STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		6/2/16

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

Electronically Signed | 05/27/2016

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to completely assess residents in the areas of mental status, mood, pain and health conditions for 6 (Residents #15, #77, #42, #16, #3 & #31) of 12 sampled residents reviewed with comprehensive Minimum Data Set (MDS) assessments. Findings included: 1. Resident # 15 was admitted to the facility on 2/17/14. The annual MDS assessment dated 2/9/16 was reviewed. The assessment indicated that Resident #15 had clear speech, usually able to make herself understood and able to understand others. The assessment revealed that the resident was not interviewed for the Brief Interview for Mental Status (BIMS), mood and pain assessment as the areas were blank or with dashes on the boxes. An interview was conducted on 5/3/16 at 2:20 PM with the Social Worker (SW). She indicated she completed Section C (cognitive patters/mental status)and Section D (mood)of the MDS. She stated the MDS Coordinator completed Section J (health conditions/pain). She indicated she completed Section C and Section D for Resident #15. She stated that she was unable to complete the interviews with Resident #15 during the seven day look back period, so she had not answered the questions. The unanswered questions were indicated with a dash or were left blank. The SW stated that Resident #15 would have been able to complete the brief interview for mental status and the resident mood interview if she had asked the questions, but she had not done so during the seven day look back period. She indicated she had not known the assessment was due and that was why she had not completed the interviews in	F 272	This corrective action plan will serve as Penick Village□s allegation of compliance with the requirements of 42 CFR, Part 483, Subpart B for long-term care facilities as of November 19, 2009. Residents #15, #77, #42, #16, #3 and #31 will have updated comprehensive assessments by June 2nd. All residents have potential to be affected by this practice. An audit of the comprehensive assessments due in May was completed on 5-26-16 by MDS Coordinator to identify any other incomplete assessments. As a result of the audit performed by MDS Coordinator, all assessments due in were completed and locked by 6-2-16. Our MDS coordinator is putting into place a calendar system she has used for years to track quarterly and annual assessments. Our MDS coordinator educated all Inter-Disciplinary Team (IDT) members on the calendar system on 5-11-16. Our new calendar system tracks all assessments that are due each week and each month. IDT members will be given a weekly calendar each week by our MDS Coordinator identifying all assessments to be completed that week. We have also started using a 100 Day Tool for each and every resident that is using Medicare Benefits as a way to keep track Assessment Reference Dates. DON will perform a weekly audit of 3 assessments	

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F 272	Continued From page 2 the appropriate timeframe. The SW stated the MDS Coordinator completed the schedule of assessments that were due. She revealed that routinely over the past six months she had received a schedule too late to complete the interviews in the required timeframe and she had left the questions blank. She indicated she had voiced her concerns to the previous administrator, but the problem had not been corrected. She stated the new Administrator was aware of the issues and was addressing the concerns. An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns. An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern. 2. Resident # 77 was admitted to the facility 2/9/16. The admission MDS assessment dated 2/16/16 was reviewed. The assessment indicated that Resident #77 had clear speech, able to make herself understood and usually able	F 272	to be completed and report findings at QA meeting The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review the 3 selected comprehensive assessments to ensure they are complete, create a POC and document findings to be reported at our next QA meeting on June 27, 2016.	

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to understand others. The assessment revealed that the resident was not interviewed for pain as the boxes for pain assessment were blank.
An interview was conducted on 5/3/16 at 2:20 PM with the Social Worker (SW). She stated the MDS Coordinator completed Section J (health conditions/pain).

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.
3. Resident #42 was admitted to the facility on 12/15/15. Cumulative diagnoses included Parkinson's disease.

The Admission Minimum Data Sets (MDS) for Resident #42 indicated Resident #42 had unclear speech, was usually understood and was usually able to understand others. Section C, the Cognitive Patterns section, was not fully completed. Question C0100 was coded to

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indicate a brief interview for mental status (questions C0200 through C0500) was to be conducted. Questions C0200 through C0500 were coded with dashes that indicated the questions were not answered. Section D, the Mood section, was not fully completed. Question D0100 was coded to indicate a resident mood interview (questions D0200 through D0300) was to be conducted. Questions D0200 through D0300 were coded with dashes that indicated the questions were not answered.

On 05/03/2016 at 2:20 PM, an interview was conducted with the social worker. She stated she completed sections C, D and E of the MDS and was the one who had completed those areas for Resident #42. She said when they were first taught on the MDS, they were told they should try to complete the interview and answer the section that asks if a resident interview should be conducted as a "1" even if they were unable to complete the interview. She said she was unable to do the resident interview within the look back period for this resident. The social worker stated Resident #42 would have been able to answer the questions, but she didn't ask them. The social worker said that she didn't know it was due and that was why she wasn't able to do the interview in the look back period. The social worker stated the MDS schedule came from the MDS coordinator and, if they did not get a schedule, they were not aware of who was due for an MDS. If she did not get the schedule, she did not get to complete the interview and she would insert dashes. She stated she would conduct the assessment after the assessment reference date (ARD) when she found out it was due and the interview was probably not within the look-back period. The social worker stated it

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happened routinely that she would get late MDS schedules-over the last six months or more. She said it hadn't happened in the past week or two. The social worker stated she started voicing her concerns about six months ago or more to the MDS coordinator and the administrator at that time. She stated, since the new administrator came, he realized the MDS's were not up to date and was addressing the concerns.

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.

4. Resident #16 was admitted to the facility on 11/10/15. Cumulative diagnoses included hypertension, osteoarthritis and long term use of anticoagulant medication.

An Admission Minimum Data Set dated 11/17/15 indicated Resident #16 had clear speech, was understood by others and was able to understand

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others. Section C, the Cognitive Patterns section, was not fully completed. Question C0100 was coded to indicate a brief interview for mental status (questions C0200 through C0500) was to be conducted. Questions C0200 through C0500 were coded with dashes that indicated the questions were not answered. Section D, the Mood section, was not fully completed. Question D0100 was coded to indicate a resident mood interview (questions D0200 through D0300) was to be conducted. Questions D0200 through D0300 were coded with dashes that indicated the questions were not answered.

A Quarterly MDS dated 2/17/16 indicated Resident #16 had clear speech, as understood by others and was able to understand others. The MDS indicated she was cognitively intact. Section J, the Health Conditions section, was not fully completed. Question J0200 required an answer to indicate if a pain assessment interview was to be completed with the resident. This question was coded with a dash that indicated the question was not answered. The remaining questions in the pain assessment interview, questions J0300 through J0600, were also coded with dashes that indicated the questions were not answered.

On 05/03/2016 at 2:20PM, an interview was conducted with the social worker. She stated she completed sections C, D and E of the MDS and was the one who had completed those areas for Resident #16. She said when they were first taught on the MDS, they were told they should try to complete the interview and answer the section that asks if a resident interview should be conducted as a "1" even if they were unable to complete the interview. She said she was unable

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to do the resident interview within the look back period for this resident. The social worker stated Resident #16 would have been able to answer the questions, but she didn't ask them. The social worker said that she didn't know it was due and that was why she wasn't able to do the interview in the look back period. The social worker stated the MDS schedule came from the MDS coordinator and, if they did not get a schedule, they were not aware of who was due for an MDS. If she did not get the schedule, she did not get to complete the interview and she would insert dashes. She stated she would conduct the assessment after the assessment reference date (ARD) when she found out it was due and the interview was probably not within the look-back period. The social worker stated it happened routinely that she would get late MDS schedules-over the last six months or more. She said it hadn't happened in the past week or two. The social worker stated she started voicing her concerns about six months ago or more to the MDS coordinator and the administrator at that time. She stated, since the new administrator came, he realized the MDS's were not up to date and was addressing the concerns.

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30

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PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.
5. Resident #3 was admitted to the facility on 3/30/11 with multiple diagnoses including autistic disorder and severe intellectual disabilities.

The annual Minimum Data Set (MDS) assessment dated 2/12/16 indicated Resident #3 had clear speech, was able to make herself understood, and was usually able to understand others. Section C, the Cognitive Patterns section, was not fully completed. Question C0100 was coded to indicate a brief interview for mental status (questions C0200 through C0500) was to be conducted. Questions C0200 through C0500 were coded with dashes that indicated the questions were not answered. Section D, the Mood section, was not fully completed. Question D0100 was coded to indicate a resident mood interview (questions D0200 through D0300) was to be conducted. Questions D0200 through D0300 were coded with dashes that indicated the questions were not answered. Section J, the Health Conditions section, was not fully completed. Question J0200 required an answer to indicate if a pain assessment interview was to be completed with the resident. This question was coded with a dash that indicated the question was not answered. The remaining questions in the pain assessment interview, questions J0300 through J0600, were also coded with dashes that indicated the questions were not answered.

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An interview was conducted on 5/3/16 at 2:20 PM with the Social Worker (SW). She indicated she completed Section C and Section D of the MDS. She stated the MDS Coordinator completed Section J. She indicated she completed Section C and Section D for Resident #3. She stated that she was unable to complete the interviews with Resident #3 during the seven day look back period, so she had not answered the questions. The unanswered questions were indicated with a dash. The SW stated that Resident #3 would have been able to complete the brief interview for mental status and the resident mood interview if she had asked the questions, but she had not done so during the seven day look back period. She indicated she had not known the assessment was due and that was why she had not completed the interviews in the appropriate timeframe. The SW stated the MDS Coordinator completed the schedule of assessments that were due. She revealed that routinely over the past six months she had received a schedule too late to complete the interviews in the required timeframe and she had left the questions blank. She indicated she had voiced her concerns to the previous administrator, but the problem had not been corrected. She stated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new

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Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.

6. Resident #31 was admitted to the facility on 12/7/15 with multiple diagnoses including aortic stenosis, hypertension, and hyperlipidemia.

The Admission Minimum Data Set (MDS) assessment dated 12/14/15 indicated Resident #31 was cognitively intact. Section J, the Health Conditions section, was not fully completed. Question J0200 required an answer to indicate if a pain assessment interview was to be completed with the resident. This question was coded with a dash that indicated the question was not answered. The remaining questions in the pain assessment interview, questions J0300 through J0600, were also coded with dashes that indicated the questions were not answered.

An interview was conducted on 5/3/16 at 2:20 PM with the Social Worker (SW). She stated the MDS Coordinator completed Section J of the MDS.

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present

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F 272	Continued From page 11 at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns. An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident 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 for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within the first fourteen (14) days of admission for five (5) of thirteen (13)sampled residents (Resident #42,	F 273	Residents #42, #16, #49, #56 and #31 have a comprehensive Minimum Data Set completed. ¿ May 26, 2016	6/3/16

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F 273	Continued From page 12 #16, #49, #56 and #31). The findings included: 1. Resident #42 was admitted to the facility 12/14/15. A review of the medical record revealed an Admission Minimum Data Set (MDS) dated 12/20/15. The completion date for the Care Area Assessment (CAA) of the Admission MDS (VB 1) was 2/9/16. This was fifty one (51) days after admission to the facility. An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns. An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern 2. Resident #16 was admitted to the facility on 11/10/15. A review of the medical record revealed an Admission MDS dated 11/17/15. The completion	F 273	All residents have potential to be affected by this practice. An audit of comprehensive assessment completion was completed on 5-26-16 by our new MDS Coordinator. MDS coordinator audited charts from March 2016 to May 2016 to ensure all MDS assessments had been transmitted. Any outstanding assessments were transmitted 6-3-16 Our new Penick Village MDS Coordinator reviewed, signed off, and completed any assessments that needed completion. Our new MDS coordinator is putting into place a calendar system she has used for years to track quarterly and annual assessments. Our MDS coordinator educated all Inter-Disciplinary Team (IDT) members on the calendar system on 5-11-16. Our new calendar system tracks all assessments that are due each week and each month and will drive completion of MDS assessments. IDT members will be given a weekly calendar each week by our MDS Coordinator identifying all assessments to be completed that week. DON will audit 3 of the assessments due during the week for completion and report findings to QA meeting. We have also started using a 100 Day Tool for each and every resident that is using Medicare Benefits as a way to keep track Assessment Reference Dates. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for	

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F 273	Continued From page 13 date for the Care Area Assessment (CAA) of the Admission MDS (VB 1) was 12/3/15. This was twenty three (23) days after admission to the facility. An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns. An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern. 3. Resident #49 was admitted to the facility 1/15/16. A review of the medical record revealed an Admission MDS dated 1/22/16. The completion date for the Care Area Assessment (CAA) of the Admission MDS (VB 1) was 2/4/16. This was twenty (20) days after admission to the facility. An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had	F 273	the next 90 days to review 3 selected comprehensive assessments to identify any incomplete assessments and create a POC. Documented findings and completion dates will be reported at the next QA meeting June 27, 2016.	

