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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to periodically assess 1 of 1 resident (Resident #7) observed with medications at bedside for the ability to safely administer medications without staff supervision. The findings included: A review of the facility policy on 'Self-Administration of Medications' (not dated) indicated the facility shall permit residents who are competent and physically able to self-administer their medications if the following were met: 1. The self-administration was ordered by physician or other authorized prescriber and documented in the resident ' s medical record. 2. Specific instructions for administration of prescription medications were printed on the medication label. The implementation procedures for this policy included an interdisciplinary team assessment to determine if the resident was competent, along with an assessment of the resident ' s cognitive, physical and visual ability to carry out this responsibility. If the team determined that the resident was competent, the attending physician was to be contacted to request a specific order	F 176	This plan of correction is the Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F176 Resident #7 was assessed for the ability to safely administer medications without staff supervision using the medication self-administration assessment on 9/21/16 by second shift charge nurse. Resident #7 care plan was updated on 9/21/16 by MDS nurse to reflect the self-administering of medications. 100% audit of all residents to include resident #7 was completed to identify residents who self-administer medications through room observations and review of current physician orders and care plans on 10/12/16 by QI Nurse. No other residents were identified that	10/24/16

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

Electronically Signed | 10/14/2016

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F 176	Continued From page 1 for self-administration of the medication. The procedures also indicated a re-assessment of the resident ' s ability to self-administer medications would be completed every 3 months. Resident #7 was initially admitted to the facility on 1/12/12 with cumulative diagnoses which included glaucoma. A review of Resident #7 ' s medical record revealed a Physician ' s Telephone Order was received on 11/6/15. The order indicated Resident #7, " May keep eye gtts (drops) at bedside and self-administration from 8 AM to 8 PM then back on med cart. " A review of a Medication Self Administration Assessment form dated 2/2/16 and e-signed by the facility ' s Director of Nursing (DON) was completed. The assessment form included a " Satisfactory " response to 6 questions which asked if the resident demonstrated an ability to read aloud instruction for use on medication package, to verbalize the times which medications were to be taken, to verbalize an understanding of the purpose of medications to be administered, to open medication packages correctly, to correctly administer medications with proper procedure, and to demonstrate secure storage for medication kept in his/her room. The form indicated, " Based on the above assessments it is the judgment of the interdisciplinary team that: Resident can safely self-administer medications. " The Medication Self Administration Assessment form did not indicate the name(s) or instruction(s) for the medications the resident was assessed to safely self-administer.	F 176	self-administer medications during the audit. The Facility Consultant, DON and Staff Facilitator will in-service all licensed nurses to include the nursing supervisor #1 on the policy and procedure of self-administering medications to include frequency of assessments by 10/24/16. All newly hired nurses will be in-serviced regarding the policy and procedure of self-administering medications to include frequency of assessments during orientation by the Staff Facility. When a resident request to self-administer medications, the hall nurse will notify the MDS nurse or nursing supervisor to assess the resident to determine the resident's ability to safely administer medications without staff supervision utilizing the medication self administration assessment form. If determined safe, the MDS nurse or nursing supervisor will obtain a physician's order, update the resident's care plan, and reassess the resident's ability to safely administer medications without staff supervision utilizing the medication self administration assessment form initially and quarterly utilizing a Medication self-administering QI tool weekly x 8 weeks and monthly x 1 month. The hall nurse, MDS nurse, or Nursing Supervisor will be retrained by the DON for any identified concerns during the audit. The DON will review and sign the Medication self-administering QI tool weekly x 8 weeks and monthly x 1 month for completion and to ensure all areas of concern were addressed.	

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F 176	Continued From page 2 A review of Resident #7 ' s current physician orders included the following medications, in part: --1% Voltaren gel (a nonsteroidal anti-inflammatory topical medication used for acute pain) applied to the left elbow 4 times daily; --1% Voltaren gel applied as 3 grams (gm) to the right hip 4 times daily as needed (maximum 32 gm total per day to all affected joints); --0.05% Desonide lotion (a topical steroid) applied to scalp daily as needed for itching (may keep at bedside), may self-administer; --1% prednisolone solution (a steroid eye drop) instilled as one drop in the left eye three times daily for four weeks; --1% prednisolone solution instilled as one drop in the right eye every morning; --0.005% latanoprost solution (an eye drop used for the treatment of glaucoma) instilled as one drop to each eye every night at bedtime (wait 3-5 minutes between two eye medications); --0.5% timolol solution (an eye drop used for the treatment of glaucoma) instilled as one drop to each eye twice daily (wait 10 minutes before administration of other eye medications); --0.15% brimonidine solution (an eye drop used for the treatment of glaucoma) instilled as one drop to each eye three times daily (wait 3-5 minutes between two eye medications). A review of Resident #7 ' s most recent quarterly Minimum Data Set (MDS) dated 9/8/16 revealed the resident had intact cognitive skills for daily decision making. He was independent with all of his Activities of Daily Living (ADLs), with the exception of requiring limited assistance from staff for bed mobility, and supervision for dressing and personal hygiene. A review of Resident #7 ' s interdisciplinary Care	F 176	The Executive QI committee will meet monthly and review the Medication self-administering medication tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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Plan Progress Notes dated 9/14/16 revealed two questions were answered in relation to the self-administration of medications. The questions included: 1) Is the resident self-administering medications? Answered, " Yes " ; and, 2) If yes, have staff evaluated the resident ' s cognitive and physical ability to self-administer medications? Answered, " Yes. "

A review of the resident ' s current Care Plan (revised 9/14/16) was completed. The Care Plan included the following area of Focus, along with the corresponding Goal and Interventions:
Focus- " Self Administration of Medications: Resident has requested to execute right to self-administer medications " (initiated 3/17/16);
Goal- " Resident will self-administer Voltaren Gel to R (right) hip appropriately thru next review " (revised on 9/14/16);
Interventions
-- " Ask resident to verbalize understanding of and demonstrate proper technique for administration of medication " (initiated 3/17/16);
-- " May keep medication at bedside per physician ' s order " (initiated on 3/17/16);
-- " Observe self administration of medication by resident and document " (initiated 3/17/16);
-- " Re-assess resident ' s competency to self-administer medication on a consistent and regular basis " (initiated 3/17/16);
-- " Resident will self-administer Voltaren Gel to R hip BID (twice daily) " (initiated 3/17/16).

On 9/19/16 at 12:45 PM, Resident #7 was observed to have 4 vials of prescription eye drops placed in a small basket sitting on his pillow. The eye drops included 0.005% latanoprost solution, 0.5% timolol solution, 0.15% brimonidine solution, and 1% prednisolone solution. Upon inquiry, the

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resident stated he always put these eye drops in his eyes himself. The resident reported he had a corneal transplant and could see fairly well out of his right eye, but could only see some light with his left eye.

An interview was conducted on 9/20/16 at 4:09 PM with the facility ' s MDS Coordinator. The MDS Coordinator assumed responsibility for completing residents ' MDS assessments and interdisciplinary care plans. Upon inquiry as to what procedures the facility followed to ensure a resident could safely self-administer medications, the nurse indicated the nursing supervisor or charge nurse was responsible to complete an assessment for the resident. The MDS nurse then stated she would put the self-administration of medications on the resident ' s care plan.

An interview was conducted on 9/21/16 at 1:47 PM with Nursing Supervisor #1. During the interview, Nursing Supervisor #1 reported she had completed assessments for Resident #7 on the self-administration of medications. She noted the facility used a form to determine if the resident was capable of self-administering his medications. Upon further inquiry as to when these assessments had been completed, the nursing supervisor stated, "I can't remember ...I don't think I've done a recent one. "

A follow-up interview was conducted with the MDS Coordinator on 9/21/16 at 2:24 PM. The MDS Coordinator reported care planning had been done for Resident #7 within the past week. Upon inquiry, the MDS Coordinator reported she was not aware that the resident was self-administering any medications other than Voltaren Gel.

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F 176	Continued From page 5 An interview was conducted on 9/21/16 at 3:30 PM with the facility ' s Regional Nurse Consultant. Upon review of Resident #7 ' s medical records, the Nurse Consultant reported the 2/2/16 assessment was the only Medication Self Administration Assessment completed for this resident. A telephone interview was conducted on 9/21/16 at 4:00 PM with the facility ' s consultant pharmacist. During the interview, the pharmacist reported she was not involved in the assessment of Resident #7 for the self-administration of medications. A follow-up interview was conducted on 9/21/16 at 4:35 PM with the DON. During the interview, the DON stated she would expect residents who were self-administering medications to be assessed quarterly, have a current physician ' s order to self-administer medications, and to be care planned for the self-administration of the medications.	F 176		
F 242 SS=G	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by:	F 242		10/24/16

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F 242	Continued From page 6 Based on observations, resident interview, staff interviews and record review, the facility violated 1 of 1 resident's (Resident #10) rights, who required a motorized wheelchair for independent mobility, by not allowing the resident to bring and utilize his motorized wheelchair to the facility, which resulted in a loss of his independent mobility both inside and outside of the facility. The findings include: Resident #10 was originally admitted to the facility on 7/29/16, with diagnoses including, muscle weakness (generalized), depression, paraplegia, and injury of cervical spinal cord. Review of a Home visit/agreement note, written by the facility Social Worker, dated 7/27/16 at 11:30 AM, was signed by Resident #10. The home visit/agreement note which was witnessed by the facility Social Worker prior to Resident #10's admission to the facility, read in part, "Resident informed writer that he had a motorized wheelchair and wanted to know if he could bring the wheelchair to the facility. Writer informed Resident that the facility administrator said corporate was not allowing new admits to bring their motorized wheelchairs into the facility due to accidents and liability. Resident stated when he went for rehabilitation a couple of years ago in another facility he was unable to have his chair. Resident asked if the facility would provide him with a regular wheelchair, writer answered yes. Resident asked if staff would take him outside to smoke. Writer answered yes. Resident stated, well I am ready to come to the nursing home. I plan on staying long term."	F 242	F242 Therapy evaluated for safety and use of resident #10 motorized wheelchair on 9/28/16. Resident #10 began to utilize the motorized wheelchair for mobility on 9/28/16. 100% interview will be conducted of alert and oriented residents to include resident #10 by the Social Worker to determine whether resident choices to include mobility are being honored by 10/13/16. These interview questions includes: Do you feel your choices regarding activities, schedules, plan of care and mobility are being honored? If no, please explain. Any concerns will be addressed on a Resident Concern form and forwarded to appropriate personnel to include therapy for mobility concerns. The Social Worker will review and provide a copy of the federal resident rights with all alert and oriented residents to include resident #10 with the emphases on the right to self-determination, i.e. making choices in the nursing home by 10/13/16. The Facility Consultant will in-service the Administrator, DON and Social Worker on the residents federal rights to include the right to self-determination, i.e. making choices in the nursing home; honoring resident choices to include mobility to assure no loss of independence and initiating a therapy evaluation for the utilization of motorized wheelchairs for residents safety and use by 10/24/16. The Social Worker will interview 10% of alert and oriented residents to include resident #10 to ensure residents choices	

