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	345233	A. BUILDING _____ B. WING _____	C 10/06/2016

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SUNRISE REHABILITATION & CARE	**306 DEER PARK ROAD NEBO, NC 28761**

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F 000	INITIAL COMMENTS On 09/22/16 the Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section completed a complaint investigation at the facility which identified non compliance. Prior to the 2567 report for the 09/22/16 complaint investigation being provided to the facility a two day complaint intake was received, investigated and completed on 10/06/16 which identified additional non compliance. The exit date for this survey was extended from 09/22/16 to 10/06/16 to capture both of these complaint investigations. Event ID #V54A11.	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157		11/1/16

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

Electronically Signed | 10/27/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record reviews and Physician Assistant and staff interviews the facility failed to notify the Physician or Responsible Party for a resident who had 2 falls with bruising, abrasions and a skin tear to his head and failed to notify the Physician when the resident was agitated and combative during neurological checks after 2 falls for 1 of 3 residents sampled for supervision to prevent accidents (Resident #20), failed to notify the physician of PT/INR (prothrombin time/international normalized ration) test results for 2 of 4 sampled residents on Coumadin (a blood thinner medication) (Residents #4 and #5) and failed to notify the physician of twelve days of missed estrogen medication for 1 of 3 residents with medications reviewed (Resident #13). The findings included: 1. Resident #20 was admitted to the facility on 09/22/16 from home and was transferred to the hospital on 09/26/16 after a fall with a head injury due to a subdural hematoma. A review of Resident #20's diagnoses included thyroid disease, high blood pressure, osteoarthritis, amnesia, dementia and Alzheimer's disease.	F 157	1.Resident #20 was discharged to the hospital on 9/26/16. Resident #4 had a stat PT/INR drawn on 8/29/16 with MD notification on 8/29/16. Resident #5 was discharged to the hospital on 9/13/16. Resident # 13 was discharged to home on 9/28/16. 2. All residents have the potential to be affected. Incidents reports from the last 90 days were reviewed to ensure MD/RP notification had occurred and that appropriate interventions were initiated and care planned. Medical records for residents currently residing in the facility were reviewed to ensure that labs were drawn per MD order, that results were on the chart, and that MD notification had occurred. MARs/TARs for residents currently residing in the facility were reviewed to ensure that no delay in administration has occurred. 3. Education given the Director of Clinical Support/Designee to be completed by 10/28/16 with Licensed Nurses regarding notification of MD/RP related to incident	

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F 157	Continued From page 2 A review of an Admission Nursing Evaluation dated 09/22/16 at 12:35 PM indicated in part Resident #20 was alert and confused and was uncooperative. The document revealed Resident #20 required no assistance with walking, transfers or bed mobility but was frequently incontinent of bowel and bladder. A section labeled Fall Risk Evaluation indicated Resident #20 was disoriented to person, place and time at all times and had 3 or more falls in the past 3 months. A review of an interim admission care plan dated 09/22/16 indicated Resident #20 was at risk for falls related to unsteady gait and had poor safety awareness due to dementia and his fall risk score was 19 (a score of 10 or above indicated fall risk). The goal was listed that Resident #20 would not sustain major injury related to falling over next review and the interventions were listed to complete fall risk screen on admission, place call bell in easy reach, cue Resident #20 for safety awareness and assist for toileting and transfers as needed and keep environment safe. A review of a nurse's note dated 09/25/16 at 9:30 AM by Nurse #5 revealed a staff member told her Resident #20 was in the floor. The notes indicated Resident #20 was found sitting in the floor in front of a closet and he had a laceration to his mid forehead and bleeding was controlled with gauze pads and the Physician on call was notified and orders were received to send Resident #20 to the hospital for treatment and evaluation. A review of a nurse's note dated 09/25/16 at 12:40 PM by Nurse #5 revealed Resident #20 was back in the facility from the hospital.	F 157	reports, changes in condition, to include refusal of neurological checks, agitation, and medication errors. Education also included MD notification of lab results, labs that are unable to be obtained and if redraw orders were needed. 4. Audits will be conducted 5 times weekly of lab logs with follow up as indicated, new MD orders to ensure RP notification as appropriate, MARs/TARs for omissions/circled items, PRN documentation to include injection sites, incident reports to ensure proper documentation and follow up is present, to include neurological checks by the DON/Designee/Unit Managers. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	

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A review of a Neurological Evaluation Flow Sheet dated 09/25/16 revealed neurological (neuro) checks were indicated every 30 minutes from 1:00 PM until 3:00 PM but "agitated" was handwritten on the form, then neuro checks were indicated every hour from 3:00 PM until 8:00 PM but "agitated/refused" was handwritten on the form and a neuro check was indicated at 12:00 AM but "refused" was written on the form. Further review of the Neurological Evaluation Flow Sheet revealed there was no documentation of neuro checks after 12:00 AM

A review of a nurse's note dated 09/25/16 at 7:20 PM by Nurse #6 revealed Resident #20 was in bed but had refused vital signs and neuro checks and was agitated and combative with staff.