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several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.

4. Resident #56 was admitted to the facility on 9/14/15.

A review of Resident #56's medical record revealed an Admission Minimum Data Set (MDS) assessment dated 9/27/15. The completion date for the Care Area Assessment (CAA) of the Admission MDS (V0200B1) was 11/20/15. This was sixty-seven (67) days after Resident #56's admission to the facility.

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30

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PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.

5. Resident #31 was admitted to the facility on 12/7/15.

A review of Resident #31's medical record revealed an Admission Minimum Data Set (MDS) assessment dated 12/14/15. The completion date for the Care Area Assessment (CAA) of the Admission MDS (V0200B1) was 1/5/16. This was twenty nine (29) days after Resident #31's admission to the facility.

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated the MDS Coordinator was not present at the facility. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that incomplete MDS assessments were an identified area of concern. She indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility

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F 273	Continued From page 16 was in the process of implementing multiple changes to address the areas of concern.	F 273		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS 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 quarterly Minimum Data Set (MDS) assessments within 92 days of the Assessment Reference Date (ARD) of the most recent MDS assessment for 2 of 12 sampled residents (Residents #31 and #56). The findings included: 1a. Resident #56 was admitted to the facility on 9/14/15. A review of Resident #56's medical record revealed an Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/27/15. Resident #56 had a quarterly MDS assessment with an ARD of 12/28/15. The MDS assessment required a signature of a Registered Nurse (RN) Assessment Coordinator to verify its completion. This quarterly MDS assessment was indicated to be completed on 2/10/16 (Question Z0500B). This quarterly assessment was completed 136 days after the most recent MDS assessment's ARD (9/27/15).	F 276	Residents #31 and #56 have a quarterly Minimum Data Set completed on 5-26-16 All residents have potential to be affected by this practice. An audit of quarterly Minimum Data Set assessment was completed on 5-26-16 by our new MDS Coordinator. Our new Penick Village MDS Coordinator reviewed, signed off, and completed any quarterly assessments that needed completion by 5-9-16 and 5-10-16. All quarterly and annual assessments due in May 2016 were opened and completed by 6-2-16. Our new MDS coordinator is putting into place a calendar system she has used for years to track quarterly and annual assessments. Our MDS coordinator educated all Inter-Disciplinary Team (IDT) members on the calendar system on 5-11-16. Our new calendar system tracks all assessments that are due each week and each month and will drive completion of MDS assessments. IDT members will	6/2/16

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F 276	Continued From page 17 An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated she signed the MDS assessments to verify their completion. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that MDS assessments not being completed in a timely manner was an identified area of concern. The DON indicated the new Administrator was aware of the issues and was addressing the concerns. An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that timeliness of MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern. 1b. Resident #56 was admitted to the facility on 9/14/15 A review of Resident #56's medical record revealed a quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/28/15. Resident #56 had a quarterly MDS assessment with an ARD of 3/29/16. The MDS assessment required a signature of an Registered Nurse (RN) Assessment Coordinator to verify its completion. This quarterly MDS assessment was indicated to be completed on 4/18/16 (Question Z0500B).	F 276	be given a weekly calendar each week by the MDS Coordinator identifying all assessments to be completed that week. DON will audit 3 charts weekly for completion using calendar and report findings to QA meeting. We have also started using a 100 Day Tool for each and every resident that is using Medicare Benefits as a way to keep track Assessment Reference Dates. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review 3 selected quarterly assessments to identify any incomplete assessments and create a POC. Documented findings and completion dates will be reported at the next QA meeting June 27, 2016.	

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This quarterly assessment was completed 113 days after the most recent MDS assessment's ARD (12/28/15).

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated she signed the MDS assessments to verify their completion. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that MDS assessments not being completed in a timely manner was an identified area of concern. The DON indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that timeliness of MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.

2. Resident #31 was admitted to the facility on 12/7/15.

A review of Resident #31's medical record revealed an Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/14/15.

Resident #31 had a quarterly MDS assessment with an ARD of 3/15/16. The MDS assessment required a signature of a Registered Nurse (RN) Assessment Coordinator to verify its completion.

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F 276	Continued From page 19 This quarterly MDS assessment was indicated to be completed on 3/30/16 (Question Z0500B). This quarterly assessment was completed 108 days after the most recent MDS assessment's ARD (12/14/15). An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated she signed the MDS assessments to verify their completion. She stated that the facility had several issues with the MDS Coordinator and MDS assessments. She revealed that MDS assessments not being completed in a timely manner was an identified area of concern. The DON indicated the new Administrator was aware of the issues and was addressing the concerns. An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that timeliness of MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.	F 276		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		6/2/16

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F 278	Continued From page 20 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to accurately code behaviors for one of two residents reviewed for behaviors (Resident #42) and for PASRR (Preadmission Screening Resident Review) on the MDS (Minimum Data Set) for one of one residents reviewed for PASRR level 2 (Resident #3). The findings included: 1. Resident #42 was admitted to the facility on 12/15/15. Cumulative diagnoses included atrial fibrillation and Parkinson's disease. A Quarterly Minimum Data Set (MDS) dated 3/21/16 indicated Resident 342 was moderately	F 278	Resident #42 will had an updated comprehensive assessment completed 6-1-16. Resident #3 had an updated assessment to reflect the current PASRR level. All residents have the potential to be affected by this practice. An audit of the comprehensive assessments was completed on 5-26-16 by our new MDS coordinator and a review of Section A (PASRR) and Section E(Behaviors). Discrepancies were corrected.	

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F 278	Continued From page 21 impaired in cognition. No mood indicators were noted. Behaviors were documented as physical behaviors directed towards others and verbal behaviors directed towards others occurred 1-3 days during the assessment period. A review of Resident #42's physician's orders revealed an order for Lorazepam (medication for anxiety) 0.5 milligrams every six hours as needed for agitation. A review of the March 2016 Medication Administration Record (MAR) revealed Resident #42 received Lorazepam 0.5 milligrams for agitation on March 15th which was during the assessment period. A review of Resident #42's care plan was conducted. There was no care plan for behaviors. A Social work note dated 3/21/16 stated Resident #42 was social with staff. No refusal of care or behaviors were noted. A review of the nursing notes for the assessment period of 3/16-3/21/16 was conducted. There were no behaviors noted. On 5/04/2016 at 11:28AM, an interview was conducted with the social worker. She stated she was the person who completed the section of the MDS for behaviors. The social worker reviewed the behavior charting for Resident #42. She stated Resident #42 had no behaviors and the information on the MDS was wrong. She stated she did not know why the information for Resident #42 was incorrect and if behaviors were documented on the MDS, she would have	F 278	Our MDS coordinator is putting into place a calendar system she has used for years to track quarterly and annual assessments. Our MDS coordinator educated all Inter-Disciplinary Team (IDT) members on the calendar system on 5-11-16. Our new calendar system tracks all assessments that are due each week and each month and will drive completion of MDS assessments. IDT members will be given a weekly calendar each week identifying all assessments to be completed that week. DON will perform a weekly audit using the calendar to ensure assessments are completed and report findings to QA meeting. We have also started using a 100 Day Tool for each and every resident that is using Medicare Benefits as a way to keep track Assessment Reference Dates. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review 3 quarterly assessments and comprehensive assessments to identify any incomplete assessments and create a POC. Documented findings and completion dates will be reported at the next QA meeting June 27, 2016. A review of resident PASSR levels and the accuracy of our MDSs will also be monitored each week by the DON.	

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documented the reason in her social work noted.

2. Resident #3 was admitted to the facility on 3/30/11 with multiple diagnoses including autistic disorder and severe intellectual disabilities. The annual Minimum Data Set (MDS) assessment dated 2/12/16 coded Resident #3 as a Preadmission Screening and Resident Review (PASRR) level II with the condition of Mental Retardation.

On 5/2/16 the facility completed an entrance conference worksheet that listed PASRR level II residents. Resident #3 was listed as PASRR level II.

A record review of Resident #3's hard copy and electronic medical record revealed no documentation of a PASRR Level II determination.

An interview was conducted on 5/3/16 at 3:00 PM with the Director of Nursing (DON). She indicated she expected the MDS to be coded accurately.

An interview was conducted on 5/4/16 at 11:28 AM with the Social Worker (SW). The SW revealed she reviewed the record for Resident #3 and she was not a PASRR Level II. She indicated the MDS was coded incorrectly. She additionally indicated the information provided on the entrance conference worksheet was incorrect. She stated the facility had mistakenly identified Resident #3 as a PASRR Level II. The SW revealed she previously thought Residen #3 was a PASRR Level II, but after her review of the information she determined she was not.

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F 278	Continued From page 23 An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He indicated that accuracy was one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a	F 279	The Care Plan of resident #49 was updated to include her behaviors,	6/2/16

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F 279	Continued From page 24 comprehensive care plan for one of two residents reviewed for behaviors (Resident #49), for active medical conditions/ medications and the need for assistance with activities of daily living (ADL ' s) for one of twelve sampled residents (Resident #49) and for the use of psychotropic medication with behaviors for one of five resident reviewed for unnecessary medications (Resident #51). The findings included: 1. a. Resident #49 was admitted to the facility 1/15/16. Cumulative diagnoses included dementia without behaviors and adjustment disorder with depression. A history and physical dated 1/25/16 indicated Resident #49 was admitted to the hospital with altered mental status superimposed on her dementia. Admission physician orders included the following medications: Trazadone (antidepressant medication) 50 milligrams by mouth daily, Sertraline (antidepressant medication) 25 milligrams by mouth daily and Klonopin (anxiety medication) 0.5 milligrams twice daily as needed and Remeron (antidepressant) 15 milligrams nightly. A review of the January Medication Administration Record (MAR) revealed Resident #49 received. Sertraline, Remeron and Trazadone as ordered by the physician. Klonopin was not administered during January. An Admission Minimum Data Set dated 1/22/16 indicated Resident #49 was moderately impaired in cognition. No mood or behaviors were noted during the assessment period. Medications	F 279	psychotropic medication use, and dermatological conditions and need for assistance with ADLs by new MDS Coordinator by 5-29-16. Resident #51 had a new comprehensive care plan completed that includes but is not limited to risk of refusing medication and behaviors by MDS Coordinator by 5-29-16. All residents have potential to be affected by this practice. An audit of the comprehensive care plans will be completed on 5-29-16 by our new MDS Coordinator to ensure accuracy of the care plans. If further deficiencies are identified, an updated comprehensive care plan will be completed within 30 days. Comprehensive Care Plans were updated by MDS Coordinator All full-time, part-time, and PRN licensed nursing staff will be in-serviced by DON on proper response to refusal of medications and care, non-baseline behavior reporting, and how care plans reflect baseline behaviors by June 2. Any new licensed staff will be educated during their orientation period by DON. DON will perform audit of 3 selected care plans to ensure care plans are appropriate and report findings to QA meeting. Agenda and attendance results of above in-services will be shared at next QA meeting June 27, 2016. In-services on refusal of medications and or care, non-baseline behavior reporting, and how care plans reflect baseline behaviors will be completed annually thereafter by DON.	