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F 242	Continued From page 7 According to the most recent Admission Minimum Data Set (MDS) dated 8/5/16, Resident #10's cognition was intact. He required extensive assistance in the areas of bed mobility, toileting and personal hygiene. He was totally dependent in transfers, dressing, bathing and locomotion on and off the unit. Review of Resident #10's Care Area Assessment Summary (CAA) dated 8/9/16, revealed the resident was at risk for complications of immobility, such as contractures and depression. The CAA noted, " Resident with diagnosis: Depression. Dependent for mobility." A review of Resident #10's Care plan dated 8/9/16, revealed problem areas that read in part, " Feelings of sadness, emptiness, anxiety, uneasiness and depression characterized by ineffective coping. The other problem areas included low self-esteem, tearfulness, motor agitation and withdrawal from care/activities related to: Admission to facility and relocation. The goal was to have improved mood state, happier, calmer appearance, no signs/symptoms of depression and no anxiety or sadness through the next review. The interventions included to discuss feelings about placement with resident, document mood state, sadness, anxiety and signs/symptoms of depression and encourage resident to take an active social role within facility." During an interview on 09/19/2016 at 2:24 PM Resident #10 wanted to know if there was a reason why he could not bring his motorized wheelchair to the facility. He revealed he had a motorized wheelchair at home that he had been using for twenty years or more and he was told by	F 242	are being honored to include mobility utilizing a Resident choice Interview tool. Resident choice interview tool will be completed weekly x 8 weeks and monthly x 1 month. Any new concerns will be addressed on a resident concern form by Social Worker and forwarded to appropriate personnel to include therapy for mobility concerns. The Administrator will review and initial the Resident Interview QI tool and resident concern form for completion and ensure all areas of concerns were addressed weekly x 8 weeks and monthly x 1 month. The Executive QI committee will meet monthly and review Resident choice Interview tools and Resident Concern Form and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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the Social Worker that the " head person " (Administrator) said he could not bring his motorized wheelchair to the facility because he might run into someone or the motorized wheelchair might make too much noise. He revealed staff let him use a manual wheelchair which he could not push independently. Resident #10 stated staff had to push him in the manual wheelchair wherever he wanted to go and he had used the manual wheelchair since he was admitted to the facility.

During an interview on 09/19/2016 at 2:29 PM the Occupational Therapist stated she did not see any reason why Resident #10 could not use a motorized wheelchair. She revealed he was cognitively intact and they could not find any adaptations for the manual wheelchair that would provide him independence.

During an observation on 09/20/2016 at 8:38 AM, the Occupational Therapist was pushing Resident #10 in his manual wheelchair to the therapy room.

During an interview on 09/20/2016 at 3:41 PM, the facility Social Worker (SW) revealed she conducted a home visit with Resident #10 prior to his admission to the facility. The Social Worker stated during the home visit Resident #10 asked if he could bring his motorized wheelchair to the facility if he decided to come. The SW stated she made him aware that the Administrator was not accepting any new admissions bringing motorized wheelchairs into the facility. The Social Worker stated Resident #10 asked why motorized wheelchairs were no longer allowed in the facility and she told him it was because of incidents in the facility involving residents with motorized

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wheelchairs and liability. The Social Worker said Resident #10 explained he could drive his motorized wheelchair and he would not hit anyone. The Social Worker stated she asked Resident #10 if he still wanted to come to the facility even though he could not bring his motorized wheelchair and the resident said yes. She stated she explained to him one more time to make sure he understood that the facility was not allowing any more motorized wheelchairs in the facility. The Social Worker recalled Resident #10 said he understood, but he hoped it would change eventually so that he could bring his motorized wheelchair to the facility. The Social Worker emphasized she did another home visit with Resident #10 to have him sign paperwork, to make sure he had someone to clean his apartment as well as to make sure he had transportation to pick him up, since he decided he wanted to come to facility. She revealed she typed up everything about what they discussed and they initialed and signed the agreement.

During an interview on 09/20/2016 at 3:18 PM, the Administrator explained, before Resident #10 was admitted to the facility, the facility's Social Worker conducted a home visit and Resident #10 was informed that the facility had a new policy of not taking on anymore residents with motorized wheelchairs. The Administrator revealed during the home visit, Resident #10 signed information the Social Worker reviewed with him regarding the facility was not admitting any more residents in motorized wheelchairs, and he agreed not to bring his motorized wheelchair to the facility. The Administrator revealed there had been some safety issues with residents in motorized wheelchairs running into staff and other residents. She said they grandfathered two residents with

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motorized wheelchairs already in the facility and one of the residents was in the hospital. The Administrator stressed it was a burden to residents when a motorized wheelchair broke down and the resident did not have the money to fix it. The Administrator was asked for a copy of the facility policy not allowing anymore residents with motorized wheelchairs to be admitted to the facility.

During another interview on 09/20/2016 at 4:05 PM Resident #10 stated the Social Worker told him he could not bring his motorized wheelchair with him to the facility and she would have to talk to her boss about it. Resident #10 said when he was told he could not bring his wheelchair to the facility he felt that they took his legs away from him and he was not used to people pushing him in a wheelchair. Resident #10 stated he knew how to put the motorized wheelchair on low speed and drive in the middle of the hallway not close to resident's rooms to prevent from scaring them if they came out of their rooms. Resident #10 added that if he had his motorized wheelchair in the facility he could independently go whenever he got ready to go. Resident #10 stressed if he had known there was never a possibility of bringing his motorized wheelchair to the facility he would have not given up his home.

During another interview on 09/21/2016 at 10:00 AM, the Occupational Therapist (OT) revealed Resident #10 was progressing slowly. She stated Resident #10 would not be able to use a manual wheelchair and he would benefit from using a motorized wheelchair. The Occupational Therapist revealed she was not informed about incidents when residents in motorized wheelchairs were running into staff and residents.

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She stated if she had known, she would have done an evaluation and instructed residents on the proper use of the motorized wheelchairs and would have made sure that the residents could function in the motorized wheelchairs safely.

During an interview on 09/21/2016 at 2:03 PM, the facility Physical Therapist/Rehabilitation Director revealed the facility had a policy of trying to the limit use of motorized wheelchairs. He said he learned about the policy three weeks ago when he asked Resident #10 if he could bring his motorized wheelchair to the facility. The Rehabilitation Director stated he inquired about it and was told by the Administrator that they were trying to get rid of motorized wheelchairs for safety concerns. He stated no one reported any motorized wheelchair incidents to him. The Rehabilitation Director revealed he had not assessed Resident #10 in a motorized wheelchair because Resident #10 did not have his motorized wheelchair to practice. He revealed Resident #10 used his motorized wheelchair when he was at home and he would benefit from using a motorized wheelchair in the facility.

During an interview on 09/21/2016 at 3:35 PM the Administrator revealed she didn't have a definite number of accidents caused by residents in motorized wheelchairs hitting staff and residents. She said she did not have any dates nor did she present any documentation of when the incidents occurred. She stated the last two incidents one of the two residents with motorized wheelchairs ran into a staff member. She stated there were no injuries caused by the accidents. The Administrator said both of the residents in motorized wheelchairs almost ran over resident's feet and bumped into them. The Administrator

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said on 6/1/16 the facility decided to implement the policy not to admit any more residents with motorized wheelchairs in the facility. She stated they felt residents in motorized wheelchairs had the potential to become a hazard. When asked again about the facility's written policy, the Administrator revealed the facility did not have a written policy which specified they did not allow residents in motorized wheelchairs from being admitted to the facility.

During another interview on 09/22/2016 at 10:50 AM, the Administrator explained her concern was that the facility had two residents capable of using motorized wheelchairs and if they kept admitting residents with motorized wheelchairs it had the potential to become a hazardous situation. She revealed she was looking at the bigger picture because the facility had narrow halls and if there were so many residents in the facility with motorized wheelchairs it would become a hazard. The Administrator stated this was something they would revisit.

During an observation on 09/22/2016 at 11:30 AM, Resident #10 was being pushed in his manual wheelchair from therapy to his room.

During another interview on 09/22/2016 at 2:51 PM, Resident #10 revealed he's had a doctor's order for his motorized wheel chair for years. Resident #10 stated this facility was the only one that asked him to leave his wheelchair at home. He revealed his motorized wheelchair was the only way he could get around independently and it was a substitute for him walking. He said it was easy for staff to say not to bring his motorized wheelchair to the facility, but if they put themselves in his situation they would feel the

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F 242	Continued From page 13 same way. Resident #10 revealed he was able to live an independent life with his motorized wheelchair and without his motorized wheelchair someone had to get everything for him. Resident #10 said no one in the facility had seen him in his motorized wheelchair. He revealed if he had his motorized wheelchair he would drive his motorized wheelchair with care. During an interview on 9/22/2016 at 3:38 PM, the Medical Director revealed he felt motorized wheelchairs were dangerous and the facility had a policy not to accept any more residents in motorized wheelchairs. He emphasized he did not feel the facility was violating Resident #10's rights by not allowing him to bring his motorized wheelchair from home to the facility.	F 242		
F 246 SS=G	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and record review, the facility failed to accommodate 1 of 1 resident (Resident #10), who required a motorized wheelchair for independent mobility, by not allowing the resident to bring and utilize his motorized wheelchair in the facility, which resulted in a loss of his independent	F 246	F246 Therapy evaluated for safety and use of resident #10 motorized wheelchair on 9/28/16. Resident #10 began to utilize the motorized wheelchair for mobility on 9/28/16.	10/24/16

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F 246	Continued From page 14 mobility both inside and outside of the facility. The findings include: Resident #10 was originally admitted to the facility on 7/29/16, with diagnoses including, muscle weakness (generalized), depression, paraplegia, and injury of cervical spinal cord. Review of a Home visit/agreement note, written by the facility Social Worker, dated 7/27/16 at 11:30 AM, was signed by Resident #10. The home visit/agreement note which was witnessed by the facility Social Worker prior to Resident #10's admission to the facility, read in part, "Resident informed writer that he had a motorized wheelchair and wanted to know if he could bring the wheelchair to the facility. Writer informed Resident that the facility administrator said corporate was not allowing new admits to bring their motorized wheelchairs into the facility due to accidents and liability. Resident stated when he went for rehabilitation a couple of years ago in another facility he was unable to have his chair. Resident asked if the facility would provide him with a regular wheelchair, writer answered yes. Resident asked if staff would take him outside to smoke. Writer answered yes. Resident stated, well I am ready to come to the nursing home. I plan on staying long term." According to the most recent Admission Minimum Data Set (MDS) dated 8/5/16, Resident #10's cognition was intact. He required extensive assistance in the areas of bed mobility, toileting and personal hygiene. He was totally dependent in transfers, dressing, bathing and locomotion on and off the unit.	F 246	100% of interview will be conducted of alert and oriented residents to include resident #10 by the Social Worker to determine whether resident choices/preferences and accommodations to include mobility are being honored by 10/13/16. These interview questions includes: Do you feel your choices regarding activities, schedules, plan of care and mobility are being honored? If no, please explain. Any concerns voiced will be addressed on a Resident Concern form and forwarded to appropriate personnel to include therapy for mobility concerns. The Social Worker will review and provide a copy of the federal resident rights with all alert and oriented residents to include resident #10 with the emphasis on reasonable accommodations of resident needs and preferences except when it endangers the health and safety of the resident or other residents and the right to self-determination, i.e. making choices in the nursing home by 10/13/16. The Facility Consultant will in-service the Administator, DON and Social Worker on the residents federal rights to include the right to self-determination, i.e. making choices in the nursing home; honoring resident choices to include mobility to assure no loss of independence and initiating a therapy evaluation for the utilization of motorized wheelchair for safety/use completed by 10/24/16. The Social Worker will interview 10% of alert and oriented residents to include resident #10 to ensure resident's choices/preferences and	