A review of an incident report dated 09/26/16 at 1:05 AM by Nurse #6 revealed Resident #20 was found on the floor sitting up in front of the bed with a superficial abrasion on the top of his head and normal saline and gauze were used to clean the abrasion. The report indicated Resident #20 was trying to get out of bed and a section labeled notification of Physician and family was blank.

A review of a nurse's note dated 09/26/16 at 1:10 AM by Nurse #6 revealed Resident #20 was found on the floor sitting in front of the bed with a superficial abrasion on the top of his head that was cleaned with normal saline and gauze. The notes indicated Resident #20 refused vital signs and neuro checks from a previous fall and he had a dressing intact on the midline of his forehead.

A review of a nurse's note dated 09/26/16 at 3:45 AM by Nurse #7 revealed Resident #20 was

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found in floor after the nurse " heard his head hit floor." The notes indicated Resident #20 had a bruise near the middle of his right ear and a skin tear to the top of his head on the right side. The notes further indicated the skin tear was cleaned with normal saline and a wet to dry dressing was applied and Resident #20 refused vital signs and was fighting staff when they tried to help him to bed. The notes also indicated the nurse would contact family at an appropriate time in the morning.

A review of an incident report dated 09/26/16 at 3:45 AM by Nurse #7 revealed Resident #20 was found in the hall just outside of his room with a bruise over his right ear and a skin tear to the top of his head on the right side. The notes indicated the skin tear was cleaned with normal saline and a wet to dry dressing was applied and the report indicated Resident #20 was walking when he fell. A review of a section for notification of the Physician and family was blank.

A review of a Neurological Evaluation Flow Sheet dated 09/26/16 revealed a check mark in a box at the top of the form which indicated Resident #20 had an unwitnessed fall and to complete checks as follow every 15 minutes for 1 hour, then every 30 minutes for 3 hours and then every hour for 4 hours. A review of hand written documentation indicated neuro checks were documented as "refused" every 15 minutes from 3:45 AM until 4:45 AM then were documented as "refused" every 30 minutes from 5:15 AM until 6:15 AM and there was no documentation of neuro checks after 6:15 AM.

A review of a PA note dated 09/26/16 revealed Resident #20 was combative at times and had

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received IM Ativan which caused him to have ataxia (loss of full control of body movements). The note further revealed Resident #20 had fallen on a couple of occasions and was sent out to the hospital for evaluation and had a Computerized Tomography (CT) scan which was negative for any acute findings but he had a superficial laceration of the scalp which was treated with a dressing. The notes indicated this morning he was lying in bed and at this time and was not responding verbally and was gotten up by a couple of NAs but was very unstable on his feet. The notes indicated to refer to psychiatry for evaluation and treatment of dementia with behavioral disturbance and continue Ativan 0.5 mg IM every 6 hours when necessary for anxiety and agitation and monitor closely for any problems with ataxia and continue measures for fall prevention.

During an interview on 10/04/16 at 12:55 PM with Nurse #5 she explained nurses had access to Physicians through the on call service 24 hours a day. She stated anytime orders needed to be changed or a resident had a change in condition nurses were supposed to call the Physician and the Responsible Party (RP). She explained neuro checks were supposed to be done after a resident fell and if the resident refused them the Physician should be notified. She stated she did not recall if she had notified the Physician when Resident #20 refused neuro checks after he returned from the hospital on 09/25/16 but she should have. She further stated if she had not documented in her notes that she had called the Physician then she probably had not called them.

During an interview on 10/04/16 at 1:43 PM with the PA who had examined Resident #20 on

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09/26/16 he explained the Medical Director had resigned from his duties at the facility within the last couple of weeks and a new Medical Director would be coming to the facility tomorrow. He stated staff had access to on call physician's 24 hours a day but he was the only medical provider who had seen Resident #20 at the facility and was aware he had fallen several times. He further stated he had told facility staff if Resident #20 continued to fall that eventually he would have a subdural hematoma and confirmed that had happened with his last fall on 09/26/16 at 10:00 PM. He explained he thought Resident #20 had balance problems before he came to the facility and was agitated and was uncooperative with staff.

During a telephone call on 10/04/16 at 1:55 PM an attempt was made to contact the RP but there was no answer.

On 10/04/16 at 1:57 PM a phone call was received from a family member of Resident #20 who stated Resident #20 was unable to take phone calls at this time. She explained the RP had told her she was upset when the facility had not called her after 2 of the resident's falls during the night but had found out about them when she went to the facility the next morning.

During an interview on 10/05/16 at 7:59 AM with Nurse #7 she explained she came to work on 09/26/16 at 3:00 AM and was told in report Resident #20 had fallen several times and his last fall was at 1:30 AM but as the nurse was reporting to her Resident #20 fell again at 3:45 AM. She stated she went to check Resident #20's vital signs and do neuro checks but Resident #20 was agitated and combative and

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refused to allow her to check him. She stated she didn't think about it at the time but should have called the Physician on call to let them know Resident #20 had refused neuro checks and was combative.