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F 279	Continued From page 25 received during the assessment period included six days of antidepressant medication. A Care Area Assessment (CAA) for psychotropic medication stated psychotropic medications would be addressed in the falls CAA. A CAA for falls stated Resident #49 required the daily use of antipsychotic medication and was at risk for adverse reactions due to their use. Resident #49 had a physician ' s order for antianxiety medication but had not required its use during the look back period. Proceed to care plan which included provide medications per physician ' s order, monitor for adverse reactions and periodic review by physician/ pharmacist for use for possible gradual dosage reduction. A psychiatric consult dated 2/18/16 stated facility staff felt Resident #49 was depressed based on her outbursts of weeping. A nursing note dated 2/26/16 stated Resident #49 was seen by psychiatric services and psychotropic medications were evaluated. A physician's order was obtained to decrease Klonopin 0.5 milligrams twice daily as needed to 0.5 milligrams daily as needed. Trazadone 50 milligrams by mouth every night was decreased to 25 milligrams by mouth nightly. Remeron (antidepressant) was decreased from 15 milligrams daily to 7.5 milligrams daily. Continue with Sertraline 25 milligrams daily. A psychiatric consult dated 3/17/16 indicated no concerns were noted. A request was made to taper medications and psychiatry staff felt Resident #49's weeping was not due to depression but dementia.	F 279	The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review 3 selected quarterly and comprehensive assessments to identify any incomplete assessments and create a POC. Documented findings and completion dates will be reported at the next QA meeting. The agenda and the attendance logs from the in-services mentioned above will also be reported at the next QA meeting by DON. And In-services on refusal of medications and or care, non-baseline behavior reporting, and how care plans reflect baseline behaviors will be completed annually thereafter by DON.	

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A psychiatry note dated 3/25/16 stated Klonopin was increased to 0.5 milligrams every 12 hours as needed for agitation. No other changes in medication was noted.

A psychiatric progress note dated 4/20/16 indicated that Resident #49 ' s anxiety may be chronic and made worse by constant itching.

Resident #49's care plan was reviewed. There was only one area care planned for Resident #49 which was for falls and did not include the use of psychotropic medications or behaviors.

On 5/04/2016 at 5:27PM, an interview was conducted with the Director of Nursing. She reviewed Resident #49's care plan and stated that Resident #49 ' s care plan should have included her use of psychotropic medications and behaviors. She stated she did not know why Resident 49's care plan only consisted of falls. The Director of Nursing stated it was the responsibility of the MDS coordinator to write the care plans and the facility had identified that there was a problem when they had conducted their mock survey in March.

1. b. Resident #49 was admitted to the facility 1/15/16. Cumulative diagnoses included dementia without behavior, chronic obstructive pulmonary disease (COPD), hypertension, diabetes hypothyroidism and adjustment disorder with depression.

An Admission Minimum Data Set (MDS) dated 1/22/16 indicated Resident #49 was moderately impaired in cognition. Resident #49 required

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extensive assist with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene. Limited assistance was needed with ambulation in the room and only occurred 1-2 x in the hallway. Total assistance was needed with bathing. Supervision was needed with eating. She was frequently incontinent of bladder and bowel. Diagnoses documented included hypertension, diabetes, thyroid disease, dementia, depression, COPD, metabolic encephalopathy, dysphagia, cognitive communication deficit, muscle weakness and difficulty walking. Pain management was noted as received scheduled pain medication, received prn (as needed) pain medications or was offered and declined. Weight was noted as 110 pounds with no weight loss or gain. Medications administered during the assessment period included: 2 days of injections, 1 day of insulin, 6 days of antidepressant medication and 5 days of diuretic medication.

A Care Area Assessment (CAA) for cognition stated Resident #49 had short term memory deficits and was able to make her needs known to staff. She was pleasant and talkative. This area would be care planned.

A CAA for activities of daily living (ADL) stated Resident #49 required supervision to limited assistance with ADL tasks. Cognitive deficits were present and she required curing at times. Resident #49 was able to follow simple directions and made her needs known. She remained at risk for decline in her physical abilities and this area would be care planned.

The CAA for urinary status, nutritional status, pressure ulcers and pain were also triggered and

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noted that all the areas would be addressed in Resident #49's care plan.

Physician orders were reviewed and revealed, in part, the following:
Check fasting blood sugar before breakfast and supper.
Check weekly weight related to weight loss.
Lasix (diuretic) 20 milligrams daily
Aricept (for dementia) 10 milligrams nightly
Humalog sliding scale insulin (for diabetes)
Strawberry ensure twice a day; magic cup with meals (due to weight loss).
Ivermectin 3 mg 3 tabs (12 mg) on days 1, 2, 8, 9 and 15 (for scabies)
Januvia (diabetic medication) 50 milligrams daily
Levothyroxine (thyroid medication) 100 micrograms daily. Check pulse weekly.
Metoprolol ER (for blood pressure) 25 milligrams twice daily
Remeron (antidepressant medication) 15 milligrams nightly
Sodium chloride (for chronic low sodium level) 1 gram twice daily
Trazadone 50 milligrams 1/2 tab (25 milligrams) nightly
Clonazepam (anxiety medication) 0.5 milligrams every 12 hours as needed for agitation

A review of Resident #49's care plan revealed the only area addressed in Resident #49's care plan was falls. There was not a care plan for cognition, urinary status, nutritional status, pressure ulcers, pain, diabetes and/or the use of diuretic medication or psychotropic medications.

On 5/04/2016 at 5:27PM, an interview was conducted with the Director of Nursing. She

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reviewed Resident #49's care plan and stated that Resident #49 ' s care plan should have included her need for assistance with ADL's, her medical conditions and the use of diabetic medications and psychotropic medications and behaviors. She stated she did not know why Resident 49's care plan only consisted of falls. The Director of Nursing stated it was the responsibility of the MDS coordinator to write the care plans and the facility had identified that there was a problem when they had conducted their mock survey in March.

2. Resident #51 was admitted to the facility on 9/11/15 with multiple diagnoses including dementia, anxiety, and depression.

Resident #51's admission physician orders dated 9/11/15 indicated Seroquel (antipsychotic) 25 milligrams (mg) once every 12 hours, Ativan (antianxiety) 0.5mg twice daily, Ativan 0.5mg as needed (prn) every 6 hours, and Lexapro (antidepressant) 5mg once daily.

A review of the September 2015 Medication Administration Record (MAR) revealed Resident #51 received Seroquel, Ativan, and Lexapro as ordered by the physician.

An Admission Minimum Data Set (MDS) assessment dated 9/22/15 indicated Resident #51 had significantly impaired cognition. No mood or behaviors were noted during the assessment period. Medications received during the assessment period included seven days of an antipsychotic medication, seven days of an antianxiety medication, and six days of an antidepressant medication. A Care Area

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Assessment (CAA) indicated the care area of psychotropic medications was triggered by the assessment, but was not indicated to be care planned.

The medical record was reviewed. Resident #51 had no care plan in September 2015.

A Nursing Progress Note (NPN) dated 9/24/15 indicated Resident #51 refused to get up on three attempts.

A review of the October 2015 MAR revealed Resident #51 refused a total of 19 medications on 3 distinct calendar days. This included 2 refusals for Ativan, 1 refusal for Lexapro, and 2 refusals for Seroquel.

The medical record was reviewed. Resident #51 had no care plan in October 2015.

A NPN dated 10/10/15 indicated resident refused medications.

A NPN dated 10/19/15 indicated Resident #51 refused to get out of bed that morning and refused her antibiotic medication.

A NPN dated 10/27/15 indicated Resident #51 refused to get out of bed and was combative with staff, had verbal behaviors and refused treatment.

A physician's progress note dated 10/28/16 indicated Resident #51 was combative, non-compliant with taking her medications and with therapy that week. She was combative with morning care. She had refused to get out of bed. Resident #51 was indicated to have dementia

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with behavioral issues.

A review of the November 2015 MAR revealed Resident #51 refused a total of 36 medications on 4 distinct calendar days. This included 3 refusals for Ativan, 2 refusals for Lexapro, and 3 refusals for Seroquel.

The medical record was reviewed. Resident #51 had no care plan in November 2015.

Nursing Assistant (NA) documentation indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A NPN dated 11/10/15 indicated Resident #51 spit out medications, refused each attempt, and had verbal behaviors.

A NPN dated 11/11/15 indicated Resident #51 refused to get out of bed.

A physician's order dated 11/13/15 indicated an increase in Lexapro from 5mg once daily to 10mg once daily.

A physician's order dated 11/13/15 indicated a reduction in Ativan from 0.5mg twice daily to 0.25mg twice daily.

A NPN dated 11/13/15 indicated Resident #51's family was in the facility and expressed concern over her depressed and sleepy all of the time.

A NPN dated 11/17/15 indicated Resident #51 refused medications on five attempts.

A NPN dated 11/20/15 indicated Ativan 0.5mg prn was administered to Resident #51.

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A physician's order dated 11/20/15 indicated a reduction of Lexapro from 10mg once daily to 5mg once daily.

A NPN dated 11/25/15 indicated Resident #51 refused medications and her breathing treatment.

NA documentation dated 11/27/15 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A NPN dated 11/27/15 indicated Resident #51 refused to get out of bed, was combative with staff, and had verbal behaviors.

A review of the December 2015 MAR revealed Resident #51 refused a total of 87 medications on 9 distinct calendar days. This included 9 refusals for Ativan, 6 refusals for Lexapro, and 9 refusals for Seroquel.

The medical record was reviewed. Resident #51 had no care plan in December 2015.

A NPN dated 12/2/15 indicated Resident #51 refused medications on several attempts.

A NPN dated 12/3/15 indicated Resident #51 refused all morning medications on three attempts.

NA documentation dated 12/11/15 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected of care.

NA documentation dated 12/12/15 indicated Resident #51 had verbal behaviors.

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NA documentation dated 12/16/15 indicated Resident #51 had verbal behaviors, physical behaviors, other behaviors, and had rejected care.

A NPN dated 12/16/15 indicated Resident #51 refused all medications on four attempts.

A Social Service quarterly note dated 12/22/16 indicated no mood concerns reported by Resident #51 and no refusals noted during the seven day look back period of the quarterly MDS.

The quarterly MDS for Resident #51 dated 12/23/15 indicated she was cognitively intact. No mood or behaviors were noted during the assessment period. Medications received during the assessment period included seven days of an antipsychotic medication, seven days of an antianxiety medication, and six days of an antidepressant medication.

A NPN dated 12/28/15 indicated family had requested staff walk away from Resident #51 if there were refusals of care or medication.

NA documentation dated 12/29/15 indicated Resident #51 had verbal behaviors and had rejected care.

A review of the January 2016 MAR revealed Resident #51 refused a total of 106 medications on 9 distinct calendar days. This included 10 refusals for Ativan, 9 refusals for Lexapro, and 10 refusals for Seroquel.

NA documentation dated 1/3/16 indicated Resident #51 had verbal behaviors.

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A Care Conference Note dated 1/8/16 indicated a care conference was held for Resident #51. Resident #51's family was in attendance.

A Care Plan was initiated for Resident #51 on 1/8/16. There was no care plan for Resident #51 prior to 1/8/16. The care plan did not address psychotropic medications (Seroquel, Ativan, and Lexapro) with behaviors that included a pattern of medication refusals.