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F 246	Continued From page 15 Review of Resident #10's Care Area Assessment Summary (CAA) dated 8/9/16, revealed, the resident was at risk for complications of immobility, such as contractures and depression. The CAA noted, " Resident with diagnosis: Depression. Dependent for mobility." A review of Resident #10 ' s Care plan dated 8/9/16, revealed problem areas that read in part, " Feelings of sadness, emptiness, anxiety, uneasiness and depression characterized by ineffective coping. The other problem areas included low self-esteem, tearfulness, motor agitation and withdrawal from care/activities related to: Admission to facility and relocation. The goal was to have improved mood state, happier, calmer appearance, no signs/symptoms of depression and no anxiety or sadness through the next review. The interventions included to discuss feelings about placement with resident, document mood state, sadness, anxiety and signs/symptoms of depression and encourage resident to take an active social role within facility. " During an interview on 09/19/2016 at 2:24 PM Resident #10 wanted to know if there was a reason why he could not bring his motorized wheelchair to the facility. He revealed he had a motorized wheelchair at home that he had been using for twenty years or more and he was told by the Social Worker that the head person, (Administrator) said he could not bring his motorized wheelchair to the facility because he might run into someone or the motorized wheelchair might make too much noise. He revealed staff let him use a manual wheelchair which he could not push independently. Resident	F 246	accommodations are being honored to include mobility utilizing a Resident choice Interview tool weekly x 8 weeks and monthly x 1 month. Any concerns voiced will be addressed on a resident concern form by Social Worker and forwarded to appropriate personnel to include therapy for mobility concerns. The Administrator will review and initial the Resident choice Interview QI tool and resident concern forms for completion and to ensure all area of concern were addressed weekly x 8 weeks and monthly x 1 month. The Executive QI committee will meet monthly and review the Resident choice Interview tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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#10 stated staff had to push him in the manual wheelchair wherever he wanted to go and he had used the manual wheelchair since he was admitted to the facility.

During an interview on 09/19/2016 at 2:29 PM, the Occupational Therapist stated she did not see any reason why Resident #10 could not use a motorized wheelchair. She revealed he was cognitively intact and they could not find any adaptations for the manual wheelchair that would provide him independence.

During an observation on 09/20/2016 at 8:38 AM, the Occupational Therapist was pushing Resident #10 in his manual wheelchair to the therapy room.

During an interview on 09/20/2016 at 3:41 PM, the facility Social Worker (SW) revealed she conducted a home visit with Resident #10 prior to his admission to the facility. The Social Worker stated during the home visit Resident #10 asked if he could bring his motorized wheelchair to facility if he decided to come. The SW stated she made him aware that the Administrator was not accepting any new admissions bringing motorized wheelchairs into the facility. The Social Worker stated Resident #10 asked why motorized wheelchairs were no longer allowed in the facility and she told him it was because of incidents in the facility involving residents with motorized wheelchairs and liability. The Social Worker said Resident #10 explained he could drive his motorized wheelchair and he would not hit anyone. The Social Worker stated she asked Resident #10 if he still wanted to come to the facility even though he could not bring his motorized wheelchair and the resident said yes.

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She stated she explained to him one more time to make sure he understood that the facility was not allowing any more motorized wheelchairs in the facility. The Social Worker reported Resident #10 said he understood, but he hoped it would change eventually so that he could bring his motorized wheelchair to the facility. The Social Worker emphasized she did another home visit with Resident #10 to have him sign paperwork, to make sure he had someone to clean his apartment as well as to make sure he had transportation to pick him up, since he decided he wanted to come to facility. She revealed she typed up everything about what they discussed and they initialed and signed the agreement.

During an interview on 09/20/2016 at 3:18 PM, the Administrator explained, before Resident #10 was admitted to the facility, the facility's Social Worker conducted a home visit and Resident #10 was informed the facility had a new policy of not taking on anymore residents with motorized wheelchairs. The Administrator revealed during the home visit Resident #10 signed information the Social Worker reviewed with him regarding the facility was not admitting any more residents in motorized wheelchairs. She stated Resident #10 agreed not to bring his motorized wheelchair to the facility. The Administrator revealed there had been some safety issues with residents in motorized wheelchairs running into staff and other residents. She said they grandfathered two residents with motorized wheelchairs already in the facility and one of the residents was in the hospital. The Administrator stressed it was a burden to residents when a motorized wheelchair broke down and the resident did not have the money to fix it. The Administrator was asked for a copy of the facility policy not allowing anymore

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residents with motorized wheelchairs to be admitted to the facility.

During another interview on 09/20/2016 at 4:05 PM Resident #10 stated the Social Worker told him he could not bring his motorized wheelchair with him to the facility and she would have to talk to her boss about it. Resident #10 said when he was told he could not bring his wheelchair to the facility he felt that they took his legs away from him and he was not used to people pushing him in a wheelchair. Resident #10 stated he knew how to put the motorized wheelchair on low speed and drive in the middle of the hallway not close to resident's rooms to prevent from scaring them if they came out of their rooms. Resident #10 added that if he had his motorized wheelchair in the facility he could independently go whenever he got ready to go. Resident #10 stressed if he had known there was never a possibility of bringing his motorized wheelchair to the facility he would have not given up his home.

During an interview on 09/20/2016 at 6:14 PM, Resident #10's family member revealed the motorized wheelchair was Resident #10's car. She stated he was able to go where ever he wanted to go wearing his vest and flag on his motorized wheelchair. Resident #10's family member said he was able to travel all downtown in his hometown.

During an interview on 09/20/2016 at 6:24 PM, a Home Health Care Aide who cared for Resident #10 in his home revealed he handled his motorized wheelchair very well. She added that Resident #10 did not run into anyone in his motorized wheelchair and he maneuvered his motorized wheelchair very well in his home.

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During another interview on 09/21/2016 at 10:00 AM, the Occupational Therapist (OT) revealed Resident #10 was progressing slowly. She stated Resident #10 would not be able to independently use a manual wheelchair and he would benefit from using a motorized wheelchair. The Occupational Therapist revealed she was not informed about incidents when residents in motorized wheelchairs were running into staff and residents. She stated if she had known, she would have done an evaluation and instructed residents on the proper use of the motorized wheelchairs and would have made sure that the residents could function in the motorized wheelchairs safely.

During an interview on 09/21/2016 at 2:03 PM, the facility Physical Therapist/Rehabilitation Director revealed the facility had a policy of trying to the limit use of motorized wheelchairs. He said he learned about the policy three weeks ago when he asked Resident #10 if he could bring his motorized wheelchair to the facility. The Rehabilitation Director stated he inquired about it and was told by the Administrator that they were trying to get rid of motorized wheelchairs for safety concerns. The Rehabilitation Director stated no one reported any motorized wheelchair incidents to him. The Rehabilitation Director revealed he had not assessed Resident #10 in a motorized wheelchair because Resident #10 did not have his motorized wheelchair to practice. He revealed Resident #10 used his motorized wheelchair when he was at home and he would benefit from using a motorized wheelchair in the facility.

During an interview on 09/21/2016 at 3:35 PM the

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Administrator revealed she didn't have a definite number of accidents caused by residents in motorized wheelchairs hitting staff and residents. She said she did not have any dates nor did she present any documentation of when the incidents occurred. She stated the last two incidents one of the two residents with motorized wheelchairs ran into a staff member. She stated there were no injuries caused by the accidents. The Administrator said both of the residents in motorized wheelchairs almost ran over resident's feet and bumped into them. The Administrator said on 6/1/16 the facility decided to implement the policy not to admit any more residents with motorized wheelchairs in the facility. She stated they felt residents in motorized wheelchairs had the potential to become a hazard. When asked again about the facility's written policy, the Administrator revealed the facility did not have a written policy which specified they did not allow residents in motorized wheelchairs from being admitted to the facility.

During another interview on 09/22/2016 at 10:50 AM, the Administrator explained her concern was that the facility had two residents capable of using motorized wheelchairs and if they kept admitting residents with motorized wheelchairs it had the potential to become a hazardous situation. She revealed she was looking at the bigger picture because the facility had narrow halls and if there were so many residents in the facility with motorized wheelchairs it would become a hazard. The Administrator stated this was something they would revisit.

During an observation on 09/22/2016 at 11:30 AM, Resident #10 was being pushed by a staff member in his manual wheelchair from therapy to

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F 246	Continued From page 21 his room. During another interview on 09/22/2016 at 2:51 PM, Resident #10 revealed he had a doctor ' s order for his motorized wheel chair for years. Resident #10 stated this facility was the only one that asked him to leave his motorized wheelchair at home. He revealed his motorized wheelchair was the only way he could get around independently. Resident #10 revealed he was able to live an independent life with his motorized wheelchair and without his motorized wheelchair someone had to get everything for him. Resident #10 said no one in the facility had seen or assessed his ability to drive his motorized wheelchair. He stated he would drive his motorized wheelchair with care. During an interview on 9/22/2016 at 3:38 PM, the Medical Director revealed he felt motorized wheelchairs were dangerous and the facility had a policy not to accept any more residents in motorized wheelchairs. He emphasized he did not feel the facility was violating Resident #10's rights by not allowing him to bring his motorized wheelchair from home to the facility.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to clean or maintain	F 253	F253 On 9/22/16 a new heating/air conditioning	10/24/16