During an interview on 10/05/16 at 8:20 AM with the South Wing Unit Manager she stated it was her expectation for nurse's to call a resident's physician or their RP after a every resident fall and if they did not answer, they should leave a message. She stated she recalled hearing that Resident #20's RP arrived at the facility after 1 of his falls but could not remember the exact date and time and was upset because no one had called her. She stated if a resident had no injury when they fell during the night it would be reasonable to wait until early morning to call the RP but Resident #20 had 5 falls while he lived in the facility and hit his head every time he fell and the Physician and RP should have been notified. She also stated Nurse #7 should have called the RP on 09/26/16 since Resident #20 had fallen twice during the night and hit his head each time he fell.

During an interview on 10/05/16 at 9:20 AM the Director of Nursing stated it was her expectation for staff to call the Physician after every resident fall and if they did not answer to at least leave them a message. After a review of Resident #20's medical record she verified there was no documentation of notification to the Physician or his RP on the incident reports or nurse's notes for Resident #20's fall on 09/26/16 at 1:05 AM or 3:45 AM and stated if it wasn't documented it wasn't done. She further stated after review of the Neurological Evaluation Forms regarding the documentation of Resident #20's refusals and

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agitation she stated it was her expectation for nurses to call the Physician to notify them of the refusals and agitation and obtain any additional orders from the Physician. She also stated it was her expectation that staff should have called Resident #20's RP to notify her of the 2 falls during the night on 09/26/16 since he had hit his head during both falls and had abrasions, bruising and a skin tear.

2. Resident #4 was admitted to the facility on 07/28/16 with diagnoses that included heart disease, kidney disease, and peripheral vascular disease. Review of the admission Minimum Data Set dated 08/04/16 revealed Resident #4 was cognitively intact and received anticoagulant medications 7 days a week.
The prothrombin time (PT) is a lab test used to help diagnose the cause of unexplained bleeding or inappropriate blood clots. The international normalized ratio (INR) is a calculation based on results of a PT and is used to monitor individuals who are being treated with the blood-thinning medication Coumadin.
Review of the medical record indicated Resident #4 had physician orders that originated on 08/22/16 that indicated the following lab to be drawn: PT with INR on 08/25/16. Resident #4 also had orders to take Coumadin 3.5 mg. on 08/23/16 and 8/24/16, and Coumadin 2.5 mg. on 08/25/16. No further Coumadin orders were noted.
Further review of the medical record revealed Resident #4 did not have a PT with INR drawn on 08/25/16. Review of nurse's notes dated 08/26/16 indicated the lab was drawn at 5:20 PM on 08/26/16 and sent to the hospital laboratory for evaluation. Review of the 24 hour nursing report revealed the PT with INR for Resident #4 was

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redrawn on 08/27/16 at 7:15 AM due to an insufficient specimen for testing. Review of the lab reports from the hospital noted the lab was received at 9:40 AM. Review of the nurse's notes dated 08/28/16 at 10:00 PM, indicated the on-call physician was not notified of the results of the PT with INR until that time.

On 09/21/16 at 12:00 noon an interview was conducted with the Medical Director (MD) and Resident #4's primary care physician. The MD stated Resident #4 had difficulty metabolizing Coumadin and this led to numerous changes in his Coumadin orders and repeated PT with INR levels. The MD indicated the medical staff should have been notified when the labs were initially missed on 08/25/16, and additional orders could have been made regarding Coumadin orders and lab work. The MD noted the medical staff depended on facility staff to perform Coumadin lab work as ordered and report Coumadin levels to medical staff immediately so adjustments to dosages could be made as needed.

On 09/21/16 at 1:30 PM an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated Resident #4's PT with INR was missed on 8/25/16 and was discovered by Nurse #1 on 08/26/16 and was redrawn that afternoon and sent to the hospital laboratory. The SDC stated the facility received a fax later that evening that indicated an insufficient specimen to perform the test. The SDC indicated the lab test was redrawn on the morning of 08/27/16, sent to the hospital laboratory, and the lab result was sent back to the facility sometime that day on first or second shift. Neither the facility nor the lab could confirm the exact time the result was returned, but it was faxed back to the facility on 08/27/16. She further acknowledged from the time the lab results were faxed back to the facility

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on 08/27/16 and the on-call MD was notified of the results at 10:00 PM on 8/28/16, there was poor communication between the nursing staff. She stated she expected the MD to be notified of the results as soon as they were obtained.
On 09/21/16 at 3:45 PM an interview was conducted with Nurse #2. He stated he was the nurse on duty on second shift on 08/27/16 when the lab results for Resident #4's PT with INR was available. He revealed he may have missed the results when they returned from the lab, and stated he had not been informed of a pending lab. Nurse #2 acknowledged the lab results should have been called to the MD as soon as they were available.
On 09/21/16 at 2:45 PM an interview was conducted with the DON. She stated the lab could not confirm when the results for the PT with INR were returned to the facility, but it was either on first or second shift on 08/27/16. The DON indicated it was her expectation that the results would have been called to the on call medical staff immediately. She stated it was poor communication that led to the delay in the notification of the lab results to the MD on 08/28/16 at 10:00 PM.

