit a completed discharge assessment for resident # 1 was submitted on 2/5/19 by the MDS Coordinator. Residents in the facility have the potential to be affected by the alleged deficient practice. An audit for completed assessment being transmission was done by the Interim Director of Nursing on 1/5/19 any concerns identified were addressed.	

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F 640	Continued From page 14 11/09/18 the resident was sent to the Emergency Department. On 11/10/18 a Discharge - Return Not Anticipated Minimum Data Set was initiated for Resident #1 and completed on 11/30/18. Further review revealed the MDS had not been transmitted or accepted and the status of the assessment was listed as "completed." On 01/17/19 at 1:45 PM the Administrator and interim Director of Nursing (DON) / Regional Consultant were interviewed together. The DON explained that facility was currently without a MDS Coordinator and the facility was relying on sister facilities to help complete MDS assessments. The Administrator reported the facility had a MDS Coordinator during the time Resident #1's MDS was completed and was unable to explain why the former MDS Coordinator failed to transmit the assessment. The former MDS Coordinator was unable to be interviewed.	F 640	The RN MDS Coordinator started employment January 24, 2019. The MDS Coordinator was educated by the Interim Director of Nursing on 2/4/19 regarding the survey results that the facility failed to submit a completed assessment. MDS Coordinator educated that within 7 days after a facility complete a residents' assessment it must be transmitted to CMS. The Administrator and or Regional Nurse will audit the completion and transmission status of 5 MDS per week x 4 weeks then 2 per week x's 4 weeks. Data will be summarized and presented to the facility Quality Assurance Performance Improvement meeting monthly x 2 months by the Administrator or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 2/8/19	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		2/8/19

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F 677	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to provide showers as scheduled for 1 of 1 residents investigated for activities of daily living (Resident #2). The findings included: Resident #2 was readmitted to the facility on 07/26/18 with diagnoses that included: anemia, esophageal varices, dementia, heart failure, and others. Review of the facility's shower schedule that was updated 08/01/18 revealed that Resident #2 was scheduled for a shower on Wednesday and Saturday on 3rd shift. Review of the quarterly minimum data set (MDS) dated 08/09/18 revealed that Resident #2 was cognitively intact and required extensive assistance of one staff member with bathing. The MDS further revealed no behaviors or rejection of care were noted during the assessment reference period. Review of the Nursing Assistant (NA) activity of daily living tracking form dated 01/01/19 through 01/31/19 indicated that Resident #2 had received a shower on 01/12/19. Review of the facility's shower sheets for the month of January 2019 revealed no shower record for Resident #2. An observation and interview were conducted with Resident #2 on 01/16/19 at 3:34 PM.	F 677	Residents that required extensive assistance for Activities of Daily Living (ADL's). The Interim Director of Nursing on 1/17/19 completed an interview with resident #2 regarding the alleged deficient practice of providing care needs including showers being met and addressed appropriately. Nursing Assistant #1,#2,#3 and #4 was re-educated on 1/17/19 by the Interim Director of nursing that residents who are unable to carry out activities of daily living including showers receive the necessary services to maintain good, grooming and personal hygiene. Residents in the facility have the potential to be affected by the alleged deficient practice. Interviews and observations were completed by the Interim Director of Nursing regarding their care needs (showers) being met, this was completed by 01/31/2019. Any concerns identified were addressed. Re-education was completed for Nursing Assistants by the Interim Director of nursing, regarding the provision of showers to residents who are unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene. This re-education will be completed by 1/31/19. Remaining Nursing Assistants will have re-education completed on first scheduled shift. In addition, newly hired CNA staff will	

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F 677	Continued From page 16 Resident #2 was sitting up in his recliner in his room and was listening to music. He was dressed appropriately for the weather but appeared disheveled. Resident #2's clothes were wrinkled and had dried food spots on them and was noted to have subtle facial hair. Resident #2 stated that the facility had a lot of room for improvement when it came to his showers, he stated that the girl that used to do them had left. Resident #2 stated that he used to get 2 showers a week but now there were weeks that he went without getting a shower and confirmed that had been 2 to 3 weeks since he had 2 showers per week like he was supposed to. An interview was conducted with NA #1 on 01/17/19 at 11:07 AM. NA #1 confirmed that she worked 3rd shift at the facility on Wednesday through Sundays. NA #1 stated that on 3rd shift they did not have permanent assignments and they all worked each unit at some point. NA #1 confirmed that she had worked the unit where Resident #2 resided but stated she was not familiar with Resident #2 nor had she ever showered Resident #2. An interview was conducted with NA #2 on 01/17/19 at 12:10 PM. NA #2 confirmed that she worked 3rd shift at the facility and stated that they did not have permanent assignments, and all worked each unit at some point. NA #2 stated she had never showered Resident #2 but stated maybe one of the other NAs had done so. An attempt to speak to NA #4 was made on 01/17/19 at 11:33 AM was unsuccessful. An attempt to speak to NA #2 was made on 01/17/19 at 11:34 AM was unsuccessful.	F 677	also receive education during subsequent orientation. Audit observation of 5 resident showers will be conducted weekly x 4 weeks then 3 weekly x 2 months. Data will be summarized and presented to the facility Quality Assurance Performance Improvement meeting monthly x 3 months by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 2/8/19	