A physician's order dated 1/15/16 indicated a reduction in Ativan 0.5mg twice daily to Ativan 0.25mg twice daily for Resident #51.

A physician's order dated 1/15/16 indicated a discontinuation of Ativan 0.5mg prn every 6 hours for Resident #51.

A pharmacy note dated 1/18/16 indicated Resident #51 had occasional resistance care and medication refusals. It additionally indicated a request for a Gradual Dose Reduction (GDR) of Seroquel 25mg twice daily to once daily.

A NPN dated 1/24/16 indicated Resident #51 refused medications on two attempts.

A physician's order dated 1/25/16 indicated a reduction of Seroquel 25mg twice daily to Seroquel 25mg once every morning for Resident #51.

A review of the February 2016 MAR revealed Resident #51 refused a total of 93 medications on 8 distinct calendar days. This included 8 refusals for Ativan, 8 refusals for Lexapro, and 8 refusals for Seroquel.

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The medical record was reviewed. The care plan was not updated in February 2016.

NA documentation dated 2/3/16 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A NPN dated 2/4/16 indicated NAs had reported to the nurse that Resident #51 became resistant to care on their last rounds.

NA documentation dated 2/10/16 indicated Resident #51 had verbal behaviors and physical behaviors.

NA documentation dated 2/13/16 indicated Resident #51 had rejected care.

An Activity note indicated staff had discussed with Resident #51's family a change in her mood/behavior at activities.

NA documentation dated 2/19/16 indicated Resident #51 had verbal behaviors and had rejected care.

A review of the March 2016 MAR revealed Resident #51 refused a total of 108 medications on 10 distinct calendar days. This included 11 refusals for Ativan, 7 refusals for Lexapro, and 7 refusals for Seroquel.

The medical record was reviewed. The care plan was not updated in March 2016.

NA documentation dated 3/6/16 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

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A NPN dated 3/6/16 indicated Resident #51 had been combative with NAs, had verbal behaviors, and refused care.

A NPN dated 3/7/16 indicated Resident #51 refused NA care, had verbal behaviors, and physical behaviors that included scratching. Resident #51 had also refused morning medications.

NA documentation dated 3/8/16 indicated Resident #51 had verbal behaviors and physical behaviors.

A NPN dated 3/8/16 indicated Resident #51 had verbal behaviors and physical behaviors that included kicking. Resident #51 also refused morning medications and morning care from the NA.

A NPN dated 3/10/16 indicated Resident #51 refused medications.

A Care Conference note indicated a phone call was made to Resident #51 ' s family to schedule a care conference.

NA documentation dated 3/12/16 indicated Resident #51 had verbal behaviors.

A NPN dated 3/14/16 indicated Resident #51 had verbal behaviors and physical behaviors that included attempting to hit staff.

NA documentation dated 3/15/16 indicated Resident #51 had verbal behaviors.

NA documentation dated 3/23/16 indicated Resident #51 had verbal behaviors, physical

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behaviors, and had rejected care.

A MDS quarterly note dated 3/24/16 indicated Resident #51 had physical and verbal behaviors toward staff and family during the MDS review period.

The quarterly MDS for Resident #51 dated 3/24/16 indicated she had moderate cognitive impairment. She was indicated to have physical behaviors, verbal behaviors, and rejection of care one to three days during the assessment period. Medications received during the assessment period included six days of an antipsychotic medication, seven days of an antianxiety medication, and six days of an antidepressant medication.

A NPN dated 3/26/16 indicated Resident #51 refused care.

A review of the April 2016 MAR revealed Resident #51 refused a total of 128 medications on 15 distinct calendar days. This included 16 refusals for Ativan, 8 refusals for Lexapro, and 9 refusals for Seroquel.

The medical record was reviewed. The care plan was not updated in April 2016.

NA documentation dated 4/5/16 indicated Resident #51 had physical behaviors and had rejected care.

NA documentation dated 4/7/16 indicated Resident #51 had physical behaviors and other behaviors.

NA documentation dated 4/9/16 indicated

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Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A NPN dated 4/9/16 indicated Resident #51 was agitated, combative with staff, and refused all medications.

NA documentation dated 4/10/16 indicated Resident #51 had verbal behaviors and physical behaviors.

NA documentation dated 4/11/16 indicated Resident #51 had verbal behaviors and had rejected care.

NA documentation dated 4/12/16 indicated Resident #51 had verbal behaviors and had rejected care.

A physician's order dated 4/12/16 indicated a new order for Ativan 0.5mg prn every 6 hours for Resident #51.

A physician's order dated 4/12/16 indicated an increase in Lexapro from 5mg once daily to 10mg once at bedtime for Resident #51.

A physician's order dated 4/12/16 indicated a psychiatric consultation was ordered for Resident #51.

A NPN dated 4/12/16 indicated Resident #51 had verbal behaviors and physical behaviors toward staff. Ativan 0.5mg prn was administered. A psychiatric consultation was ordered.

A NPN dated 4/13/16 indicated Resident #51 verbally aggressive toward staff and refused care on three attempts.

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A NPN dated 4/13/16 indicated Ativan 0.5mg prn was administered to Resident #51.

A Social Service note dated 4/13/16 indicated the Social Worker (SW) spoke with Resident #51's family and they agreed to a psychiatric consultation.

A NPN dated 4/14/16 indicated Ativan 0.5mg prn was administered to Resident #51.

A Care Conference note dated 4/15/16 indicated Resident #51 had refusals of medications and a recent increase in behaviors that included verbal, physical, and refusals of care. Resident #51's family requested a reduction in Lexapro from 10mg daily to 5mg daily.

A physician's order dated 4/15/16 indicated a decrease in Lexapro from 10mg at bedtime to 5mg at bedtime for Resident #51.

A NPN dated 4/17/16 indicated Ativan 0.5mg prn was administered to Resident #51.

NA documentation dated 4/18/16 indicated Resident #51 had verbal behaviors and had rejected care.

A psychiatric consultation was completed on 4/20/16 for Resident #51.

NA documentation dated 4/22/16 indicated Resident #51 had verbal behaviors and had rejected care.

NA documentation dated 4/23/16 indicated Resident #51 had verbal behaviors and physical

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behaviors.

A NPN dated 4/25/16 indicated nursing staff spoke with Resident #51's responsible party (RP) regarding the psychiatric consultation. The RP requested contact with the psychiatric provider.

A NPN dated 4/28/16 indicated nursing staff spoke with Resident #51's RP regarding the psychiatric consultation and she agreed to an increase in Lexapro from 5mg to 10mg.

A physician's order dated 4/28/16 indicated an increase in Lexapro from 5mg at bedtime to 10mg once daily for Resident #51.

NA documentation dated 4/28/16 indicated Resident #51 had verbal behaviors.

A NPN dated 4/30/16 Ativan 0.5mg prn was administered to Resident #51.

An interview was conducted with the Director of Nursing (DON) on 5/3/16 at 3:40 PM. She stated that the MDS Coordinator was responsible for writing the care plans and completing revisions. She indicated the MDS Coordinator was not present at the facility. The DON revealed that the facility was aware that care plans were an area of concern. She indicated that issues with care plans were first identified several months ago. She stated that care plans continued to be an area of concern even after the issues were identified. She indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted with the Social Worker (SW) on 5/5/16 at 10:30 AM. She

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F 279	Continued From page 41 reviewed the medical record for Resident #51. She stated that Resident #51's care plan had a start date of 1/8/16. She indicated that Resident #51 did not have a care plan prior to 1/8/16. She additional indicated there was no care plan that addressed psychotropic medications with behaviors that included a pattern of medication refusals. An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their care plans. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that care planning was identified as an area of concern. He reported the facility was in the process of implementing multiple changes to address the areas of concern.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		6/2/16

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F 280	Continued From page 42 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview, the facility failed to complete a comprehensive care plan within seven days after the completion of the comprehensive assessment for 1 of 12 (Resident #51) sampled residents, failed to include the resident and/or responsible party in the care planning process and periodic review of the care plan for 5 of 12 (Residents #3, #56, #30,#42 and #16) sampled residents, and failed to review and revise a care plan for falls for 2 of 3 (Resident #42 and #44) sampled residents reviewed for falls. The findings included: 1. Resident #51 was admitted to the facility on 9/11/15 with multiple diagnoses including dementia, anxiety, and depression. Resident #51's Admission Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 9/22/15. The MDS assessment required a signature of a Registered Nurse Assessment Coordinator to verify its completion. This Admission MDS assessment was indicated to be completed on 9/24/15 (Question Z0500B). A review of the medical record revealed Resident #51's care plan had a start date of 1/8/16. There was no care plan for Resident #51 prior to 1/8/16. This was 106 days after the Admission MDS assessment was completed (9/24/15).	F 280	Resident #51 comprehensive care plan completed by MDS Coordinator on 5-26-16. Resident and/or family/ responsible party of residents #3, #30, #42, & #16 have been invited to attend care plan meeting by MDS Coordinator. Information has been and will to continue to be documented in ELECTRONIC MEDICAL RECORD (AOD) by MDS Coordinator. The Family of resident #56 participated in a care plan meeting on April 5, 2016 Resident #42 and #44 care plans was reviewed and revised June 2, 2016 by MDS Coordinator All residents have potential to be affected by this practice. An audit of the comprehensive was completed on 5-29-16 by MDS Coordinator to assure accuracy of the care plans. As a result of the audit incomplete care plans were updated and meetings scheduled with family. If deficiencies are identified, an updated comprehensive care plan will be completed within 30 days. All cognitively appropriate residents and applicable family / responsible parties will	

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F 280	Continued From page 43 An interview was conducted with the Director of Nursing (DON) on 5/3/16 at 3:40 PM. She stated that the MDS Coordinator was responsible for care plans. She indicated the MDS Coordinator was not present at the facility. The DON revealed that the facility was aware that care plans were an area of concern. She indicated that issues with care plans were first identified several months ago. She stated that care plans continued to be an area of concern even after the issues were identified. She indicated the new Administrator was aware of the issues and was addressing the concerns. An interview was conducted with the Social Worker (SW) on 5/5/16 at 10:30 AM. She reviewed the medical record for Resident #51. She stated that Resident #51's care plan had a start date of 1/8/16. She indicated that Resident #51 did not have a care plan prior to 1/8/16. An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their care plans. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that care planning was identified as an area of concern. He reported the facility was in the process of implementing multiple changes to address the areas of concern. 2. Resident #3 was admitted to the facility on 3/30/11 with multiple diagnoses including autistic disorder and severe intellectual disabilities. A review of Resident #3's medical record revealed her most recent care plan meeting was	F 280	be invited to participate in the care plan process going forward utilizing the MDS assessment calendar managed by the new Penick Village MDS Coordinator. Our MDS coordinator is putting into place a calendar system she has used for years to track quarterly and annual assessments. Our MDS coordinator educated all Inter-Disciplinary Team (IDT) members on the calendar system on 5-11-16. Our new calendar system tracks all assessments that are due each week and each month and will drive completion of MDS assessments. IDT members will be given a weekly calendar each week by MDS Coordinator identifying all assessments to be completed that week. We have also started using a 100 Day Tool for each and every resident that is using Medicare Benefits as a way to keep track Assessment Reference Dates. The new Penick Village MDS Coordinator will review care plans each time a resident is sent to the hospital and returns. The new Penick Village MDS Coordinator will utilize our MDS assessment calendar to invite all cognitively appropriate residents and applicable family / responsible parties to participate in the care plan process going forward. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days. The MDS Coordinator will bring copies of the care plan meeting invitations sent to family / responsible	

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F 280	Continued From page 44 held on 11/25/15. An interview was conducted with the Director of Nursing (DON) on 5/3/16 at 3:40 PM. She stated that care plans were reviewed quarterly and as needed. She additionally stated that care plan meetings were held quarterly and as needed. She indicated that the MDS Coordinator was responsible for care plan reviews, care plan revisions, care plan documentation, scheduling care plan meetings, and completion of the care plan meeting invitations to the resident and/or responsible party as applicable. She reported that the MDS Coordinator was not present at the facility. The DON indicated that care plan conferences were to be documented in the electronic medical record. She stated that a hard copy of the sign in sheet from each care plan conference was also kept in the chart. Resident #3's electronic and hard copy medical record were reviewed with the DON. She indicated that the last care plan meeting for Resident #3 was on 11/25/15. This was 161 days prior to the current date. She revealed she expected Resident #3 to have had at least one care plan meeting since 11/25/15. The DON interview continued. She revealed that the facility was aware that care plans were an area of concern. She additionally revealed that the timeliness of care plan meetings was a specific area of concern. She indicated that issues with care plans were first identified several months ago. She stated that care plans continued to be an area of concern even after the issues were identified. She indicated the new Administrator was aware of the issues and was addressing the concerns.	F 280	parties for upcoming care plan meetings and who attended the meetings. Documented findings and completion dates will be reported at the next QA meeting June 27, 2016 by MDS Coordinator.	