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F 253	Continued From page 22 the heating/air conditioning units in good repair for 22 of 37 resident rooms observed (Rooms 131, 137, 146, 174, 175, 176, 177, 178, 179, 183, 184, 186, 109, 110, 111, 113, 115, 116, 117, 118, 119, and 120); and, the facility failed to repair a door to a resident's room that would not securely close on 1 of 3 halls (Room 117). The findings included: 1) An observation made on 9/20/16 at 9:00 AM revealed the heating/air conditioning wall unit in Room 131 had an accumulation of gray/brown material on the vent and on the top of the unit itself. Additionally, the outside cover for the top vent on the unit appeared to be missing. On 9/21/16 at 11:12 AM, an observation was made of the heating/air conditioning unit in Room 131 with the facility's Maintenance Supervisor. The unit was observed to have a missing cover for the vent on top of the unit. The unit was also observed to have a gray/brown accumulation of a substance throughout the grids on the top of the unit, and a gray/brown substance on the surface of the control panel. An interview was conducted on 9/21/16 at 11:14 AM with the Maintenance Supervisor. Upon viewing the heating/air conditioning unit in Room 131, the Maintenance Supervisor stated, "There's something missing here (referring to a cover for the vent on top of the unit)." The Maintenance Supervisor reported both the Maintenance and Housekeeping Departments assumed responsibility for cleaning the heating/air conditioning units in the residents' rooms. Upon inquiry, the Supervisor reported he typically went through the facility and vacuumed the grates and	F 253	unit was installed in room 131. Room 146, the Housekeeping staff cleaned the outside of the heating/air conditioning units on 9/21/16. Room 146, The Maintenance Supervisor cleaned and vacuumed the inside of the unit on 9/22/16. The Maintenance Supervisor has repaired the plate cover for the control panel to Rooms 174, 175, 176, 177, 178, and 186 on 9/23/16. The Maintenance Supervisor has cleaned and vacuumed the inside of the units to include grates of the vents to Rooms 174, 175, 178, 179, and 186 on 9/23/16. Housekeeping has cleaned the outside of the heating/air conditioning unit for rooms 174, 175, 177, 178, 179, 184, and 186 on 9/23/16. Room 183, Maintenance has replaced the front panel of the unit on 9/26/16. Rooms 137, 109, and 115, Maintenance has installed a new unit on 9/30/16. Rooms 110, 111, 113, 116, 117, 118, 119, and 120, Housekeeping has cleaned the outside of the units to include along the edges of the control panel on 9/26/16. Rooms 110, 111, 116, 117, and 119, Maintenance has cleaned and vacuumed the inside of the units to include the grate inside the vents of the top of the units on 9/26/16. Room 111, 116, and 117, Maintenance has repaired the plate cover for the control panel on 9/26/16. The door was repaired to room 117 by Maintenance on 9/21/16. 100% observation of all other heating/air conditioning units were completed on 10/13/16 by Administrator to ensure units were clean and in good repair and of	

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F 253	Continued From page 23 vents on the units once every 3-4 months. On 9/21/16 at 11:15 AM, the Maintenance Supervisor was joined by Corporate Housekeeping Manager #1 and Corporate Housekeeping Manager #2. When Corporate Housekeeping Manager #1 was asked what responsibility the Housekeeping Department assumed for the cleaning of the units, the housekeeping manager reported the staff normally did the dusting and cleaning around the units on an "as needed" basis, noting this meant approximately 3 times a month. Upon observation of the heating/air conditioning unit in Room 131, Corporate Housekeeping Manager #1 stated, "(we) just got to work a little bit more at it." On 9/21/16 from 11:20 AM to 11:55 AM, the Maintenance Supervisor, Corporate Housekeeping Manager #1, and Corporate Housekeeping Manager #2 proceeded to complete a room to room check on the heating/air conditioning units in the residents' rooms. Additional concerns identified during this observation included: --Room 137: Two pieces off of the control panel were laying on top of the unit. Upon observation of the unit, Corporate Housekeeping Manager #2 stated it, "could be touched up." --Room 146: Multiple pieces of brown and white debris were observed to be lying on the grate of the vent on top of the unit. The Maintenance Supervisor indicated the unit needed vacuuming by the Maintenance Department. --Room 174: The plate cover for the control panel of the unit was missing. There was an accumulation of gray matter observed on the grates of the vent. --Room 175: The plate cover for the control	F 253	resident's rooms doors to ensure doors securely closed. Work orders were completed on 10/13/16 by Administrator for notification to maintenance and/or housekeeping for any identified areas of concern. Maintenance and/or housekeeping will address all areas of concerns from the audit per work order by 10/24/16. The Maintenance Supervisor was in-serviced by the Administrator on 9/23/16 to clean and vacuum the inside of the heating/air conditioning units monthly and to check for defects and make repairs as needed. A monthly schedule was provided to the Maintenance Supervisor by the Administrator on 9/23/16. 100% of Housekeeping staff have been in-serviced by the Administrator on 9/28/16 to clean the outside surfaces of the heating/air conditioning units daily. All license nurses and nursing assistants were in-serviced by the Administrator on 9/29/16 to complete a work order for defective equipment to the maintenance department. All newly hired license nurses and nursing assistants will be in-serviced by the staff facilitator regarding completing a work order for defective equipment to the maintenance department during orientation. Therapy Staff was in-serviced on 9/23/16 and Dietary staff was in-serviced on 9/26/16 by the Administrator to complete a work order on defective equipment to the maintenance department. The Supply Clerk will monitor 10% of all	

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F 253	Continued From page 24 panel of the unit was broken off; the intake vents were observed to have a gray accumulation on them, with the thickest accumulation noted on the top of the intake vent. --Room 176: The plate cover for the control panel was broken off and sitting on top of the unit. --Room 177: The plate cover for the control panel was lying on top of the unit; and, an accumulation of brown matter was observed on the control panel. --Room 178: The control panel had gray and brown matter covering the surface; there was an accumulation of gray matter on the vents; and, the plate cover for the control panel was broken off and lying on top of the unit. --Room 179: The control panel had brown matter covering its surface. At the time of the observation, Corporate Housekeeping Manager #2 commented, "It could use cleaning." The manager stated the vents needed to be vacuumed due to an accumulation of gray material observed. Corporate Housekeeping Manager #2 also reported that housekeeping needed to clean the unit as well. --Room 183: The heating/air conditioning unit was observed to have 3 strips of gray duct tape and 2 strips of clear tape on the sides of the unit. The tape appeared to be holding the front panel of the unit in place. --Room 184: Corporate Housekeeping Manager #1 stated the heating/air conditioning unit needed cleaning. The unit was observed to have a gray and brown accumulation on its top. --Room 186: The plate cover for the control panel of the unit was missing; brown debris was observed on the surface of the control panel, with the greatest accumulation noted to be around the border of the panel; multiple pieces of brown debris (approximately ½ ' in size) were observed	F 253	resident rooms heating/air conditioning units for cleanliness and need for repair to include rooms 131, 137, 146, 174, 175, 176, 177, 178, 179, 183, 184, 186, 109, 110, 111, 113, 115, 116, 117, 118, 119, 120, and 10% of all resident room doors to include room 117 to ensure residents room doors securely close weekly x 8 weeks then monthly x 1 month utilizing a Housekeeping Maintenance QI tool. The Supply Clerk will complete a work order for notification to maintenance and/or housekeeping for any identified areas of concern during the audit. The Administrator will review the Housekeeping/Maintenance QI tool and work orders weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Maintenance/Housekeeping QI Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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through the grate of the vent on top of the unit.
--Room 109: An accumulation of gray matter was observed in the grate of heating/air conditioning unit's vent; the unit's control panel had a brown crusted substance along its bottom edge.
--Room 110: Dark brown matter was observed along the edges of the controls; a gray accumulation was noted on the grate inside the vent on top of the unit.
--Room 111: The plate cover of the control panel was missing; Corporate Housekeeping Manager #2 was observed to run her finger inside the intake vent, with a dark brown substance coming off on her finger.
--Room 113: Corporate Housekeeping Manager #2 reported the heating/air conditioning unit, "needs to be wiped down." The unit appeared to have a gray accumulation on the outside of the unit.
--Room 115: Upon observation of the heating/air conditioning unit, Corporate Housekeeping Manager #2 stated, "Is that webs?" She was observed to touch the gray collection of particles on the grate on top of the unit and then she said, "Yes." The observation also revealed the heating/air conditioning grate on top of the unit had a broken piece in the right upper corner; the plate cover of the control panel was missing; and, the control panel had a gray and brown accumulation of matter across its surface.
--Room 116: An observation of the heating/air conditioning unit revealed there was a collection of debris inside the grate of the top vent; the plate cover of the control panel was missing; and, a gray and brown material was inside and around the corners of the control panel. Corporate Housekeeping Manager #2 reported the unit needed to be cleaned inside the grate, noting there was "a lot" of debris.

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--Room 117: An observation of the heating/air conditioning unit revealed there was an accumulation of a brown substance on the grate; and, the plate cover of the control panel was missing.
--Room 118: An observation of the heating/air conditioning unit revealed there was a brown substance accumulated around the bottom margin of the control panel.
--Room 119: The front air intake vent of the heating/air conditioning unit was observed to have an accumulation of gray matter; and, the top of the unit was noted to have a similar accumulation of gray matter on it.
--Room 120: During the observation of the heating/air conditioning unit, Corporate Housekeeping Manager #1 noted there was a gray accumulation on it. She stated the unit, "needs cleaning on the top and around the frame."

A follow-up interview was conducted on 9/22/16 at 8:40 AM with the Maintenance Supervisor. During the interview, the Maintenance Supervisor reported he did not have maintenance records or a fixed schedule for the checking and cleaning (vacuuming) of the heating/air conditioning units in the facility. He reported there was a Facility Work Order request form available for staff members to complete and put in the file holder on his door when maintenance services were needed. When asked, the Maintenance Supervisor stated he had not received any maintenance requests in regards to the heating/air conditioning units within the past 2-3 months.

An interview was conducted on 9/22/16 at 10:23 AM with the facility's Administrator in regards to

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the observations of the heating/air conditioning units in resident rooms. During the interview, the Administrator stated the facility was in the process of replacing the older units. She provided a copy of an email dated 9/21/16 at 5:19 PM which confirmed two new units were shipped to the facility on 8/26/16, with more units (undetermined number) scheduled for shipment the first or second week of October. The Administrator stated in-servicing had begun with Healthcare Services (Housekeeping) to educate the staff that it was part of their job to clean the heating/air conditioning units. The Administrator reported her expectation was for the heating/air conditioning units to be cleaned every day and for the old units to be replaced.

2) Resident #35 was admitted to the facility on 6/10/16 for rehabilitation services. The Admission Minimum Data Set (MDS) Assessment dated 6/17/16 noted the resident was cognitively intact and required extensive assistance with transfers, ambulation and most activities of daily living.
Upon entering Room 117 on 9/19/16 at 3:25 PM, the door to the room was observed to not close securely and would re-open ½ " -1 " when attempted to close the door. At that time the Resident stated the door would not close since she was admitted to the facility. The Resident stated if someone bumped the door from the outside, the door would open. The Resident stated she had told the staff but nothing had been done. The Resident stated she could not remember what staff members she had told about the door. The resident did not say there were any problems resulting from the door not closing securely.
On 9/20/16 at 9:00 AM the Maintenance Supervisor stated in an interview that he had not

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received a work order regarding a problem with the door to Room 117.
On 9/22/16 at 8:40 AM the Director of Nursing (DON) stated in an interview that she had visited the resident and upon leaving the resident would ask her to leave the door open just a little bit and she had not tried to close the door. The DON stated she would expect a staff member who realized the door would not close to fill out a work order to have maintenance fix the door.
On 9/22/16 at 8:53 AM an interview was conducted with Nursing Assistant (NA) #1 who cared for the resident on the 7AM-3PM shift. The NA stated she had not noticed the door to Room 117 would not close securely. The NA stated if there was a problem that maintenance needed to address she would tell the nurse who would fill out a work order.
On 9/22/16 at 10:40 AM, NA #2 who worked with the resident on the 3PM-11PM shift stated she had not noticed the door to Room 117 would not close securely. The NA stated when leaving the room, the resident would ask her to leave the door cracked a little bit.
On 9/22/16 at 11:08 AM the Maintenance Supervisor stated in an interview he was supposed to go around every day and look at all the rooms to look for any problems. The Maintenance Supervisor stated he hardly ever got the chance to do this due to having staff telling him different things that needed to be fixed. The Maintenance Supervisor explained he kept telling the staff to fill out a work order but they rarely did it. The Maintenance Supervisor stated he was the only person that worked in maintenance and he stayed busy. The Maintenance Supervisor confirmed he did not receive a work order regarding the door to Room 117 and if anyone told him about the door, he did not remember it.