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F 677	Continued From page 17 An interview was conducted with the Interim Director of Nursing (DON) on 01/17/19 at 12:30 PM. The Interim DON stated that there was a shower schedule and each shower that was due was written on the NAs assignment sheet. When the NAs took a resident to the shower they were to fill out a shower record indicating that the shower had been completed and both the NA and the nurse were to sign the bath record and place in the shower book at the nurse's station. The interim DON stated that the hall nurses should be following up on the shower schedule to make sure they were being done and indicated that the new Nursing Supervisor that they facility had just hired would also be overseeing that process once she started and got trained. The interim DON stated she fully expected each shower to be done as scheduled and if not done documented why it was not done and reported to the hall nurse.	F 677		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		2/8/19

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F 842	Continued From page 18 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F 842		

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F 842	Continued From page 19 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate medical record but failing to accurately document the administration of narcotics on the medication administration record for 1 of 4 residents sampled (Resident #2). The findings included: Resident #2 readmitted to the facility on 07/26/18 with diagnoses that included: chronic pain, osteoarthritis, and dementia. Review of a physician's order dated 07/30/18 read, oxycodone (narcotic pain medication)/acetaminophen 5/325 milligrams (mg) by mouth every 8 hours as needed for pain. Review of Resident #2's quarterly minimum data set (MDS) dated 08/09/18 revealed that Resident #2 was cognitively intact for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that during the assessment reference period Resident #2 received scheduled pain medication and reported pain frequently of a 5 on a numeric pain scale.	F 842	The Facility will maintain an accurate medical records in order to accurately document the administration of narcotics on the medication administration record for 1 of 4 residents sampled (Residents #2). Residents in the facility being administered (when necessary PRN) narcotics have the potential to be affected by the alleged deficient practice. The Regional Nurse reviewed medication administration records which was completed on 1/31/2019. Any concerns identified were addressed. The Licensed Nurses were re-educated by the Interim Director of Nursing/Regional Nurse on 1/31/2019 regarding the process of documentation of narcotics on the medication administration record. Newly hired LPN's and or RN's will receive the above education during orientation. Monitoring: Audit observation by Director of Nursing, Registered Nurse Supervisor	

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F 842	Continued From page 20 Review of Resident #2's-controlled drug record dated 11/28/18 indicated that Resident #2 received the oxycodone/acetaminophen on 12/03/18 at 7:30 AM and 3:30 PM, 12/06/18 at 11:51 AM, and 12/15/18 at 3:00 AM. The controlled drug record indicated that Nurse #2 had administered the doses on 12/03/18, 12/06/18, and 12/15/18. Review of Resident #2's Medication Administration Record (MAR) dated 12/01/18 through 12/31/18 revealed no administration of the oxycodone/acetaminophen documented on 12/03/18, 12/06/18, or 12/15/18 at 3:00 AM. An interview was conducted with Nurse #2 on 01/16/19 at 4:05 PM. Nurse #2. She stated that during her medication pass she asked Resident #2 if he was hurting and if he was then she would administer his narcotic pain medication and then document it on the back of the MAR and sign the narcotic book. Nurse #2 stated that approximately one hour later she would return to Resident #2 and ask him if the narcotic pain medication was effective. Nurse #2 stated that she had administered each medication that she had signed out for and must have mistakenly forgot to sign the MAR to reflect the administration of Resident #2's narcotic pain medication on 12/03/18, 12/06/18, and 12/15/18 at 3:00 AM. An interview was conducted with the Interim Director of Nursing (DON) on 01/17/18 at 12:30 PM. The Interim DON stated that a pain assessment was completed on admission to the facility and then pain was assessed every shift and documented on the MAR. She stated that if the resident reported pain then the narcotic pain	F 842	and or Regional Nurse of documentation of 5 PRN medications per week x 4 weeks, then 2 PRN medications x 4 weeks. Data will be summarized and presented to the facility Quality Assurance Performance Improvement meeting monthly x2 months by the Director of Nursing or Supervisor. Any issues or trends identified will be addressed by the quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 2/7/19.	

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F 842	Continued From page 21 medication would be administered and signed out for on the controlled drug record and on the MAR. The Interim DON stated that approximately one hour later the nurse would follow back up with the resident and make sure the medication was effective. The Interim DON stated she expected each administration of a narcotic medication to be signed out for on the controlled drug record and on the MAR.	F 842		