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An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their care plans. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that care planning was identified as an area of concern. He reported the facility was in the process of implementing multiple changes to address the areas of concern.

3. Resident #56 was admitted to the facility on 9/14/15 with multiple diagnoses including dementia, anxiety, and depression. The quarterly Minimum Data Set (MDS) assessment indicated she had significant cognitive impairment.

A review of Resident #56's medical record revealed one care plan meeting since admission on 4/5/16. This was 205 days after Resident #56's admission to the facility.

An interview was conducted with the Director of Nursing (DON) on 5/3/16 at 3:40 PM. She stated that care plans were reviewed quarterly and as needed. She additionally stated that care plan meetings were held quarterly and as needed. She indicated that the MDS Coordinator was responsible for care plan reviews, care plan revisions, care plan documentation, scheduling care plan meetings, and completion of the care plan meeting invitations to the resident and/or responsible party as applicable. She reported that the MDS Coordinator was not present at the facility. The DON indicated that care plan conferences were to be documented in the electronic medical record. She stated that a hard copy of the sign in sheet from each care plan

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conference was also kept in the chart.

The DON interview continued. She revealed that the facility was aware that care plans were an area of concern. She additionally revealed that the timeliness of care plan meetings was a specific area of concern. She indicated that issues with care plans were first identified several months ago. She stated that care plans continued to be an area of concern even after the issues were identified. She indicated the new Administrator was aware of the issues and was addressing the concerns.

An interview was conducted on 5/5/16 at 12:30 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their care plans. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that care planning was identified as an area of concern. He reported the facility was in the process of implementing multiple changes to address the areas of concern.

4 a. Resident #42 was admitted to the facility 12/15/15. Cumulative diagnoses included Parkinson ' s disease.

An Admission Minimum Data Set (MDS) dated 12/20/15 indicated Resident #42 had short term and long term memory impairment. He required extensive assistance with bed mobility and transfers. No ambulation occurred. The MDS indicated Resident #42 had sustained one fall since admission to the facility.

A care plan dated 12/30/15 indicated Resident #42 had an actual fall. Interventions included: Complete a fall risk assessment quarterly. Keep

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room clutter free and well lit. Call light within reach. Keep bed in low locked position. A mobility monitor for the bed and chair. Assistance needed to wear non-skid footwear. Extensive assist with transfers.

A review of the incidents and accidents for the past six months revealed Resident #42 had falls on 12/16/15, 12/24/15, 1/24/16 and 4/28/16.

An incident report dated 12/16/15 at 5:00AM stated Resident #42 was noted getting out of bed. An alarm was heard coming from the room and staff entered to find the resident lying on the floor. Follow up action indicated to have a fall mat in place when resident was in bed. Check placement every shift. Remind him to call for assistance. Use a bed/ chair alarm.

An incident report dated 12/24/15 at 12:30AM stated resident was found on the floor in his room. Follow-up action stated: landing strip. Ensure bed/ chair alarm in place.

An incident report dated 1/24/16 at 3:00PM stated staff heard the alarm sounding. Staff observed Resident #42 halfway out of bed with his legs on the fall mat. Follow-up action included the use of a concave mattress.

An incident report dated 4/28/16 at 4:30PM stated Resident #42's alarm was going off. Resident was trying to get out of bed. Nursing students and their teacher were present and assisted him to the floor mat in a sitting position. No new interventions were indicated.

On 5/04/2016 at 11:03 AM, an interview was conducted with Resident #42. He stated he had

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trouble with his legs and did not walk. Resident #42 stated he did not use his call bell but yelled out when he needed help. He also stated they kept an alarm on him when he was in the chair and in the bed.

On 5/04/2016 at 11:05 AM, an observation of Resident #42 was conducted. Resident #42 was sitting in his wheelchair with a personal care alarm attached to his shoulder. A concave mattress was noted on his bed and a fall mat was on the floor beside the bed. An alarm mat was also noted on the mattress.

A review of the care plan revealed there had been no documentation of the falls on 12/24/15, 1/24/16 or 4/28/16. None of the added interventions of the fall mat or concave mattress was indicated on the care plan.

On 5/4/16 at 5:00PM, an interview was conducted with the Director of Nursing. She stated the interdisciplinary team discussed falls in the morning meeting. She stated she made notes on the incident reports with recommendations put on the incident report. The Director of Nursing stated the MDS coordinator was in the meeting and was supposed to update the care plan. She said her expectation was for the MDS coordinator to update the care plan during or following the morning meeting on that day.

4 b. Resident #42 was admitted to the facility 12/15/15. Cumulative diagnoses included Parkinson's disease.

A Quarterly MDS dated 3/21/16 indicated Resident #42 was moderately impaired in

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cognition. He required extensive assistance for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene. Supervision was needed with eating. Total assistance was needed with bathing. Resident #42 had sustained two falls since the last assessment.

A review of the care plan revealed that a care plan conference was held with Resident #42 and his family on 12/29/15. No further care plan conferences had been held since that time and there was no documentation that Resident #42 and/or family had been involved in the care planning process since 12/29/15.

On 5/03/2016 at 2:50 PM, an interview was conducted with the Director of Nursing. She stated the MDS coordinator was the person who invited residents and family members to the care conference, scheduled the care conference and documented the care conference in the interdisciplinary notes. The Director of Nursing stated they had identified the issue of care plan conferences not being done several months ago. The issue was brought to the attention of the previous administrator with no improvement noted. She stated she informed the new administrator of the issues with the MDS coordinator in January. The facility conducted a mock survey in March and also identified the issue regarding the lack of timely care plan conferences. She stated a new MDS coordinator will begin on May 9, 2016.

5. Resident #16 was admitted to the facility on 11/10/15. Cumulative diagnoses included hypertension, osteoarthritis and long term use of anticoagulants.

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An Admission Minimum Data Set (MDS) dated 11/17/15 indicated Resident #16, per staff interview, had no short term or long term memory impairment. Modified independence was noted with decision-making skills.

A Quarterly MDS dated 2/17/16 indicated Resident #16 was cognitively intact.

A review of the medical record revealed a care plan conference was not held with Resident #16 and/or her family until 4/22/16.

On 5/03/2016 at 2:50 PM, an interview was conducted with the Director of Nursing. She stated the MDS coordinator was the person who invited residents and family members to the care conference, scheduled the care conference and documented the care conference in the interdisciplinary notes. The Director of Nursing stated they had identified the issue of care plan conferences not being done several months ago. The issue was brought to the attention of the previous administrator with no improvement noted. She stated she informed the new administrator of the issues with the MDS coordinator in January. The facility conducted a mock survey in March and also identified the issue regarding the lack of timely care plan conferences. She stated a new MDS coordinator will begin on May 9, 2016. She stated her expectation was that a new resident should have a care plan conference within the first 21 days of admission.

6. Resident #44 was admitted to the facility on 5/18/15 with multiple diagnoses including Vascular Dementia. The quarterly Minimum Data

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Set (MDS) assessment dated 2/17/16 indicated that Resident #44 had memory and decision making problems and had one fall with injury.

The care plan dated 2/17/16 was reviewed. One of the care plan problems was potential for falls. The approaches included to complete a fall risk assessment quarterly and after any fall, needed total assist with transfer using a Hoyer lift, bed in lowest position, pad at bedside and to check frequently.

The incident reports for the last six months were reviewed. The reports indicated that Resident #44 had six falls in the last six months (11/5/15 at 5:45 PM, 1/12/16 at 5:30 PM, 2/29/16 at 6:40 AM, 3/12/16 at 6:50 PM, 3/31/16 at 6:00 PM and 4/10/16 at 4:00 PM). The corrective actions for all the falls were bed/chair alarm, monitoring and pommel cushion.

On 5/4/16 at 9:45 AM, Nurse # 2 was interviewed. Nurse #2 indicated that Resident #44 was a high risk for falls. She tried to get out of bed/chair unassisted. She had an alarm in bed and chair to alert the staff that she was trying to get out of bed/chair.

The MDS Nurse was not available for interview.

On 5/3/16 at 2:50 PM, the DON was interviewed. The DON indicated that each incident report was reviewed in the standup meeting every day. She had to write the corrective action on the incident report and the MDS Nurse was expected to revise the care plan to reflect the corrective actions/interventions.

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F 280	Continued From page 52 7. Resident # 30 was admitted to the facility on 6/26/15 with multiple diagnoses including Dementia. The quarterly Minimum Data Set (MDS) assessment dated 4/3/16 indicated that Resident #30 had memory and decision making problems. Resident #30 had four MDS assessments completed since admission to the facility, 7/2/15 (admission), 10/2/15 (quarterly), 1/2/16 (quarterly and 4/3/16 (quarterly). On 5/2/16, a family interview for Resident #30 was conducted. The family member indicated that she was not invited to participate in the care planning meeting since the resident was admitted to the facility. The ID (interdisciplinary) notes were reviewed since admission and there were no documentation that the family of Resident #30 was invited to the care plan meeting. Review of the records for Resident #30 revealed no care plan sign in sheets in the chart. On 5/3/16 at 3:15 PM, the Director of Nursing (DON) was interviewed. The DON indicated that the MDS/care plan nurse was not available for interview. She expected the MDS nurse to document on the ID notes or on the care plan sign in sheets that the resident or the family member was invited to the care plan meeting.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care.	F 309		6/2/16

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F 309	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to identify and address a pattern of behavioral issues that included medication refusals resulting in six months of continued behavioral issues and refusals of antipsychotic medications, antianxiety medications, antidepressant medications, and other medications for one of five residents (Resident #51) reviewed for unnecessary medications. The findings included: Resident #51 was admitted to the facility on 9/11/15 with multiple diagnoses including dementia, anxiety, and depression. Resident #51's admission physician orders dated 9/11/15 indicated Seroquel (antipsychotic) 25 milligrams (mg) once every 12 hours, Ativan (antianxiety) 0.5mg twice daily, Ativan 0.5mg as needed (prn) every 6 hours, and Lexapro (antidepressant) 5mg once daily. A review of the September 2015 Medication Administration Record (MAR) revealed Resident #51 received Seroquel, Ativan, and Lexapro as ordered by the physician. An Admission Minimum Data Set (MDS) assessment dated 9/22/15 indicated Resident #51 had significantly impaired cognition. No mood or behaviors were noted during the assessment period. Medications received during the assessment period included seven days of an antipsychotic medication, seven days of an antianxiety medication, and six days of an	F 309	Resident #51 had a new comprehensive care plan completed on 5-29-16 by new MDS Coordinator that includes but is not limited to risk for refusing medication. Our Pharmacist consultant reviewed the medications of resident #51 medications and provide recommendations to the appropriate physician(s)on 5-18-16. Resident # 51 has standing monthly appointment with visiting psychiatric nurse practitioner which began in April 2016. Resident #51□s family has been invited to a care plan meeting by MDS Coordinator and is documented IN electronic medical record (AOD). All residents have potential to be affected by this practice. An audit of all medication refusals was conducted on 6-1-16. All full-time, part-time, and PRN Licensed nursing staff was in-serviced by DON on proper response to refusal of medications and or care, non-baseline behavior reporting, and how care plans reflect baseline behaviors by June 2, 2016. New licensed staff will be educated during orientation period. Nursing staff will be educated on reporting medication refusals to DON, family, and physician per policy during above mentioned in-service. DON will monitor any medication refusals to ensure appropriate follow-up actions have occurred. MD will be notified of any	