3. Resident #5 was admitted to the facility 08/29/16 (after hospitalization 08/16/16-08/29/16) with diagnoses which included respiratory failure, chronic obstructive pulmonary disease and atrial fibrillation.

The initial care plan for Resident #5 included the following problem areas: 1. Resident is at risk for abnormal bleeding or hemorrhage because of anticoagulation usage. Approaches to this problem area included:
-monitor and report to the physician

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signs/symptoms of abnormal bleeding and/or hemorrhage.
-schedule lab tests as ordered by the physician.

Review of admission physician orders noted Resident #5 took 1.5 milligrams of Coumadin every day. A physician's order was written on 08/30/16 for a PT/INR (a laboratory test used to dose Coumadin) to be done on 09/02/16.

A nurses progress note written 09/02/16 at 3:15 AM noted "to have PT/INR drawn this morning." Documentation on the 24 hour nurses shift report for 09/02/16 noted "PT/INR drawn this morning."

PT/INR lab results from 09/02/16 were not located on the medical record of Resident #5. On 09/20/16 at 1:11 PM the Director of Nursing (DON) verified there were no PT/INR lab results from 09/02/16 on the medical record of Resident #5. In a follow-up interview on 09/21/16 at 10:30 AM the DON stated routine lab work was drawn by the contract lab during third shift. The DON stated typically the PT/INR results would be back that same day, no later than second shift. The DON stated if the results were not back, second shift nursing staff were expected to call the lab about the results. The DON stated the system used by the facility to ensure lab work was completed as ordered was the 24 hour nursing shift report. The DON stated nursing staff was expected to document on the 24 hour nursing report when the lab was drawn up through the results being sent to the facility. The DON stated documentation on the 24 hour nursing report should be a flag to the nurse on duty of pending labs and their receipt.

On 09/20/16 at 2:00 PM the unit manager (over

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the unit Resident #5 resided) stated it was the responsibility of the nurse on duty to ensure lab results were received from the contract lab. The unit manager reviewed the medical record of Resident #5 and noted although the 09/02/16 PT/INR results were not on the record there had been a PT/INR done on 09/05/16 and those results were reviewed by the physician. The unit manager stated although there was not a physician's order she thought the PT/INR on 09/05/16 had been done because Resident #5 was admitted on Coumadin and an antibiotic. The unit manager stated typically the PT/INR was checked every 3 days if a resident was on Coumadin and an antibiotic.

In a follow-up interview on 09/21/16 at 10:30 AM the DON stated Nurse #4 worked on 09/02/16 from 7AM-7PM and would have been responsible for ensuring the PT/INR results drawn earlier that morning had returned. The DON stated if the results were not back by the end of the shift for Nurse #4 then it should have been reported to Nurse #8 who worked from 7PM-6:30 AM (09/02/16-09/03/16). The DON stated she was not aware the 09/02/16 PT/INR results had not been received by the facility or reviewed by the physician for Resident #5. The DON provided a copy of the 09/02/16 PT/INR lab results for Resident #5 which had been requested by the lab on 09/20/16. The PT/INR results read 31.7/2.47 with .8-3.5 the therapeutic INR reference range.

On 09/21/16 at 2:50 PM Nurse #4 verified she worked with Resident #5 on 09/02/16. Nurse #4 reviewed the 24 hour nursing report and stated the notation "PT/INR" written by the name of Resident #5 was a trigger for her to be looking for the lab results. Nurse #4 stated she did not recall

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anything about the results to know if the PT/INR came back or if she notified Nurse #8 at the end of the shift that the results had not been received.

On 09/21/16 at 12:00 PM the physician of Resident #5 stated he was dependent on nursing staff to inform him of PT/INR results and used the results to assess any need to change the dosing of Coumadin and to order subsequent PT/INR tests. The physician stated he was not aware the 09/02/16 PT/INR results for Resident #5 had not been received for review. In a follow-up interview on 09/21/16 at 4:55 PM the physician of Resident #5 reviewed the 09/02/16 PT/INR test results and noted the results were within therapeutic range and no changes would have been made to the Coumadin dosing.

On 09/21/16 at 5:30 PM Nurse #8 verified she worked on 09/02/16 from 7:00 PM-7:00 AM with Resident #5. Nurse #8 stated she usually worked 11:00 PM-7:00 AM but came in early on 09/02/16 to assist with staffing needs. Nurse #8 stated her typical role with labs was to fill out the requisition slips for the lab work needing to be done and write what labs were done beside the individual residents name on the 24 hour nursing report. Nurse #8 stated she could not recall anything about the PT/INR for Resident #5 on 09/02/16 including anything that might have been passed on during report by Nurse #4.