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F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to follow a physician ' s order for Gastrostomy fluids for 1 of 1 resident (Resident #60) with a recent history of and at risk for fecal impaction. The findings included: Resident #60 was admitted to the facility on 4/29/15 and re-admitted on 8/10/16 with diagnoses including Cerebrovascular Accident, Dysphagia, Gastrostomy status and recent Fecal Impaction. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 8/4/16	F 322	F322 Resident #60 gastrostomy tube was flushed per physician's order on 9/20/16 by nurse #1 with supervision by the second shift charge nurse. 100% of license nurses to include nurse #1, were observed administering medications via gastrostomy tube to ensure physician orders are being followed to include orders for gastrostomy fluids by 10/24/16 by Staff Facilitator. The Staff Facilitator immediately retrained the	10/24/16

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F 322	Continued From page 30 identified Resident #60 as having long and short term memory problems and severely cognitively impaired in making daily decisions. Resident #60 had a Gastrostomy tube (GT). Review of the Care Area Assessment (CAAs) Summary dated 5/31/16 triggered in the area of feeding tube related to the resident requiring the feeding tube to assist in maintaining or improving nutritional status characterized by weight loss related to dysphagia. Review of the Care Plan dated 5/18/16 and updated on 8/11/16 identified the problem as: tube required to assist resident in maintaining or improving nutritional status characterized by weight loss related to dysphagia. The listed goal was to receive adequate nutritional and fluid intake as evidenced by stable weight, no signs or symptoms of dehydration through next reviews. The interventions listed, in part, included water flushes as ordered by the physician. Review of the Hospital discharge summary dated 8/10/16 documented the principle diagnosis to include fecal impaction. Review of the Registered Dietician order dated 8/11/16, and signed by the physician, documented to increase the GT flush to 50ml (milliliter) of water before and after medications. Observations during a medication pass on 9/20/16 at 5:46PM showed Resident #60 being given 15 ml of water prior to the medication pass and 10ml of water after the medication pass. During an interview with Nurse #1 on 9/20/16 at 6:02PM she stated she was unaware of the specific amount of water ordered for the flushes. Nurse #1 stated she typically used smaller amounts than 50ml. During an interview with the Director of Nursing on 9/22/16 at 2PM she stated the facility needed to ensure the nurses were giving accurate fluids	F 322	license nurse for any identified areas of concern during the audit. 100% of license nurses to include nurse #1 will be in-serviced by the Director of Nursing regarding the six rights of medication administration to include following physician orders to include orders for gastrostomy fluids, by 10/24/16. All newly hired license nurses will be in-serviced regarding the six rights of medication administration to include following physician orders to include orders for gastrostomy fluids during orientation by the Staff Facilitator. The Medication Pass Audit Tool will be utilized by Staff Facilitator with observation of 10% of license nurses to include nurse #1 to ensure license nurses are following physician orders during medication administration to include gastrostomy medications and gastrostomy fluids administration weekly x 8 weeks then monthly x 1 month. Immediate retraining will be conducted with the licensed nurse for any identified issues observed during the medication pass audits by Staff Facilitator. The DON will review and initial the Medication Pass Audit Tool for appropriate medication administration to residents to include resident #60, for completion, and to ensure all areas of concern were addressed weekly x 8 weeks then monthly x 1 month. The Executive QI committee will meet monthly and review QI Medication Pass	

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F 322	Continued From page 31 according to the physician ' s orders. During an interview with the Administrator on 9/22/16 at 2:06PM she stated her expectation would be for the nursing staff to give the fluids accurately that the physician has ordered.	F 322	Audit Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacist and physician ' s interviews the facility failed to	F 329	F329 A physician order was obtained related to	10/24/16

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F 329	Continued From page 32 document the continued clinical need for Bromfenac eye drops, Pred Forte eye drops and Mucinex for 1 of 5 residents whose medications were reviewed (Resident #118). The findings included: 1. Resident #118 was admitted to the facility on 7/28/15 and had a diagnosis of chronic obstructive pulmonary disease (COPD), dementia and glaucoma. The Annual Minimum Data Set (MDS) Assessment dated 8/4/16 revealed the resident had severe cognitive impairment. a. Review of the resident ' s admission orders dated 7/28/15 revealed an order for Bromfenac solution 0.09% 1 drop in the right eye twice a day. Bromfenac is a non-steroidal anti-inflammatory eye drop. There was not a corresponding diagnosis for the eye medication. There was a note to the attending physician from the pharmacist dated 10/1/15 that requested a diagnosis for the Bromfenac eye drops and the physician ' s response was " eye. " There was no further documentation found in the clinical record regarding the reason for the Bromfenac eye drops. Review of the resident ' s September 2016 Medication Administration Record revealed the resident continued to receive the Bromfenac eye drops. Review of the clinical record revealed a note from an eye consult dated 9/12/16 that gave an order to continue the Bromfenac eye drops to the right eye twice a day but did not give a diagnosis for the medication. On 9/21/16 at 10:21 AM an interview was conducted with Nursing Supervisor #1. The Nursing Supervisor stated she was unable to find a diagnosis in the clinical record for the medication. On 9/21/16 at 3:55 PM an interview was	F 329	the clinical need for resident #118 Bromfenac eye drops, Pred Forte eye drops, and Mucinex by first shift charge nurse on 9/22/16 and Mucinex discontinued per MD order on 9/20/16. 100% audit of all residents medications to include resident #118 will be conducted by a Pharmacy Management Team Member to ensure each resident's medication has an adequate indication/supporting diagnosis for use by 10/11/16. Notification to the physician and a clarification order will be obtained by QI Nurse for all areas of concern during the audit by 10/24/16. 100% of license nurses will be in-serviced by the Director of Nursing regarding obtaining appropriate indication for use/supporting diagnosis for all newly ordered medications by 10/24/16. All newly hired license nurses will be in-serviced by the Director of Nursing regarding obtaining appropriate indication for use/supporting diagnosis for all newly ordered medication by the Staff Facilitator during orientation. The Consultant Pharmacist was in-serviced by the Regional Clinical Manager regarding the importance of ensuring each resident's medication order contain an adequate indication/supporting diagnosis for uses well as the Consultant Pharmacist's responsibility to notify facility staff if any irregularities are found during medication regimen review on 10/11/16. The hall license nurse will ensure newly ordered medications for all residents to	

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F 329	Continued From page 33 conducted with the facility ' s consulting pharmacist. The pharmacist was unable to explain why the resident received the Bromfenac eye drops. On 9/22/16 at 8:33 AM the Director of Nursing (DON) stated in an interview that on admission the charge nurse was supposed to ensure a diagnosis for all ordered medications and if there was not one, contact the primary physician to obtain a diagnosis for the medication. On 9/22/16 at 2:21 PM the DON stated in an interview the diagnosis of " eye " on the pharmacist recommendation form required further investigation by the nurse who received the form. b. Review of the admission orders for Resident #118 dated 7/28/15 revealed an order for Pred Forte Suspension 1%, 1 drop to the right eye twice a day. Pred Forte is a steroidal eye drop used for inflammation. There was not a corresponding diagnosis for the eye drop. There was a note to the attending physician from the pharmacist dated 10/1/15 that requested a diagnosis for the Pred Forte eye drops and the physician ' s response was " glaucoma. " Review of the Medication Administration Record for September 2016 revealed the resident continued to receive the Pred Forte eye drops. Review of the clinical record revealed a note from an eye consult dated 9/12/16 that gave an order to continue the Pred Forte eye drops to the right eye twice a day but did not give a diagnosis for the medication. On 9/21/16 at 10:21 AM an interview was conducted with Nursing Supervisor #1. The Nursing Supervisor stated she was unable to find a diagnosis in the clinical record for the medication. On 9/21/16 at 3:55 PM an interview was	F 329	include resident #118 have an appropriate indication for use/supporting diagnosis at the time the medication is ordered. Clarification for the supporting diagnosis/indication will be obtained from the physician as needed by the hall license nurse receiving the order. A Pharmacy Management Team Member will complete an audit of 20% of all residents' medications to include medications for resident #118 to ensure newly received medication orders have an adequate indication/supporting diagnosis for use monthly x 3 months utilizing a Pharmacy Recommendation QI Audit Tool. The Pharmacy Management Team Member will notify the hall license nurse for any identified concerns during the audit for clarification with the physician. The DON will review and initial the Pharmacy Recommendation QI Audit Tool monthly x 3 months for completion and to ensure clarification orders were obtained as appropriate. The Executive QI committee will meet monthly and review the Pharmacy Recommendation QI Audit Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 329	Continued From page 34	F 329		

conducted with the facility ' s consulting pharmacist. The Pharmacist stated that glaucoma was not an indication for Pred Forte and could not explain why the resident was on the medication.
On 9/22/16 at 8:33 AM the Director of Nursing (DON) stated in an interview that on admission the charge nurse was supposed to ensure a diagnosis for all ordered medications and if there was not one, contact the primary physician to obtain a diagnosis for the medication.
On 9/22/16 at 2:21 PM the DON stated in an interview the diagnosis of " glaucoma " on the pharmacist recommendation form required further investigation by the nurse who received the form.
c. Resident #118 was admitted to the hospital on 11/17/15 with pneumonia and COPD exacerbation and discharged back to the facility on 11/26/15 with an order for Mucinex 600mg (milligrams) three times a day. Mucinex is a medication to help loosen mucus and thin bronchial secretions to make coughs more productive.
A physician ' s progress note dated 12/07/15 noted the resident ' s pneumonia appeared to be resolved. There were no pharmacy notes to the physician about the Mucinex found in the clinical record.
On 9/21/16 at 10:21 AM, Nursing Supervisor #1 stated in an interview she called Resident #118 ' s physician on 09/20/16 regarding a diagnosis for the Mucinex and the physician discontinued the medication.
On 9/21/16 at 3:55 PM an interview was conducted with the facility ' s consulting pharmacist. The Pharmacist stated she did not know the reason the resident was taking the Mucinex but the medication was sometimes

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F 329	Continued From page 35 prescribed for residents with COPD. On 9/22/16 at 8:33 AM the Director of Nursing (DON) stated in an interview the charge nurse was supposed to ensure a diagnosis for all ordered medications and if there was not one, contact the primary physician for a diagnosis. On 9/22/16 at 3:28 PM an interview was conducted with the Physician that cared for the resident in the facility. The Physician stated she usually kept a resident on Mucinex for 5 days and the continued use of the Mucinex was an oversight.	F 329		