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F 309	Continued From page 54 antidepressant medication. The medical record was reviewed. Resident #51 had no care plan in September 2015. A Nursing Progress Note (NPN) dated 9/24/15 indicated Resident #51 refused to get up on three attempts. A review of the October 2015 MAR revealed Resident #51 refused a total of 19 medications on 3 distinct calendar days. This included 2 refusals for Ativan, 1 refusal for Lexapro, and 2 refusals for Seroquel. The medical record was reviewed. Resident #51 had no care plan in October 2015. A NPN dated 10/10/15 indicated resident refused medications. A NPN dated 10/19/15 indicated Resident #51 refused to get out of bed that morning and refused her antibiotic medication. A NPN dated 10/27/15 indicated Resident #51 refused to get out of bed and was combative with staff, had verbal behaviors and refused treatment. A physician's progress note dated 10/28/16 indicated Resident #51 was combative, non-compliant with taking her medications and with therapy that week. She was combative with morning care. She had refused to get out of bed. Resident #51 was indicated to have dementia with behavioral issues. A review of the November 2015 MAR revealed	F 309	medication refusals in excess of 3 refusals in a 30 period. Any pattern of behaviors or medication refusals will be brought to MD attention immediately to determine the need for psych services. DON will perform audit of any medication refusals or behaviors to ensure appropriate interventions are in place and report findings to QA meeting. Agenda and attendance results of above in-services will be shared at the next QA meeting by DON. In-services on refusal of medication and or care, non-baseline behavior reporting, and how care plans reflect baseline behaviors will be completed annually moving forward by DON. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review 3 resident MARs and ensure appropriate interventions are place. Documented findings and completion dates will be reported at the next QA meeting by DON. The agenda and the attendance logs from the in-services mentioned above will also be reported at the next QA meeting. And In-services on refusal of medications and or care, non-baseline behavior reporting, and how care plans reflect baseline behaviors will be completed annually moving forward by DON.	

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Resident #51 refused a total of 36 medications on 4 distinct calendar days. This included 3 refusals for Ativan, 2 refusals for Lexapro, and 3 refusals for Seroquel.

The medical record was reviewed. Resident #51 had no care plan in November 2015.

Nursing Assistant (NA) documentation indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A NPN dated 11/10/15 indicated Resident #51 spit out medications, refused each attempt, and had verbal behaviors.

A NPN dated 11/11/15 indicated Resident #51 refused to get out of bed.

A physician's order on 11/13/15 indicated an increase in Lexapro from 5mg once daily to 10mg once daily.

A physician's order dated 11/13/15 indicated a reduction in Ativan from 0.5mg twice daily to 0.25mg twice daily.

A NPN dated 11/13/15 indicated Resident #51's family was in the facility and expressed concern over her depressed and sleepy all of the time.

A NPN dated 11/17/15 indicated Resident #51 refused medications on five attempts.

A NPN dated 11/20/15 indicated Ativan .5mg prn was administered to Resident #51.

A physician's order dated 11/20/15 indicated a reduction of Lexapro from 10mg once daily to

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5mg once daily.

A NPN dated 11/25/15 indicated Resident #51 refused medications and her breathing treatment.

NA documentation dated 11/27/15 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A NPN dated 11/27/15 indicated Resident #51 refused to get out of bed, was combative with staff, and had verbal behaviors.

A review of the December 2015 MAR revealed Resident #51 refused a total of 87 medications on 9 distinct calendar days. This included 9 refusals for Ativan, 6 refusals for Lexapro, and 9 refusals for Seroquel.

The medical record was reviewed. Resident #51 had no care plan in December 2015.

A NPN dated 12/2/15 indicated Resident #51 refused medications on several attempts.

A NPN dated 12/3/15 indicated Resident #51 refused all morning medications on three attempts.

NA documentation dated 12/11/15 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected of care.

NA documentation dated 12/12/15 indicated Resident #51 had verbal behaviors.

NA documentation dated 12/16/15 indicated Resident #51 had verbal behaviors, physical behaviors, other behaviors, and had rejected

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care.

A NPN dated 12/16/15 indicated Resident #51 refused all medications on four attempts.

A Social Service quarterly note dated 12/22/16 indicated no mood concerns reported by Resident #51 and no refusals noted during the seven day look back period of the quarterly MDS.

The quarterly MDS for Resident #51 dated 12/23/15 indicated she was cognitively intact. No mood or behaviors were noted during the assessment period. Medications received during the assessment period included seven days of an antipsychotic medication, seven days of an antianxiety medication, and six days of an antidepressant medication.

A NPN dated 12/28/15 indicated family had requested staff walk away from Resident #51 if there were refusals of care or medication.

NA documentation dated 12/29/15 indicated Resident #51 had verbal behaviors and had rejected care.

A review of the January 2016 MAR revealed Resident #51 refused a total of 106 medications on 9 distinct calendar days. This included 10 refusals for Ativan, 9 refusals for Lexapro, and 10 refusals for Seroquel.

NA documentation dated 1/3/16 indicated Resident #51 had verbal behaviors.

A Care Conference Note dated 1/8/16 indicated a care conference was held for Resident #51. Resident #51's family was in attendance.

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A Care Plan was initiated for Resident #51 on 1/8/16. There was no care plan for Resident #51 prior to 1/8/16. The care plan did not address psychotropic medications (Seroquel, Ativan, and Lexapro) with behaviors that included a pattern of medication refusals.

A physician's order dated 1/15/16 indicated a reduction in Ativan 0.5mg twice daily to Ativan 0.25mg twice daily for Resident #51.

A physician's order dated 1/15/16 indicated a discontinuation of Ativan 0.5mg prn every 6 hours for Resident #51.

A pharmacy note dated 1/18/16 indicated Resident #51 had occasional resistance care and medication refusals. It additionally indicated a request for a Gradual Dose Reduction (GDR) of Seroquel 25mg twice daily to once daily.

A NPN dated 1/24/16 indicated Resident #51 refused medications on two attempts.

A physician's order dated 1/25/16 indicated a reduction of Seroquel 25mg twice daily to Seroquel 25mg once every morning for Resident #51.

A review of the February 2016 MAR revealed Resident #51 refused a total of 93 medications on 8 distinct calendar days. This included 8 refusals for Ativan, 8 refusals for Lexapro, and 8 refusals for Seroquel.

The medical record was reviewed. The care plan was not updated in February 2016.

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NA documentation dated 2/3/16 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A NPN dated 2/4/16 indicated NAs had reported to the nurse that Resident #51 became resistant to care on their last rounds.

NA documentation dated 2/10/16 indicated Resident #51 had verbal behaviors and physical behaviors.

NA documentation dated 2/13/16 indicated Resident #51 had rejected care.

An Activity note indicated staff had discussed with Resident #51's family a change in mood/behavior at activities.

NA documentation dated 2/19/16 indicated Resident #51 had verbal behaviors and had rejected care.

A review of the March 2016 MAR revealed Resident #51 refused a total of 108 medications on 10 distinct calendar days. This included 11 refusals for Ativan, 7 refusals for Lexapro, and 7 refusals for Seroquel.

The medical record was reviewed. The care plan was not updated in March 2016.

NA documentation dated 3/6/16 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A NPN dated 3/6/16 indicated Resident #51 had been combative with NAs, had verbal behaviors, and refused care.

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A NPN dated 3/7/16 indicated Resident #51 refused NA care, had verbal behaviors, and physical behaviors that included scratching. Resident #51 had also refused morning medications.

NA documentation dated 3/8/16 indicated Resident #51 had verbal behaviors and physical behaviors.

A NPN dated 3/8/16 indicated Resident #51 had verbal behaviors and physical behaviors that included kicking. Resident #51 also refused morning medications and morning care from the NA.

A NPN dated 3/10/16 indicated Resident #51 refused medications.

A Care Conference note indicated a phone call was made to Resident #51's family to schedule a care conference.

NA documentation dated 3/12/16 indicated Resident #51 had verbal behaviors.

A NPN dated 3/14/16 indicated Resident #51 had verbal behaviors and physical behaviors that included attempting to hit staff.

NA documentation dated 3/15/16 indicated Resident #51 had verbal behaviors.

NA documentation dated 3/23/16 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

A MDS quarterly note dated 3/24/16 indicated

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Resident #51 had physical and verbal behaviors toward staff and family during the MDS review period.

The quarterly MDS for Resident #51 dated 3/24/16 indicated she had moderate cognitive impairment. She was indicated to have physical behaviors, verbal behaviors, and rejection of care one to three days during the assessment period. Medications received during the assessment period included six days of an antipsychotic medication, seven days of an antianxiety medication, and six days of an antidepressant medication.

A NPN dated 3/26/16 indicated Resident #51 refused care.

A review of the April 2016 MAR revealed Resident #51 refused a total of 128 medications on 15 distinct calendar days. This included 16 refusals for Ativan, 8 refusals for Lexapro, and 9 refusals for Seroquel.

The medical record was reviewed. The care plan was not updated in April 2016.

NA documentation dated 4/5/16 indicated Resident #51 had physical behaviors and had rejected care.

NA documentation dated 4/7/16 indicated Resident #51 had physical behaviors and other behaviors.

NA documentation dated 4/9/16 indicated Resident #51 had verbal behaviors, physical behaviors, and had rejected care.

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A NPN dated 4/9/16 indicated Resident #51 was agitated, combative with staff, and refused all medications.

NA documentation dated 4/10/16 indicated Resident #51 had verbal behaviors and physical behaviors.

NA documentation dated 4/11/16 indicated Resident #51 had verbal behaviors and had rejected care.

NA documentation dated 4/12/16 indicated Resident #51 had verbal behaviors and had rejected care.

A physician's order dated 4/12/16 indicated Ativan 0.5mg prn every 6 hours for Resident #51.

A physician's order dated 4/12/16 indicated an increase in Lexapro from 5mg once daily to 10mg once at bedtime for Resident #51.

A physician's order dated 4/12/16 indicated a psychiatric consultation was ordered for Resident #51.

A NPN dated 4/12/16 indicated Resident #51 had verbal behaviors and physical behaviors toward staff. Ativan prn was administered. A psychiatric consultation was ordered.

A NPN dated 4/13/16 indicated Resident #51 verbally aggressive toward staff and refused care on three attempts.

A NPN dated 4/13/16 indicated Ativan 0.5mg prn was administered to Resident #51.

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A Social Service note dated 4/13/16 indicated the Social Worker (SW) spoke with Resident #51's family and they agreed to a psychiatric consultation.

A NPN dated 4/14/16 indicated Ativan 0.5mg prn was administered to Resident #51.

A Care Conference note dated 4/15/16 indicated Resident #51 had refusals of medications and a recent increase in behaviors that included verbal, physical, and refusals of care. Resident #51's family requested a reduction in Lexapro from 10mg daily to 5mg daily.