4. Resident #13 was admitted to the facility 08/21/16 after being hospitalized from 08/14/16-08/21/16. Facility admission medications included .625 milligrams (mg) of Premarin (estrogen) and .5 mg of Estradiol (estrogen) every day.

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Review of physician orders since admission noted on 08/24/16 the Family Nurse Practitioner ordered to discontinue the Estradiol and continue the .625 mg of Premarin every day. Review of the August 2016 Medication Administration Record (MAR) revealed the discontinuation of Estradiol and continuation of Premarin had been transcribed and administered as ordered from 08/24/16-08/31/16. Review of the September 2016 MAR noted the Premarin had not been included and administered from 09/01/16-09/12/16. The Premarin was handwritten on the September MAR 09/13/16 and administered beginning 09/13/16.

On 09/21/16 at 10:50 AM the Director of Nursing (DON) stated she was not aware of the missed Premarin from 09/01/16-09/12/16 for Resident #13. The DON stated she would have expected the physician of Resident #13 to be informed of the Premarin not being administered to Resident #13 as ordered from 09/01/16-09/12/16.

On 09/21/16 at 12:00 PM the physician of Resident #13 stated he would expect to be notified if a resident did not receive a medication as ordered. The physician of Resident #13 stated he was not aware Resident #13 had not received Premarin from 09/01/16-09/12/16.

On 09/22/16 at 11:10 AM Nurse #3 stated she routinely worked on the hall Resident #13 resided but had been on vacation the first couple weeks of September. Nurse #3 stated she knew Resident # 13 had been on Premarin since admission and recalled when seen by the Family Nurse Practitioner on 08/24/16 the Estradiol was discontinued when it was discovered there was duplicate estrogen therapy. Nurse #3 stated

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F 157	Continued From page 15 when she returned from vacation she noted the Premarin was not on the September MAR for Resident #13 and called the pharmacy to see if it had been discontinued. Nurse #3 stated she wrote the Premarin back on the September MAR when the pharmacy confirmed it had not been discontinued. Nurse #3 stated she did not report the omission of Premarin to the DON or physician and probably should have.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to follow up and address a resident's concerns or his Responsible Party's concerns about a room change which had caused the resident increased anxiety for 1 of 3 sampled residents for grievances (Resident #15). The findings included: Resident #15 was re-admitted to the facility on 04/10/15 with diagnoses which included diabetes, asthma, congestive heart failure, depression and a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 06/29/16 indicated Resident #15 was cognitively intact for daily decision making and required extensive assistance with dressing, hygiene and toileting.	F 166	1. Resident #15 grievance was resolved and room change occurred on 9/19/16. 2. All residents have the potential to be affected. Alert and oriented residents were interviewed, to include resident council to ensure there were no outstanding grievances. Grievances from the last 90 days were reviewed to ensure resolution. 3. Education to be completed by 10/28/16 with facility staff regarding the grievance process and timely resolution. 4. Grievances will be reviewed 5 times weekly for timely resolution by the Administrator X 12 weeks. Results of	11/1/16

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A review of a facility document titled Grievance/Concern Report dated 09/13/16 which was completed by the Social Services Director indicated Resident #15 and his Responsible Party (RP) were unhappy with his current room.

During an interview on 09/21/16 at 3:31 PM with the North Wing Unit Manager she explained Resident #15 had been moved from the South Wing to the North Wing in August 2016 because he could not get along with a roommate but she could not recall the exact date. She stated they had selected the room because they wanted Resident #15 in a room with an alert and oriented resident.

During an interview on 09/22/16 at 9:20 AM with Resident #15 he stated he had lived on the South Wing next to the nurse's station and really liked his room but then was moved to the North Wing because he was told he was not getting along with his roommate and had to move to another room. He stated he did not want to move from his room on the South Wing to the North Wing but was moved anyway and from the time he was moved into the room he was not happy with the room or the roommate. He explained the roommate kept the air conditioning fan on all the time and the room was too cold for him. He further stated his roommate kept the television on loud all day and night and he could not sleep and it upset his nerves and made him more anxious. He stated he had talked with the Social Services Director numerous times and told her he wanted to be moved to a different room but she kept telling him they would get him another room if a room came available. He further stated he and his RP filed a formal grievance to the Social Services Director in hopes she would find him

these reviews will be taken to the monthly QAPI committee meeting to ensure ongoing substantial compliance.

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another room but she told him he would have to wait.

During an interview on 09/22/16 at 11:11 AM the Staff Development Coordinator explained they had moved roommates out of Resident #15's room in the past because he did not get along with them. She further explained on 08/29/16 they moved Resident #15 to the North Wing because they had told him if he did not get along with his roommate he would have to move. She stated Resident #15 had looked at the room before he moved and said he would try it but after he moved in he stated he was not happy with his roommate but she was unaware the room change had upset his nerves and had caused him increased anxiety.