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F 329	Continued From page 37	F 329		
F 332 SS=D	\\\\\\\\\\\\\\\ 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 26	F 332	F332 Resident #60 gastrostomy tube was flushed per physician's order on 9/20/16 by Nurse #1 with supervision by the	10/24/16

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F 332	Continued From page 38 opportunities, resulting in a medication error rate of 7.6%, for 2 of 7 residents (Resident #60 and Resident #79) observed during medication pass. The findings included: 1) A review of the facility ' s policy, " Administration of Oral Medications Through a Nasogastric Tube or Gastrostomy Tube " (revised 12/3/12) included the following procedures for a gastrostomy tube (a tube placed into the stomach which can be used for feeding and medication administration): " 13) For Stabilized Gastrostomy Tubes (i.e., surgically placed or stabilized by external device): pour small amount of water, 1-2 ounces (30-60 milliliters) into the syringe to verify tube patency and moisten tubing to prevent feeding/medication for adhering to the tube. 14) For Unstabilized Gastrostomy Tubes: test for placement by aspiration of stomach contents. Verify tube patency by instilling small amount of water, 1-2 ounces (30-60 milliliters) in the syringe. " Resident #60 was admitted to the facility on 4/29/15 with cumulative diagnoses which included dysphagia (difficulty in swallowing) and placement of a gastrostomy tube (a surgical opening into the stomach whereby a feeding tube may be inserted and used for feeding). On 9/20/16 at 5:43 PM, Nurse #1 was observed as she prepared one - 100 milligram (mg) capsule of minocycline for administration to Resident #60. Nurse #1 mixed the contents of the minocycline capsule in 25 milliliters (ml) of water. After the nurse checked to confirm placement of the resident ' s gastrostomy tube,	F 332	second shift charge nurse. The MD was notified of resident #79 insulin administration after meals by charge nurse #1 on 9/21/16. 100% of license nurses and medication aides were observed during med pass to include nurse #1 and charge nurse #1 to ensure med error rate was less than 5% by Staff Facilitator by 10/24/16. The license nurses med pass audit included observing administering medications via gastrostomy tube to ensure physician orders are being followed to include orders for gastrostomy fluids and observation of administering insulin injections to ensure physician orders are being followed to include orders for insulin injections before meals. The Staff Facilitator will immediately retrain the license nurse and/or medication aide for any identified areas of concern during the audit. 100% of license nurses to include nurse #1 and charge nurse #1 and medication aides will be in-serviced by the Director of Nursing regarding the six rights of medication administration. 100% of license nurses to include nurse #1 and charge nurse #1 will also be in-serviced on following physician orders to include orders for gastrostomy fluids and insulin injections by 10/24/16. All newly hired license nurses and medication aides will be in-serviced regarding the six rights of medication administration by the Staff Facilitator during orientation. All newly hired license nurses will be in-serviced	

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F 332	Continued From page 39 she instilled 15 ml of water into the tube as a water flush. The nurse then poured the dissolved medication into the tube. She flushed the tube with 10 ml of water after the medication was administered. A review of Resident #60 ' s physician ' s medication orders included a current order for 100 mg minocycline given via gastrostomy tube twice daily. Further review of Resident #60 ' s physician ' s medication orders revealed an order initiated on 8/11/16 and included in the signed September 2016 Order Summary read, " Flush g-tube (gastrostomy tube) with 50 ml of water before and after meds. " An interview was conducted on 9/20/16 at 6:02 PM with Nurse #1. During the interview, Resident #60 ' s medication orders were reviewed. Upon review of the resident ' s physician orders, the nurse stated she was not aware a specific amount of water was ordered for the resident's flushes. The nurse stated she must have missed this when she reviewed the resident ' s Medication Administration Record (MAR). Nurse #1 reported she typically used smaller amounts of fluid (less than 50 ml) to flush tubing before and after medication administration. An interview was conducted on 9/21/16 at 10:31 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated the expectation would be " to follow the order " for the administration of medications and water flushes via a gastrostomy tube. 2) Resident #79 was admitted to the facility on 9/15/16 with cumulative diagnoses which included Type 2 diabetes.	F 332	regarding following physician orders to include orders for gastrostomy fluids and insulin injections during orientation by the Staff Facilitator. The Medication Pass Audit Tool will be utilized by Staff Facilitator with observation of 10% of license nurses to include nurse #1 and charge nurse #1 and medication aides to ensure med pass error rate is less than 5% weekly x 8 weeks then monthly x 1 month. The license nurses med pass audit will also include ensuring license nurses are following physician orders during medication administration to include gastrostomy medications, gastrostomy fluids administration, and insulin injections. Immediate retraining will be conducted with the licensed nurse and/or medication aide for any identified issues observed during the medication pass audits by Staff Facilitator. The DON will review and initial the Medication Pass Audit Tool for appropriate medication administration to residents to include resident #60 and #79, for completion, and to ensure all areas of concern were addressed weekly x 8 weeks then monthly x 1 month. The Executive QI committee will meet monthly and review QI Medication Pass Audit Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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On 9/21/16 at 8:41 AM, Charge Nurse #1 was observed as she asked Resident #79 if she had eaten her breakfast. The resident replied, " Yes. " A medication administration observation was made on 9/21/16 at 8:43 AM as Charge Nurse #1 administered 8 Units of Humalog insulin injected subcutaneously (under the skin) to Resident #79. An additional observation made at the time of the medication administration revealed the resident ' s breakfast tray was on her bedside tray table (with approximately 75% of the meal consumed).

A review of Resident #79 ' s physician ' s medication orders included a current order for 8 Units of Humalog insulin to be injected subcutaneously before meals.

An interview was conducted on 9/21/16 at 9:16 AM with Charge Nurse #1. Upon inquiry as to why the insulin was given after breakfast instead of before the meal, the nurse stated "I just hadn't gotten down there." The nurse reported the resident was relatively new to the facility. Charge Nurse #1 stated she may need to get the order adjusted to allow giving the insulin either with the meal or within 30 minutes of it.

An interview was conducted on 9/21/16 at 10:31 AM with the facility ' s Director of Nursing (DON). During the interview, the DON indicated the expectation was that all medications would be given as instructed by the physician ' s order. The DON reported the nursing staff needed to observe the timing aspect of the physician ' s order.

A telephone interview was conducted on 9/21/16 at 4:00 PM with the facility ' s consultant

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F 332	Continued From page 41 pharmacist. Upon review of the medication administration observation, the pharmacist indicated the timing of a medication administration should correspond with the physician ' s order.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		10/24/16

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F 356	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post complete nursing staff information, including the resident census, prior to the beginning of each shift for 51 of the previous 51 days reviewed (8/1/16 through 9/20/16); and, failed to retain staff postings for 3 days (8/20/16, 8/21/16, and 9/9/16) of the past 51 days reviewed. The findings included: An observation made on 9/19/16 at 10:40 AM revealed the nurse staffing information posted in the hallway near the nursing station was dated 9/19/16. The facility ' s resident census number was not included on the nursing staff posting. An observation made on 9/20/16 at 7:52 AM revealed the nursing staff posting dated 9/19/16 was still posted. The resident census number for the first shift on 9/19/16 was noted to be reported on the form at the time of this observation. However, the 9/19/16 census number was not recorded for the 2nd or 3rd shift. An observation made on 9/20/16 at 3:20 PM revealed the nursing staff information was posted for 9/20/16. The resident census number for the first shift was reported. However, the census number for the 2nd shift was not recorded on the posting. An interview was conducted with facility ' s Director of Nursing (DON) on 9/21/16 at 10:22 AM. The DON indicated the facility ' s 1st shift nursing supervisor was responsible to complete	F 356	F356 The DON immediately corrected and reposted the Daily Nursing Staff Sheet on 9/21/16 in the hallway near the nursing station with complete nursing staff information including the resident census prior to the beginning of the shift. 100% audit was completed by the Administrator and the Director of Nursing of all Daily Nursing Staff Sheets to ensure all sheets present and complete for a period of 3 months on 10/24/16. The Facility Consultant in-serviced the Administrative Nurses to include: The Director of Nursing, Quality Improvement Coordinator, Nursing Supervisor #1, Staff Facilitator, and weekend charge nurse on the daily posting of the Daily Nursing Staff Sheet with complete information to include the census and retaining the daily staffing sheets for 18 months on 10/24/16. The first shift charge nurse will remove the previous day staffing sheet, and post a new daily nursing staffing sheets daily to include weekends with complete information including the census. The previous day daily staffing sheet will be forward to the DON. The DON will ensure the daily nursing staff sheets are placed in a notebook and kept for 18 months. The Director of Nursing will audit the posting on the wall of the Daily Nursing Staff sheets weekly x 8 weeks and monthly x 1	

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F 356	Continued From page 43 and post the nurse staffing information each day. The DON reported that she herself assumed responsibility for the retention of the daily nursing staff postings. An interview was conducted with Nursing Supervisor #1 on 9/21/16 at 1:47 PM. During this interview, Nursing Supervisor #1 reported the 1st shift nursing supervisor or charge nurse was responsible to post the staffing information each day. Upon inquiry, the nursing supervisor stated she completed the resident census data for the 1st shift based on the midnight census report. The nursing supervisor also reported she completed the nurse staffing data for all 3 shifts for the day, based upon the Daily Staffing Sheet (schedule) provided by the DON. The nursing supervisor stated the resident census data for the 2nd shift was " supposed to " be completed by the 2nd shift charge nurse and the 3rd shift census data was to be recorded by either of the two nurses on duty for that shift. The nursing supervisor reported all nursing staff postings were turned in to the DON after being taken down. A review of the retained nursing staff postings from 8/1/16 to 9/20/16 revealed none of the daily postings included resident census data from all 3 shifts. Further review of the nursing staff postings from 8/1/16 to 9/20/16 revealed the daily postings had not been retained for 8/20/16, 8/21/16, or 9/9/16. A follow-up interview was conducted with the DON on 9/21/16 at 4:47 PM. Upon inquiry, the DON reported the 1st shift nursing supervisor responsible for posting the nursing staff information was scheduled to begin her workday at 7:00 AM in the morning. The DON	F 356	month to ensure daily posting includes complete information prior to the beginning of the shift and are retained in a notebook utilizing the Daily Staff Sheet QI Tool. Retraining will be immediately conducted by the Director of Nursing for any identified areas of concern. The Administrator will review and initial the Daily Staffing Sheet QI Tool and Retention notebook weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Daily Staff Posting QI Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 356	Continued From page 44 acknowledged the daily nursing staff information was typically posted after the start of the shift. She also confirmed the daily nursing staff posting did not include the resident census data for all three shifts and that some of the postings may not have been retained. The DON stated her expectation was for the nurse staffing to be posted in a timely manner and to be kept up to date throughout the 24-hour day for each shift. She reported the posting needed to include resident census and staffing data. The DON also stated she would expect the nursing staff postings to be retained for 18 months.	F 356		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the	F 368	F368	10/24/16