A physician's order dated 4/15/16 indicated a decrease in Lexapro from 10mg at bedtime to 5mg at bedtime for Resident #51.

A NPN dated 4/17/16 indicated Ativan 0.5mg prn was administered to Resident #51.

NA documentation dated 4/18/16 indicated Resident #51 had verbal behaviors and had rejected care.

A psychiatric consultation was completed on 4/20/16 for Resident #51.

NA documentation dated 4/22/16 indicated Resident #51 had verbal behaviors and had rejected care.

NA documentation dated 4/23/16 indicated Resident #51 had verbal behaviors and physical behaviors.

A NPN dated 4/25/16 indicated nursing staff spoke with Resident #51's responsible party (RP)

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regarding the psychiatric consultation. The RP requested contact with the psychiatric provider.

A NPN dated 4/28/16 indicated nursing staff spoke with Resident #51's RP regarding the psychiatric consultation and she agreed to an increase in Lexapro from 5mg to 10mg.

A physician's order dated 4/28/16 indicated an increase in Lexapro from 5mg at bedtime to 10mg once daily for Resident #51.

NA documentation dated 4/28/16 indicated Resident #51 had verbal behaviors.

A NPN dated 4/30/16 Ativan 0.5mg prn was administered to Resident #51.

An interview was conducted with the Social Worker (SW) on 5/5/16 at 10:30 AM. The SW indicated that ideally she was informed of residents with behaviors by nursing staff verbally. She stated that sometimes she was informed and sometimes she was not. She stated that if nursing staff reported behaviors to her it was then discussed in the morning meeting. She indicated she had not routinely reviewed behavior documentation. She stated that if a resident was having repetitive behaviors and/or medication refusals she expected to be informed. She indicated that multiple medication refusals were a concern to her.

The interview with the SW continued. She stated she was familiar with Resident #51. She indicated staff had informed her of a behavioral incident that occurred with Resident #51 in April. She stated she then completed a referral for a psychiatric consultation for Resident #51 due to

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new physical behaviors. She indicated Resident #51 had a psychiatric consultation a couple of weeks ago. She revealed she was unaware of Resident #51 having had behaviors prior to April. She indicated she was informed in April by Resident #51's family that she had some medication refusals. She revealed she was not aware of medication refusals prior to being informed by Resident #51's family. The medical record of Resident #51 was reviewed with the SW. She revealed she had not been informed of the behaviors and medication refusals that initially began in October 2015 and had continued through April 2016. She indicated she would have discussed a psychiatric consultation early on with Resident #51's family had she been informed of the behaviors and medication refusals.

An interview was conducted with the Director of Nursing (DON) on 5/5/16 at 10:45 AM. She indicated that behavioral issues were expected to be reported in the daily morning meeting by nursing staff. She stated that medication refusals were not reported in the morning meeting. She indicated she expected to be informed verbally by nursing staff of any repetitive medication refusals.

The interview with the DON continued. She stated she was familiar with Resident #51. She revealed she became aware of Resident #51's behavioral issues and repetitive medication refusals in April. She indicated she was not aware of the behavioral issues and repetitive medication refusals prior to April. She stated that she should have been informed by nursing staff when the behavioral issues and medication refusals became a pattern.

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F 312	Continued From page 66	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to feed 3 (Residents # 18, 11 & 45) of 3 sampled residents who needed extensive assistance or totally dependent on the staff with eating. Findings included: 1. Resident #18 was admitted to the facility on 11/19/12 with multiple diagnoses including Multiple Sclerosis and Paraplegia. The quarterly Minimum Data Set (MDS) assessment dated 2/13/16 indicated that Resident #18 ' s cognition was moderately impaired and she needed extensive assistance with eating. The care plan dated 3/8/16 was reviewed. One of the care plan problems was Resident #18 required total or extensive assistance with eating and the approaches included to assist her with all her meals. On 5/2/16 at 11:35 AM, a dining observation was conducted on the station 2 hall. At 11:40, a dietary aide was observed to bring the lunch tray to the room of Resident #18. A continuous observation was conducted from 11:40 AM until	F 312	Resident #11 is being fed when the meal is received. Resident #45 passed away on May 23, 2016. The care plan of resident #18 care plan has been updated to reflect how the resident prefers to have her meals delivered and served by MDS Coordinator. Staff educated on resident's preferences on 5-26-16 Dining Service process has been observed by DON several times during different meals. Residents who need assistance with dining have potential to be affected by this process. The Dining process for residents who need assistance will be assessed in partnership with the nursing team and dining service team. The new process will consist of dining services staff member will report to nursing floor with meals to be delivered and a designated nursing assistant will assist with the tray delivery ensuring that all trays are set up appropriately and residents that need assistance with meals	6/2/16

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F 312	Continued From page 67 12:25 PM. There was no staff member observed to enter the room to feed Resident #18. There were 3 nurse's aides working on the hall, 2 NAs (nurse aides) were in the dining room and 1 NA was helping station 1 to feed residents. At 12:20 PM, 2 NAs were observed collecting trays and when NA #1 was interviewed, she stated that they were just finished feeding residents in the dining room. NA #1 stated that Resident #18 needed assistance with eating. She added that they were short 1 NA and that was the reason why there was no staff member feeding residents in their rooms. On 5/3/16 at 5:00 until 6:00 PM, a continuous dining observation was conducted on station 2 hall. At 5:15 PM, the dinner tray was served to Resident #18 by a dietary staff. There was no staff member observed to enter the room of Resident #18 to assist her with eating. At 5:50 PM, NA #3 was interviewed. She stated that they have 5 feeders on the hall including Resident #18 and they tried to feed everybody. On 5/4/16 at 5:00 PM, Resident #18 was interviewed. She stated that she had to wait 30-45 minutes frequently to be fed. On 5/5/16 at 8:30 AM, the DON was interviewed. She stated that she expected staff to feed residents as soon as the tray was served. She indicated that they were not short of staff. The NAs did not have a system in feeding residents. 2. Resident #11 was admitted to the facility on 9/24/07 with multiple diagnoses including Dementia. The quarterly MDS assessment dated	F 312	are assisted when trays are placed in front of resident. Dining services staff will not deliver any tray without nursing staff member present to assist with meal set up. The updated process will be documented and the staff will be in-serviced on updates on 6-2-16 by DON (nursing) and Dietitian (dining services). After implementing the new process on 6-2-16 it will be observed on a regular basis for next 90 days including weekends by DON and the process will be reviewed the staff at monthly nursing meetings for systemic improvements in partnership with the dining services team. DON will monitor how long it takes for residents to begin eating meal after food is provided. In-services was completed on 6-2-16 for all nursing staff and Dining Services tray delivery personnel to be sure each person has a clear understanding of our process for delivery, set up and assistance during meal times. Our Director of Nursing and/or Clinical Manager will observe different meal times several times per week during the next 90 days and randomly thereafter to ensure our processes are being followed and that residents are being assisted properly and in a timely fashion. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review the meal observation results. Documented findings and completion dates will be reported at	

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F 312	Continued From page 68 2/26/16 indicated that Resident #11 had memory and decision making problems and needed extensive assistance with eating. The care plan dated 2/26/16 was reviewed. One of the care plan problems was Resident #11 required total care with eating. One of the approaches was to feed the resident with all meals. On 5/2/16 at 11:35 AM, a dining observation was conducted on the station 2 hall. At 11:40, a dietary aide was observed to bring the lunch tray to the room of Resident #11. A continuous observation was conducted from 11:40 AM until 12:25 PM. There was no staff member observed to enter the room to feed Resident #11. There were 2 nurse's aides working on the hall, 1 NA was in the dining room with a trainee and 2 NAs (1 NA from station 2) were on the hall feeding residents. On 5/2/16 at 12:25 PM, Nurse #3 was interviewed. Nurse #3 stated that they were supposed to have 4 NAs but they were short 2 so 1 NA from station 2 came to help feed residents. On 5/2/16 at 12:26 PM, NA # 4 was interviewed. She stated that they have 4-5 feeders on the hall. She stated that they tried their best to feed residents. NA #4 verified that Resident #11 needed assistance with eating. On 5/5/16 at 8:30 AM, the DON was interviewed. She stated that she expected staff to feed residents as soon as the tray was served. She indicated that they were not short of staff. The NAs did not have a system in feeding residents.	F 312	the next QA meeting by DON. The agenda and the attendance logs from the in-services mentioned above will also be reported at the next QA meeting.	

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3. Resident #45 was admitted to the facility on 12/17/13 with multiple diagnoses including Vascular Dementia. The quarterly MDS assessment dated 3/11/16 indicated that Resident #45 had memory and decision making problems and was totally dependent on the staff with eating.

The care plan dated 3/11/16 was reviewed. One of the care plan problems was Resident #45 required total care with eating. One of the approaches was to feed the resident with all meals.

On 5/2/16 at 11:35 AM, a dining observation was conducted on the station 2 hall. At 11:40, a dietary aide was observed to bring the lunch tray to the room of Resident #45. A continuous observation was conducted from 11:40 AM until 12:25 PM. There was no staff member observed to enter the room to feed Resident #45. There were 2 nurse's aides working on the hall, 1 NA was in the dining room with a trainee and 2 NAs (1 NA from station 2) were on the hall feeding residents.

On 5/2/16 at 12:25 PM, Nurse #3 was interviewed. Nurse #3 stated that they were supposed to have 4 NAs but they were short 2 so 1 NA from station 2 came to help feed residents.

On 5/2/16 at 12:26 PM, NA # 4 was interviewed. She stated that they have 4-5 feeders on the hall. She stated that they tried their best to feed residents. NA #4 verified that Resident #45 needed assistance with eating.

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F 312	Continued From page 70 On 5/5/16 at 8:30 AM, the DON was interviewed. She stated that she expected staff to feed residents as soon as the tray was served. She indicated that they were not short of staff. The NAs did not have a system in feeding residents.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to implement an effective intervention to prevent further fall for 1 (Resident #44) of 3 sampled residents with accidents. Findings included: Resident #44 was admitted to the facility on 5/18/15 with multiple diagnoses including Vascular Dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/17/16 indicated that Resident #44 had memory and decision making problems and had one fall with injury. The assessment also indicated that Resident #44 needed extensive assist with transfers. The care plan dated 2/17/16 was reviewed. One	F 323	Fall risk assessment for resident #44 was completed by DON on 61-16. Interventions will be updated on care plan Care plan was updated to address fall prevention protocols by 6-2-16. A care plan conference with the family / responsible party was scheduled by MDS coordinator For residents who may have been affected by this deficient practice, residents who are at risk for falls were identified, interventions were reviewed and care plans were updated as necessary. DON will perform audit of residents at risk for falls by 6-2-16 and ensure interventions are in place on	6/2/16

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F 323	Continued From page 71 of the care plan problems was potential for falls. The approaches included to complete a fall risk assessment quarterly and after any fall, needed total assist with transfer using a Hoyer lift, bed in lowest position, pad at bedside and to check frequently. The incident reports for the last six months were reviewed. The report dated 11/5/15 at 5:45 PM indicated that the resident was found on the floor in front of the wheelchair. The corrective action were ensure chair alarm in place and functioning and pommel cushion was properly placed. The report dated 1/12/16 at 5:30 PM indicated that Resident #44's alarm went off and found resident on the floor. A skin tear was noted to the left forearm. The corrective action were to continue the alarm and monitoring of resident. The report dated 2/29/16 at 6:40 AM indicated that the resident was found on the floor beside the bed. The corrective action were continue bed/chair alarm and monitoring. The report dated 3/12/16 at 6:50 PM indicated that the resident slid out of wheelchair to the floor. The corrective actions were continue with chair alarm, monitoring and pommel cushion. The report dated 3/31/16 at 6:00 PM revealed that the resident was found on the floor mat. The corrective actions were continue bed alarm and monitoring. The report dated 4/10/16 at 4:00 PM revealed that the resident was on the floor next to her wheelchair. When assessed, the resident was not moving her leg so she was sent to the emergency room. The resident came back with no fracture. The corrective action were monitoring and fall precaution. Resident #44 was observed on 5/3/16 at 5:30 PM. She was up in wheelchair in her room and	F 323	resident and on care plan DON and MDS coordinator will review residents who are at risk for falls daily for and update interventions and care plans as necessary on an on-going basis. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review residents who are at risk for falls documented findings will be reported at the next QA meeting by DON.	