During an interview on 09/22/16 at 11:58 AM with the Social Services Director she confirmed she managed grievances and anybody could fill out grievance forms that were available at her office or at the nurses stations. She stated when she received grievance forms she logged them in a book to keep track of them. She explained she took the grievances to the morning meetings and they discussed them and they were given to the appropriate department manager to investigate. She stated usually the department manager resolved it and then she kept the information in a notebook and her goal was for grievances to be resolved in 3 days. She confirmed she was involved with a room change for Resident #15 and he saw the room on the North Wing before he moved. She stated when Resident #15 looked at the room he expressed concerns about moving to the room because he thought the room was too small and didn't like the roommate but she thought it would work out over time. She

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explained Resident #15 was moved into the room on the North Wing because they wanted to move him into a room with another alert and oriented resident and their options were limited. She stated right after he moved into the room he asked for his old room back but another resident had already been moved into the room he had been in previously. She stated she visited with Resident #15 during the evening after he was moved and he complained that the room was too cold so she talked to the roommate and the air was turned off but she was unsure what happened after that because she did not do any followup to see if the problem ws fixed or if he had any other concerns. She verified a grievance was filed on 09/13/16 by Resident #15 and he told her to please hurry and find him another room. She explained she also talked with Resident #15's RP on the phone on 09/13/16 because she was upset he had not been moved. She stated she should have followed through with Resdient #15's concerns about his room change when he filed the grievance. She further stated Resident #15 had told her that he wanted to be in a room by himself but he did not have the resources to pay for a private room. She verified the facility had empty beds but she had not evaluated to see if any of the rooms were compatible for Resident #15 to move into because of his history of not getting along with other residents.

During an interview on 09/22/16 and 12:36 PM the DON explained Resident #15 had been moved from the South Wing to the North Wing on 08/29/16 because of problems with a roommate. She confirmed the roommate in the room on the North Wing where Resident #15 was moved also had a history of not getting along with

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F 166	Continued From page 19 roommates. She explained since both residents were alert and oriented they thought it might work out however, they did not get along and the problems escalated until they had a verbal altercation on 09/18/16. She explained it was her expectation that the grievance system the facility had in place should have been utilized to look at Resident #15's concerns about the room and the room change should have been reevaluated to see if the move was compatible with him and his roommate. She stated she expected for nursing staff to communicate with social work and staff should have completed grievance forms to address Resident #15's concerns about the room change. During an interview on 09/22/16 at 1:06 PM the Administrator stated it was her expectation for staff to use the grievance system to address resident's concerns. She explained the facility bed capacity was 140 but the census was 116 and she was unaware if staff had attempted to find Resident #15 another room prior to 09/19/16. She further explained when she was made aware of an altercation between Resident #15 and his roommate she directed staff to move Resident #15 on 09/19/16 and he was moved that same day. She stated staff should have followed up with Resident #15 and his RP about their concerns regarding his room.	F 166		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		11/1/16

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F 309	Continued From page 20 and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer an anti-viral medication for 1 of 4 residents reviewed for care to maintain well being. (Resident #3) The findings included: Resident #3 was admitted to the facility 04/26/16 with diagnoses which included diabetes. Review of a progress note dated 09/09/16 by the Family Nurse Practitioner (FNP) for Resident #3 read, "He was seen yesterday by another clinician for evaluation of a skin lesion on his nose. Bactroban was ordered. Today, the lesion has vesicles and apparently looks worse than it did yesterday" and "vesicles on right side of nose, near right eye." The FNP ordered Acyclivor (an anti-viral medication) 800 milligrams, five times a day for five days. An order was written on 09/09/16 for the Acyclivor but it was not dated as processed until 09/14/16. Review of the September 2016 Medication Administration Record (MAR) for Resident #3 noted the Acyclivor was written on the MAR 09/14/16 with the first dose given 09/15/16. On 09/21/16 at 2:50 PM Nurse #4 stated when she came on duty 09/14/16 she noticed there was a FNP order written for Resident #3 on 09/09/16 that had not been processed. Nurse #4 stated she processed the order for Acyclivor on 09/14/16	F 309	1. Resident #3 antiviral medication was initiated on 9/15/16. Resident will continue to receive medications per MD orders. 2. All residents have the potential to be affected. MD orders of the last 90 days for residents currently residing in the facility was reviewed to ensure any new orders had appropriate follow up. 3. Education by the Director of Clinical Support/Designee to be completed by 10/28/16 with Licensed Nurses regarding daily chart checks to ensure any new orders have been addressed, the notification of RPs when new MD orders are received and review of the 24-hour report. 4. Audits of new MD orders and chart checks will be completed 5 X weekly by the DON/Designee/Unit Managers to ensure appropriate notification and follow through has been completed. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	

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and included it on the September 2016 MAR for Resident #3. Nurse #4 stated she sent the order to the pharmacy and, after review of the September 2016 MAR, confirmed the Acyclivor was administered from 09/15/16-09/19/16. Nurse #4 stated she had not been on duty on the hall Resident #3 resided between 09/09/16 and 09/14/16 and could not explain what happened. Nurse #4 stated typically the physician or Family Nurse Practitioner would flag the handwritten order to alert staff of the need to process the order.