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F 368	Continued From page 45 facility failed to offer each resident a bedtime snack for 1 of 4 residents interviewed about bedtime snacks (Resident #35). Resident #35 was admitted to the facility on 6/10/16 for rehabilitation services. The Admission Minimum Data Set (MDS) Assessment dated 6/17/16 noted the resident was cognitively intact. On 9/19/16 at 3:25 PM a resident interview was conducted with Resident #35. During the interview, the Resident stated last night she got the first bedtime snack since she had been in the facility. The Resident stated until last night she had never been offered a bedtime snack. On 9/21/16 at 1:34 PM the Dietary Manager stated in an interview the snacks go out on the hall around 8PM. The Dietary Manager stated there were snacks sent out for residents with orders for snacks and they always included extra snacks for anyone that wanted a snack. On 9/21/16 at 3:21 PM, NA (Nursing Assistant) #3 stated in an interview there was a list of residents that received a scheduled bedtime snack. The NA stated the residents whose name was not on the list could get a snack if they asked for it. The NA stated she did not go around and offer every resident a snack at bedtime. On 9/21/16 at 3:30 PM, NA #4 stated in an interview the snacks come out around 8:00 PM. The NA stated that certain residents have orders for bedtime snacks and they pass out these snacks. The NA stated if there are extra snacks and a resident asks for a snack, they give them one. On 9/21/16 at 3:39 PM, NA #6 stated in an interview that snacks come out about 7:00 PM and they try to get them out to the residents within one hour. The NA stated if the resident asked for a snack they would give them one. The NA stated he did not go around and ask each resident if	F 368	Resident #35 is no longer a resident in the facility. 100% of residents were offered a bed time snack on 10/11/16 by second shift nursing assistants and reviewed by second shift charge nursing on 10/11/16. 100% of license nurses and CNAs to include NA #3, NA #4, and NA #6 will be in-serviced regarding offering each resident a bedtime snack daily with documentation of acceptance and refusals by 10/24/16. All newly hired license nurses and CNAs will be in-serviced regarding offering each resident a bedtime snack daily with documentation of acceptance and refusals. The assigned hall CNA will be responsible for offering each resident a bedtime snack daily and document on a resident census sheet if the resident accepted or refused the snack. The second shift charge nurse will interview 10% of alert and oriented residents weekly x 8 weeks then monthly x 1 month regarding offering of snacks. Retraining will be conducted with the assigned CNA by the Director of Nursing for any identified areas of concern. The Director of Nursing will review and initial the Resident Snack Interview Tool and resident census sheet weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet	

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F 368	Continued From page 46 they wanted a snack. On 9/22/16 at 8:26 AM, the Director of Nursing (DON) stated in an interview that the NAs passed out bedtime snacks to the residents on their assignment and snacks were provided to other residents if they asked for one. The DON stated they did not wake up residents if they were asleep to offer them a snack. The DON stated she had never told the staff to offer each resident a snack but to provide a snack to the residents that asked for one.	F 368	monthly and review the Resident Snack Interview Tool and resident census sheet and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacist and physician interviews the consulting pharmacist failed to follow up on the physician ' s response to a request for a diagnosis for Bromfenac and Pred Forte eye drops and failed to ensure a continued clinical need for Mucinex for 1 of 5 residents whose medications were reviewed (Resident #118). The findings included: 1. Resident #118 was admitted to the facility on 7/28/15 and had a diagnosis of chronic	F 428	F428 A physician order was obtained related to the clinical need for resident #118 Bromfenac eye drops, Pred Forte eye drops, and Mucinex by first shift charge nurse on 9/22/16. Physician order to discontinue Mucinex on 9/20/16 by first shift charge nurse. 100% audit of all residents medications to	10/24/16

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F 428	Continued From page 47 obstructive pulmonary disease (COPD), dementia and glaucoma. The Admission Minimum Data Set (MDS) Assessment revealed the resident had severe cognitive impairment. a. Review of the resident ' s admission orders dated 7/28/15 revealed an order for Bromfenac solution 0.09% 1 drop in the right eye twice a day. Bromfenac is a non-steroidal anti-inflammatory eye drop. There was not a corresponding diagnosis for the eye medication. There was a note to the attending physician from the pharmacist dated 10/1/15 that requested a diagnosis for the Bromfenac eye drops and the physician ' s response was " eye. " There was no further documentation found in the clinical record regarding the reason for the Bromfenac eye drops. Review of the clinical record revealed a note from an eye consult dated 9/12/16 that gave an order to continue the Bromfenac eye drops to the right eye twice a day but did not give a diagnosis for the medication. On 9/21/16 at 10:21 AM an interview was conducted with Nursing Supervisor #1. The Nursing Supervisor stated she was unable to find a diagnosis in the clinical record for the medication. On 9/21/16 at 3:55 PM an interview was conducted with the facility ' s consulting pharmacist. The pharmacist was unable to explain why the resident received the Bromfenac eye drops. On 9/22/16 at 8:33 AM the Director of Nursing (DON) stated in an interview the pharmacist came in once a month to review the resident ' s medications and she expected the pharmacist to ensure there was a diagnosis for the medications ordered for the resident. On 9/22/16 at 2:10 PM the Nursing Supervisor	F 428	include resident #118 will be conducted by a Pharmacy Management Team Member to ensure each resident's medication has an adequate indication for use/supporting diagnosis by 10/11/16. Notification to the physician and a clarification order will be obtained by QI Nurse for all areas of concern during the audit by 10/24/16. 100% of license nurses will be in-serviced by the Director of Nursing regarding obtaining appropriate indication for use/supporting diagnosis for all newly ordered medications by 10/24/16. All newly hired license nurses will be in-serviced by the Director of Nursing regarding obtaining appropriate indication for use/supporting diagnosis for all newly ordered medication by the Staff Facilitator during orientation. The Consultant Pharmacist was in-serviced by the Regional Clinical Manager regarding the importance of ensuring each resident's medication order contain an adequate indication for use as well as the Consultant Pharmacist's responsibility to notify facility staff if any irregularities are found during medication regimen review on 10/11/16. The hall license nurse will ensure newly ordered medications for all residents to include resident #118 have an appropriate indication for use/supporting diagnosis at the time the medication is ordered. Clarification for the appropriate indication for use/supporting diagnosis will be obtained from the physician as needed by the hall license nurse receiving the order.	

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F 428	Continued From page 48 stated in an interview that she had spoken with the hospital and the Bromfenac eye drops had been ordered for macular edema. On 9/22/16 at 2:21 PM the DON stated in an interview she would expect the pharmacist to review her recommendations to the physician for an appropriate response. b. Review of the resident ' s admission orders dated 7/28/15 revealed an order for Pred Forte Suspension 1%, 1 drop to the right eye twice a day. Pred Forte is a steroidal eye drop used for inflammation. There was not a corresponding diagnosis for the eye drop. There was a note to the attending physician from the pharmacist dated 10/1/15 that requested a diagnosis for the Pred Forte eye drops and the physician ' s response was " glaucoma. " Review of the clinical record revealed a note from an eye consult dated 9/12/16 that gave an order to continue the Pred Forte eye drops to the right eye twice a day but did not give a diagnosis for the medication. On 9/21/16 at 10:21 AM an interview was conducted with Nursing Supervisor #1. The Nursing Supervisor stated she was unable to find a diagnosis in the clinical record for the medication. On 9/21/16 at 3:55 PM an interview was conducted with the facility ' s consulting pharmacist. The Pharmacist stated that glaucoma was not an indication for Pred Forte and could not explain why the resident was on the medication. On 9/22/16 at 8:33 AM the Director of Nursing (DON) stated in an interview the pharmacist came in once a month to review the resident ' s medications and would expect the pharmacist to ensure there was a diagnosis for the medications ordered for the resident.	F 428	A Pharmacy Management Team Member will complete an audit of 20% of all residents' medications to include medications for resident #118 to ensure newly received medication orders have an adequate indication for use and follow of previous responses of physician recommendations or requests for diagnosis of medications monthly x 3 months utilizing a Pharmacy Recommendation QI Audit Tool. The Pharmacy Management Team Member will notify the hall license nurse for any identified concerns during the audit for clarification with the physician for newly received medications or previously requested medications. The DON will review and initial the Pharmacy Recommendation QI Audit Tool monthly x 3 months for completion and to ensure clarification orders were obtained as appropriate. The Executive QI committee will meet monthly and review the Pharmacy Recommendation QI Audit Tool and address any issues, concerns and to make changes to needed, to include continued frequency of monitoring x 3 months.	

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On 9/22/16 at 2:10 PM the Nursing Supervisor stated in an interview that she had spoken with the hospital and the Pred Forte eye drops had been ordered for macular edema.
On 9/22/16 at 2:21 PM the DON stated in an interview she would expect the pharmacist to review her recommendations to the physician for an appropriate response.
c. Resident #118 was admitted to the hospital on 11/17/15 with pneumonia and COPD exacerbation and discharged back to the facility on 11/26/15 with an order for Mucinex 600mg (milligrams) three times a day. Mucinex helps to loosen mucus and thin bronchial secretions to make coughs more productive.
A physician ' s progress note dated 12/07/15 noted the resident ' s pneumonia appeared to be resolved. There were no pharmacy notes to the physician about the Mucinex found in the clinical record.
On 9/21/16 at 10:21 AM, Nursing Supervisor #1 stated in an interview she called the physician regarding a diagnosis for the Mucinex and the physician discontinued the medication.
On 9/21/16 at 3:55 PM an interview was conducted with the facility ' s consulting pharmacist. The Pharmacist stated she did not know the diagnosis for the Mucinex but the medication was sometimes prescribed for residents with COPD.
On 9/22/16 at 8:33 AM the Director of Nursing (DON) stated in an interview the pharmacist came in once a month to review the resident ' s medications and would expect the pharmacist to ensure a diagnosis for all medications.
On 9/22/16 at 3:28 PM an interview was conducted with the Physician that cared for the resident in the facility. The Physician stated she usually kept a resident on Mucinex for 5 days and

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F 428	Continued From page 50 the continued use of the Mucinex was an oversight. The Physician stated the pharmacist usually notified her of this kind of thing.	F 428		

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F 428	Continued From page 51	F 428		

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F 428	Continued From page 52	F 428		
F 431 SS=D	\\\\\\\\\\\\\\\\ 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		10/24/16

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F 431	Continued From page 53 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to safely and securely store medications kept at bedside for 1 of 1 resident (Resident #7) who self-administered medications. The findings included: A review of the facility policy on " Self-Administration of Medications " (not dated) included the following procedural statement: " If the resident demonstrates the ability to self-administer medications, a further assessment of the safety of the bedside medication storage shall be done. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or who room with, residents who self-administer. " Resident #7 was initially admitted to the facility on 1/12/12 with cumulative diagnoses which included	F 431	F431 A lock was placed on resident #7 nightstand to safely and securely store medications that resident self-administers on 9/21/16 by maintenance with supervision of DON. 100% audit of all residents to include resident #7 was completed to identify residents who self-administer medications through room observations and review of current physician orders and care plans on 10/12/16 by QI Nurse to ensure that medications kept in room are safely and securely stored. No other residents were identified that self-administer medications during the audit. The Facility Consultant, DON and Staff Facilitator will in-service all licensed nurses to include the nursing supervisor #1 on the policy and procedure of self-administering medications to include frequency of assessments and	