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F 323	Continued From page 72 the chair alarm was attached to her. On 5/4/16 at 9:30 AM, Resident #44 was observed in bed. A bed pad alarm was observed. On 5/4/16 at 9:45 AM, Nurse # 2 was interviewed. Nurse #2 indicated that Resident #44 was a high risk for falls. She tried to get out of bed/chair unassisted. She had an alarm in bed and chair to alert the staff that she was trying to get out of bed/chair. On 5/3/16 at 2:50 PM, the DON was interviewed. The DON indicated that each incident report was reviewed in the standup meeting every day. She had to write the corrective action on the incident report and the MDS Nurse was expected to revise the care plan to reflect the corrective actions/interventions. The interventions for Resident #44 were bed/chair alarms and pommel cushion.	F 323		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334		6/8/16

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F 334	Continued From page 73 immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 334		

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F 334	Continued From page 74 (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to offer and to administer influenza and pneumococcal vaccines to 3 (Residents # 49, #77 & #56) of 5 sampled residents reviewed. Findings included: The facility's policy on Influenza and Pneumococcal Vaccination dated November, 2013 were reviewed. The Influenza Vaccination policy read in part " If the resident had not received the influenza immunization/vaccination in the last 12 months and or during the current year's flu season and the resident was not allergic to the eggs, Gentamycin Sulfate, Neomycin, Polymyxin, Thimerosol or Sodium Bisulfate, the immunization shall be offered to the resident along with education regarding the benefits and potential side effects of the immunization. The immunization shall then be provided to the resident and documented on the immunization form on the resident's record and in the electronic charting system. " The Pneumococcal Immunization policy read in part " prior to offering the pneumococcal immunization, each resident or the resident's legal representative shall receive education regarding the benefits and potential side effects	F 334	The charts of residents #49, #77 and #56 were audited to ensure that appropriate vaccines were offered, given, refused, or already received by DON Additionally ensuring that residents who received or refused vaccination at Penick Village and their loved ones were educated on vaccine safety and efficacy. The above residents were offered vaccines. Results documented in AOD Our DON and Admissions Coordinator will complete an audit of all existing residents to ensure that appropriate vaccines were offered, given, refused, or already received by 6-8-16. All residents who have not had vaccines have been offered vaccine and information documented in AOD in. Residents who received or refused vaccination at Penick Village and their loved ones were educated on vaccine safety and efficacy. Information will be documented in AOD. DON will monitor and audit to ensure vaccines are offered and documented in AOD.	

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F 334	Continued From page 75 of the immunization. Residents shall be offered a pneumococcal immunization, unless the immunization was medically contraindicated or the resident had already been immunized. The medical record shall reflect that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization and that the resident either received the pneumococcal immunization or did not receive it due to medical contraindication or refusal. " 1. Resident # 49 was admitted to the facility on 1/15/16. The immunization form on the resident's medical record and the electronic records for Resident #49 were reviewed. The immunization form both on the medical record and the electronic records were blank for the influenza and pneumococcal vaccine indicating that the resident had not received both immunizations. On 5/5/16 at 8:30 AM, the Director of Nursing (DON)was interviewed. The DON indicated that the infection control nurse was not available for interview. She stated that she expected the infection control nurse to document on the immunization form both on the resident's medical records and on the electronic records the date the immunizations were administered or had been refused. The DON further stated that she could not find documentation that the immunizations for influenza and pneumococcal vaccines had been administered to Resident #49. The DON added that Resident #49 was admitted from other nursing facility and the facility might have administered the immunizations to the resident but she indicated that the infection control nurse should have called the facility on admission to verify this information.	F 334	Our Admissions Coordinator will review all new admission paperwork for vaccine information. Consent will obtained and education provided for residents choosing to receive a vaccine at Penick Village. Residents deciding to refuse the vaccine will sign a refusal form which will be documented. Vaccines will be administered and data on vaccine administration or refusal will be documented in AOD. Our Admissions Coordinator will perform monthly audits to ensure all residents have current flu and pneumococcal vaccines or a refusal document on file. Infection Control Nurse will offer and administer vaccines yearly.DON will monitor to ensure vaccines are given with a weekly audit for the next 90 days. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review vaccine data and ensure vaccines are up to date.	

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PENICK VILLAGE	500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 76	F 334		

2. Resident #77 was admitted to the facility on 2/9/16. The immunization form on the resident's medical record and the electronic records for Resident #77 were reviewed. The immunization form both on the medical record and the electronic records were blank for the influenza and pneumococcal vaccines indicating that the resident had not received both immunizations.
On 5/5/16 at 8:30 AM, the Director of Nursing was interviewed. The DON indicated that the infection control nurse was not available for interview. She stated that she expected the infection control nurse to document on the immunization form both on the resident's medical records and on the electronic records the date the immunizations were administered or had been refused. The DON further stated that she could not find documentation that the immunizations for influenza and pneumococcal vaccines had been administered to Resident #77. The DON added that Resident #77 was admitted from other nursing facility and the facility might have administered the immunizations to the resident but she indicated that the infection control nurse should have called the facility on admission to verify this information.

3. Resident #56 was admitted to the facility on 9/14/15. The immunization form on the resident's medical record and the electronic records for Resident #56 were reviewed. The immunization form both on the medical record and the electronic records were blank for the pneumococcal vaccine indicating that the resident had not received the immunization.
On 5/5/16 at 8:30 AM, the Director of Nursing was interviewed. The DON indicated that the infection control nurse was not available for interview. She stated that she expected the

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F 334	Continued From page 77 infection control nurse to document on the immunization form both on the resident's medical records and on the electronic records the date the immunizations were administered or had been refused. The DON further stated that she could not find documentation that the immunization for pneumococcal vaccine had been offered or administered to Resident #56.	F 334		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		6/2/16

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F 441	Continued From page 78 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to prophylactically treat staff members immediately, who had prolonged skin to skin contact with 1 (Resident # 49) of 1 sampled resident who had a confirmed diagnosis of scabies, failed to investigation how the resident acquired the scabies and failed to have a documented action plan to control the spread of scabies. Three (Nurse #2, NA (nurse aide) #1 and NA #2) of three direct care staff members developed rashes and were treated. Findings included: Resident #49 was originally admitted to the facility on 9/3/15 and was readmitted on 1/15/16 with multiple diagnoses including Dementia. The admission Minimum Data Set (MDS) assessment dated 1/22/16 and the quarterly MDS assessment dated 4/23/16 indicated that Resident #49 had short term memory problem and had moderate impairment in decision making. The assessments also indicated that Resident #49 was receiving ointments and medications other than to feet under the skin/ulcer treatment. The facility's policy on infection control dated 9/11/15 was reviewed. The policy did not address scabies. The nurse's notes for Resident #49 were	F 441	An investigation of the origin of the skin condition of resident #49 will be completed by 6-2-16 by DON. All residents and staff members will be prophylactically treated. An action plan to include prophylactically treating all potentially exposed staff, residents, and family members completed by 6-2-16. All staff members, residents, and family members will be educated on scabies. Action plan will be completed by 6-2-16. All residents and staff have been assessed for scabies. As of 6-2-16 1 resident had active rash and had been treated. no reported symptoms of new onset of scabies reported by staff. We have developed a new action plan for a scabies outbreak response to include treatment of new outbreaks and response by staff. All staff members and residents will be prophylactically treated with education on care of linen and exposed family members. Staff educated on importance of reporting any new symptom to MD immediately. All staff members	

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F 441	Continued From page 79 reviewed. The notes dated 4/21/16 at 1:43 PM indicated that the resident was sent to the dermatology clinic with new orders for (brand name) moisturizing cream to the body twice a day and Triamcinolone ointment (topical corticosteroid and emollient combination) twice a day for 14 days then every other day at bedtime to red and itchy rash. The notes dated 4/27/16 at 9:16 PM indicated that the dermatology clinic had called the facility and notified the nurse that Resident #49 was positive for scabies. The attending physician was notified of the result and ordered Elimite cream (anti scabicidal agent), apply from head down, leave on for 10 hours and wash off, repeat in 1 week and Ivermectin (anti parasite drug) 3 milligrams (mgs), take 3 tablets by mouth. The physician had ordered also to put Resident #49 on contact isolation. Review of the dermatopathology report revealed that a skin biopsy was obtained from the left palm and left anterior shoulder of Resident #49 on 4/21/16. The result of the biopsy was reported to the facility on 4/27/16 and the diagnosis was scabies. On 5/2/16 at 10:30 AM, Resident #49 was observed. She was sitting in a wheelchair in her room. There was a contact precaution sign on the door and an isolation cart outside the door. On 5/2/16 at 10:35 AM, Nurse #1 was interviewed. She stated that the facility had one resident on isolation. She indicated that Resident #49 was on contact precaution due to scabies. On 5/3/16 at 10:30 AM, NA #1 was interviewed. NA #1 stated that Resident #49 was taken off isolation on 5/2/16 and 2 other residents (rooms 169 and 171) were noted to have rashes and were placed on isolation on 5/3/16. NA #1 further indicated some staff members had developed rashes just before the resident was diagnosed	F 441	including part-time and PRN staff will be in-serviced on the new action plan and necessary procedures and precautions by 6-2-16. All infections will be tracked as they are discovered by infection nurse. Current Infection Control policies will be reviewed and updated by 6-2-16 by DON. Staff will be in-serviced on any changes by 6-2-16. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) will meet weekly until at least 6 months after the last confirmed case to review each and every potential case and treatment plan. All infections and infestations along with the corresponding treatment plans and any outbreak prevention measures taken will be reported in the QA meetings by DON.	

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with scabies. All staff members who worked on the hall where Resident #49 had resided were treated with Elimite cream on 4/29/16, 2 days after Resident #49 was diagnosed with scabies.
On 5/3/16 at 10:35 AM, Nurse #2 was interviewed. He stated that he worked 7A-7P on the hall where Resident #49 had resided. He indicated that the resident had the rashes for months and was treated with cream. The resident had been to the dermatology clinic in the past and on 4/21/16, the clinic did the scraping and the result was scabies. He confirmed that he developed rashes right after the resident was diagnosed with scabies and he received Elimite cream on 4/29/16.
On 5/3/16 at 10:36 AM, NA #2 was interviewed. She stated that she worked on the hall where Resident #49 had resided. She confirmed that she developed rashes just before the resident was diagnosed with scabies and she was treated with Elimite cream on 4/29/16.
On 5/4/16 at 8:30 AM and at 2:55 PM, the Director of Nursing (DON) was interviewed. The DON indicated that the infection control nurse was not available for interview. She indicated that the facility had no policy that was specific for scabies. She stated that after Resident #49 was diagnosed with scabies, the attending physician and the health department were notified. The attending physician had ordered Elimite cream and Ivermectin for the resident. The health department advised them to disinfect the room and to wash all clothing and linens in the room. The physician ordered not to treat other residents unless they were symptomatic. The DON indicated that she did not do an investigation on how the resident acquired the scabies. The DON also indicated that she did not have a documented action plan to try to control the

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F 441	Continued From page 81 spread of scabies to other residents and staff. She added that the staff members were treated with Elimite cream.	F 441		