On 09/21/16 at 3:48 PM the Director of Nursing (DON) stated she was not aware there had been a delay in the administration of Acyclivor for Resident #3 and indicated it should have been started no later than 09/10/16. The DON stated that typically the physician or FNP would flag an order that needed to be processed and noted there had been some problems with orders not being flagged to alert nursing staff of a new order.

On 09/21/16 at 4:00 PM the FNP that wrote the order for the Acyclivor for Resident #3 on 09/09/16 stated the expectation would have been for the first dose of the medication to be administered 09/09/16 or 09/10/16. The FNP stated she was not aware there had been a delay in administration of the Acyclivor and stated she was surprised to hear that because when Resident #3 was next evaluated on 09/16/16 there was marked improvement in the lesions. The FNP stated she was aware that new orders should be flagged for nursing staff to process and could not speak to the particular order on 09/09/16 to know it had been flagged.

On 09/22/16 at 10:30 AM Nurse #1 stated she

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F 309	Continued From page 22 was on duty during the day shift on 09/09/16 and stated she remembered the FNP stating she was going to order the Acyclivor for Resident #3. Nurse #1 stated typically second shift nursing staff processed orders but could not recall any specifics about the order for Acyclivor for Resident #3. On 09/22/16 attempts were made to contact the nurse that worked with Resident #3 during second shift on 09/09/16 but the attempts were unsuccessful.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews and Physician Assistant interview and staff interviews the facility failed to protect a resident from falls and injury who fell 5 times within a 37 hour time frame resulting in lacerations and hematomas to his head and the last fall resulted in a subdural hematoma for 1 of 3 residents sampled for supervision to prevent accidents (Resident #20). The findings included: Resident #20 was admitted to the facility on	F 323	1. Resident #20 was discharged to the hospital on 9/26/16. 2. All residents have the potential to be affected. Incident reports from the last 90 days were reviewed to ensure notification of MD/RP has occurred and that interventions are care planned as appropriate. Fall risk assessments/evaluations have been completed for residents currently residing in the facility. Residents identified as	11/7/16

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F 323	Continued From page 23 09/22/16 from home with diagnoses which included thyroid disease, high blood pressure, osteoarthritis, amnesia, dementia and Alzheimer's disease. A review of an Admission Nursing Evaluation dated 09/22/16 at 12:35 PM indicated in part Resident #20 was alert and confused and was uncooperative. The document revealed Resident #20 required no assistance with walking, transfers or bed mobility but was frequently incontinent of bowel and bladder. A section labeled Fall Risk Evaluation indicated Resident #20 was disoriented to person, place and time at all times and had 3 or more falls in the past 3 months and a section labeled Side Rail Evaluation indicated no side rails. A review of an interim admission care plan dated 09/22/16 indicated Resident #20 was at risk for falls related to unsteady gait and had poor safety awareness due to dementia and his fall risk score was 19 (a score of 10 or above indicated fall risk). The goal was listed that Resident #20 would not sustain major injury related to falling over next review and the interventions were listed to complete fall risk screen on admission, place call bell in easy reach, cue Resident #20 for safety awareness and assist for toileting and transfers as needed and keep environment safe. A review of a Care Card indicated Resident #20 required supervision and cueing with transfers, walking, toileting every 2 hours and non-skid socks and shoes. A review of a nurse's note dated 09/23/16 at 9:45 PM by a second shift Nursing Supervisor revealed staff encouraged Resident #20 to go to	F 323	having multiple falls were reviewed to ensure appropriate interventions were in place. 3. Education by the Director of Clinical Support/Designee to be completed by 10/28/16 with Licensed Nurses regarding notification of MD/RP related to incident reports, changes in condition, to include refusal of neurological checks, agitation, combative behaviors, the initiation of interventions post fall and documentation of such in the medical record . Education given by the Administrator/Designee to be completed by 11/7/16 with staff to include CNAs and IDT team members. Residents having a fall or multiple falls will be reviewed in the clinical meeting and the next resident at risk meeting to ensure interventions are initiated and appropriate. 4. Audits of incident reports for MD/RP notification, initiation of new interventions after incidents, review of neurological checks (as appropriate) and documentation in medical records will be completed 5 X weekly by the DON/Designee/Unit Managers. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	

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bed and he would lay down for a short period of time but then got back up. The notes further revealed Resident #20 had a slow, steady shuffle gait and appeared somewhat unsteady when he walked and his Responsible Party (RP) denied Resident #20 had falls at home but another family member who was present indicated Resident #20 had 3 recent falls while at home.