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F 431	Continued From page 54 glaucoma. A review of Resident #7 ' s medical record revealed a Physician ' s Telephone Order was received on 11/6/15. The order indicated Resident #7, " May keep eye gtts (drops) at bedside and self-administration from 8 AM to 8 PM then back on med cart. " A review of a Medication Self Administration Assessment form dated 2/2/16 and e-signed by the facility ' s Director of Nursing (DON) was completed. The assessment form included 6 questions, one of which asked if the resident was able to demonstrate secure storage for medication kept in his/her room. The response to this question was checked, " Satisfactory. " A review of Resident #7 ' s current physician orders included the following medications, in part: --1% prednisolone solution (a steroid eye drop) instilled as one drop in the left eye three times daily for four weeks; --1% prednisolone solution instilled as one drop in the right eye every morning; --0.005% latanoprost solution (an eye drop used for the treatment of glaucoma) instilled as one drop to each eye every night at bedtime (wait 3-5 minutes between two eye medications); --0.5% timolol solution (an eye drop used for the treatment of glaucoma) instilled as one drop to each eye twice daily (wait 10 minutes before administration of other eye medications); --0.15% brimonidine solution (an eye drop used for the treatment of glaucoma) instilled as one drop to each eye three times daily (wait 3-5 minutes between two eye medications). On 9/19/16 at 12:45 PM, Resident #7 was	F 431	safely and securely storing medications that are kept in residents rooms by 10/24/16. All newly hired nurses will be in-serviced regarding the policy and procedure of self-administering medications to include frequency of assessment and safely and securely storing medications that are kept in residents rooms during orientation by the Staff Facilitator. When a resident request to self-administer medications, the hall nurse will notify MDS nurse or nursing supervisor to assess the resident to determine the resident's ability to safely administer medications without staff supervision utilizing the medication self administration assessment form. If determined safe, the MDS nurse or nursing supervisor will obtain a physician's order update the resident's care plan, ensure the resident medications are safely and securely stored in resident room, and quarterly reassess the resident's ability to safely administer medications without staff supervision utilizing the medication self administration assessment form per policy. The QI nurse will conduct room observations, review current physician orders and care plans for all residents to include resident #7 to identify residents who self-administer medications to ensure the medication self administration assessment form was completed initially and quarterly, and to ensure medications are safely and securely stored in resident room utilizing a Medication self-administering QI tool	

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F 431	Continued From page 55 observed to have 4 vials of prescription eye drops placed in a small basket sitting on his pillow. The eye drops included 0.005% latanoprost solution, 0.5% timolol solution, 0.15% brimonidine solution, and 1% prednisolone solution. Upon inquiry, the resident stated he always put these eye drops in his eyes himself. Resident #7 reported he kept the eye drops in his room each day, and returned them to the hall nurse each evening. A telephone interview was conducted on 9/21/16 at 4:00 PM with the facility ' s consultant pharmacist. During the interview, the pharmacist was asked how the facility could ensure Resident #7 ' s self-administered medications were securely stored. The pharmacist stated, " I guess the facility would have to assess both situations--resident's right to self-administer versus the potential for issues with a resident going into the room. " An interview was conducted on 9/21/16 at 4:35 PM with the DON. When asked if she thought Resident #7 ' s self-administered medications were securely stored in his room during the daytime, the DON stated she could not say they were. However, the DON indicated she would expect the facility to ensure the safe and secure storage of self-administered medications at all times.	F 431	weekly x 8 weeks then monthly x 1 month. The hall nurse, MDS nurse, or Nursing Supervisor will be retrained by the DON for any identified concerns during the audit. The DON will review and sign the Medication self-administering QI tool weekly x 8 weeks and monthly x 1 month for completion to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Medication self-administering medication tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 441 SS=D	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.	F 441		10/24/16

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F 441	Continued From page 56 (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 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 observations and staff interviews, the facility failed to disinfect a shared glucometer (device used to measure a resident ' s blood sugar level) in accordance with the manufacturer's directions for the disinfectant after	F 441	F441 Medication Aide #1 was in-serviced on proper glucometer cleaning to include following the manufacturer's directions for disinfecting after glucometer use and the	

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F 441	Continued From page 57 the glucometer was used for 1 of 1 resident (Resident #13) observed receiving blood glucose (blood sugar) monitoring. The findings included: The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose monitoring and insulin administration. The CDC guidelines have indicated that if glucometers are shared, the device must be cleaned and disinfected between each patient use. A review of the facility's policy on Cleaning and Disinfection of Glucometers dated 3/8/11 stated in part, "If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer ' s directions using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal, bloodborne pathogen to include HIV (human immunodeficiency virus), HBV (hepatitis B virus), and HCV (hepatitis C virus) label claim or a dilute bleach solution of 1:10 to 1:100 concentration. " During an observation on 9/20/16 at 3:28 PM, Medication Aide (Med Aide) #1 used a glucometer to obtain a blood glucose reading for Resident #13. After the reading was taken, the med aide was observed as she used a disinfectant wipe [PDI Sani-Cloth Bleach] to wipe the surface of the glucometer for 15 seconds. She then wrapped the glucometer in a dry tissue and set it in a plastic cup on top of the medication cart. A continuous observation was made of this glucometer as it remained on top of the	F 441	facility policy on glucometer cleaning on 9/20/16 by Staff Facilitator. A return demonstration was given by Medication Aide #1 on proper glucometer cleaning to the Staff Facilitator on 9/21/16 after receiving the re-education with no identified areas of concern. 100% of license nurses and Medication Aides will be observed on glucometer cleaning to ensure manufacturer's directions for disinfecting after glucometer use on all residents requiring finger stick blood sugars to include resident #13 are being followed by 10/24/16. The license nurse and/or Medication Aide will be immediately retrained during the observation by Staff Facilitator for any identified areas of concern. 100% of license nurses and medication aides will be in-serviced regarding glucometer cleaning to include following the manufacturer's directions for disinfecting after use and the facility glucometer cleaning policy by 10/24/16 by the Staff Facilitator. All newly hired licensed nurses and medication aide will receive the education regarding glucometer cleaning to include following the manufacturer's directions for disinfecting after use and the glucometer cleaning policy in orientation by the Staff Facilitator. The Staff Facilitator will observe 10% of license nurses and medication aides to include Medication Aide #1 weekly x 8 weeks then monthly x 1 month to ensure	

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F 441	Continued From page 58 medication cart. At 3:34 PM, Med Aide #1 prepared to do a blood glucose check for the next resident (Resident #43). The med aide removed the glucometer from the cup, set it on the medication cart, and then went to retrieve a re-supply of blood glucose strips. At 3:38 PM, the med aide returned with the blood glucose strips and inserted a test strip into the glucometer which had been previously used for Resident #13. Med Aide #1 knocked on Resident #43 ' s door and began to enter her room. The med aide was stopped and a request was made for her to step out of the resident ' s room and into the hallway. At that time, inquiry was made as to what procedures needed to be followed for disinfecting a shared glucometer between uses. At 3:40 PM, the manufacturer labeling instructions for the disinfectant wipes used on the glucometer were reviewed with Med Aide #1. The product labeling instructions indicated disinfection with the wipes required a 4 minute wet contact time. Upon review of the instructions, Med Aide #1 stated she was unsure as to what the instructions meant. At that time, the med aide indicated she would normally clarify something like this with either the hall nurse or charge nurse. At 3:43 PM, the facility's Charge Nurse was approached and a request made for clarification of the procedures required to disinfect a shared glucometer. An interview was conducted on 9/20/16 at 3:43 PM with Charge Nurse #1 in the presence of Med Aide #1. During the interview, the facility procedures for the disinfection of shared glucometers was discussed. Upon inquiry, Charge Nurse #1 reported the shared glucometers needed to be wiped with a disinfectant wipe, then wrapped in a wet disinfectant wipe for 4 minutes before re-use.	F 441	proper glucometer cleaning to include following the manufacturer's directions for disinfecting after glucometer use. The Staff Facilitator will immediately retrain the licensed nurse and/or medication aide for any identified concerns during the audit. The DON will review and initial the results of the Glucometer Cleaning Audit Tools weekly x 8 weeks then monthly x 1 month for completion and ensure all areas of concerns were addressed. The DON will present the results of the Glucometer Cleaning Audit Tools at the Executive Quality Assurance Meeting monthly x 3 months for trends and the need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 59 A follow-up interview was conducted on 9/20/16 at 3:44 PM with Med Aide #1. During the interview, the med aide stated she did not know the glucometer needed to be wrapped in a wet disinfectant wipe for 4 minutes. Med Aide #1 stated she thought she was supposed to just wipe the glucometer off with a disinfectant wipe and then wait 4 minutes before using it again for another resident. An interview was conducted on 9/21/16 at 10:31 AM with the facility ' s Director of Nursing (DON) regarding the cleaning and disinfection of shared glucometers. The DON reported the facility had a policy on the disinfection of glucometers and was in the process of re-educating staff on it. The DON stated her expectation for the disinfection of the glucometer was, " To follow the policy. "	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520		10/24/16

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F 520	Continued From page 60 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in December 2015. This was for two recited deficiencies which were originally cited in November of 2015 on a recertification survey and on the current recertification survey. The deficiencies were in the areas of infection control and free from medication error rate greater than 5%. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F441- Based on observations and staff interviews, the facility failed to disinfect a shared glucometer (device used to measure a resident ' s blood sugar level) in accordance with the manufacturer's directions for the disinfectant after the glucometer was used for 1 of 1 resident	F 520	F520 The Administrator, DON and QI Nurse were educated by the Corporate consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include for infection control and free from medication error rate greater than 5% by 10/24/16. The Administrator will complete 100% audit of previous citations and action plans within the past year to include infection control and free from medication error rate greater than 5% to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans will be revised and updated and presented to the QI Committee by DON by 10/24/16 for any concerns identified. All data collected for identified areas of concerns to include infection control and free from medication error rate greater	

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F 520	Continued From page 61 (Resident #13) observed receiving blood glucose (blood sugar) monitoring. During a recertification survey of 11/19/2015 the facility was cited for failing to perform hand hygiene and glove during care. On the current recertification survey the facility was cited for failing to properly clean the glucometer. 2. F332- Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.6%, for 2 of 7 residents (Resident #60 and Resident #79) observed during medication pass. During a recertification survey of 11/19/15 the facility was cited for failing to be free of a medication error rate of 5% or greater as evidenced by a medication error rate of 6.89%. On the current recertification survey the facility was cited for failing to be free of a medication error rate of 5% or greater as evidenced by a medication error rate of 7.6%. During an interview on 09/22/16 at 2:30pm the Administrator stated that concerns were brought to the Quality Assessment meetings and action plans were put into place. She stated the facility had developed a plan for infection control and for the medication error rate over 5%. Audits were conducted; however, with the staff turnover and staff being nervous, the plan appeared to not have worked.	F 520	than 5% will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QI Nurse. The Corporate Consultant will ensure the facility is maintaining an effective Quality Assurance program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include infection control and free from medication error rate greater than 5% and all current citations and QI plans are followed and maintained Quarterly x 2. The Facility Consultant will immediately retrain the Administrator, DON and QI nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	