A review of a nurse's note dated 09/23/16 at 6:00 AM by Nurse #8 revealed Resident #20 rested very little last night and was walking in and out of resident rooms with a shuffling gait and repeatedly asked how could he get out of there.

A review of a nurse's note dated 09/23/16 at 1:35 PM by Nurse #5 revealed Resident #20 was wandering in the hallway with a shuffling gait and had increased confusion.

A review of a nurse's note dated 09/24/16 at 2:00 PM by Nurse #5 revealed the on-call physician was notified regarding Resident #20 ' s increased agitation and an order was received for Ativan 1 milligram (mg) intramuscularly (IM) every 6 hours as needed for increased anxiety or agitation.

A review of a nurse's note dated 09/24/16 at 4:00 PM revealed Resident #20 was kicking and punching at staff and Ativan 1 mg was given IM.

A review of an incident report dated 09/25/16 at 9:10 AM by Nurse #5 revealed Resident #20 was found sitting in the floor in front of a closet with a laceration and a hematoma (a raised area from blood collected under the skin) to his mid forehead. The notes further revealed Resident #20 was assisted with first aid to control bleeding and was sent to the emergency room.

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A review of a change in condition form titled Situation, Background, Assessment and Request (SBAR) dated 09/25/16 at 9:10 AM by Nurse #5 revealed Resident #20 had an unwitnessed fall with a laceration to his forehead.

A review of a nurse's note dated 09/25/16 at 9:30 AM by Nurse #5 revealed a staff member told her Resident #20 was in the floor. The notes indicated Resident #20 was found in his room sitting in the floor in front of a closet and he had a laceration to his mid forehead and bleeding was controlled with gauze pads. The notes further indicated the physician on call was notified and orders were received to send Resident #20 to the hospital for treatment and evaluation. The notes revealed emergency medical services (EMS) was in the facility at 9:55 AM to transport Resident #20 to hospital.

A review of a nurse's note dated 09/25/16 at 12:40 PM by Nurse #5 revealed Resident #20 was back in facility from the hospital.

A review of the interim care plan revealed it was updated on 09/25/16 to place a fall mat at the side of Resident #20's bed.

A review of a nurse's note dated 09/25/16 at 7:20 PM by Nurse #6 revealed Resident #20 was in bed but had refused vital signs and neuro checks and was agitated and combative with staff. The notes indicated Resident #20 did not verbalize his needs and would continue to monitor frequently.

A review of an incident report dated 09/26/16 at 1:05 AM by Nurse #6 revealed Resident #20 was found on the floor sitting up in front of the bed

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with a superficial abrasion on the top of his head and normal saline and gauze were used to clean the abrasion. The report indicated Resident #20 was trying to get out of bed.

A review of a nurse's note dated 09/26/16 at 1:10 AM by Nurse #6 revealed Resident #20 was found on the floor sitting in front of the bed with a superficial abrasion on the top of his head that was cleaned with normal saline and gauze. The notes indicated Resident #20 refused vital signs and neuro checks from a previous fall and he had a dressing intact on the midline of his forehead. The notes further indicated Resident #20 was confused and combative with staff, refused to stay in bed, refused to eat, refused oral medications and did not verbalize needs. The notes revealed will monitor Resident #20 frequently.

A review of a nurse's note dated 09/26/16 at 3:45 AM by Nurse #7 revealed Resident #20 was found in floor after the nurse "heard his head hit floor." The notes indicated Resident #20 had a bruise near the middle of his right ear and a skin tear to the top of his head on the right side. The notes further indicated the skin tear was cleaned with normal saline and a wet to dry dressing was applied. The notes also indicated Resident #20 refused vital signs and was fighting staff when they tried to help him to bed and continue to monitor Resident #20.

A review of an incident report dated 09/26/16 at 3:45 AM by Nurse #7 revealed Resident #20 was found in the hall just outside of his room with a bruise over his right ear and a skin tear to the top of his head on the right side. The notes indicated the skin tear was cleaned with normal saline and

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a wet to dry dressing was applied and the report indicated Resident #20 was walking when he fell.

A review of a nurse's note dated 09/26/16 at 4:30 AM by Nurse #7 revealed Resident #20 was in bed and was confused. The notes further revealed Resident #20 raised his hands and arms when approached to obtain vital signs and a bandage to his head was intact with no bleeding through the bandage.

A review of the interim care plan revealed it was updated on 09/26/16 for bed in lowest position, physician review of medications, encourage resident to toilet frequently and wear non-skid socks and shoes.

A review of a nurse's note dated 09/26/16 at 1:00 PM by Nurse # 1 revealed the Physician's Assistant (PA) was in and reviewed notes and new orders were received to refer to psychiatry for consult. The notes further revealed Resident #20 was disoriented and did not respond appropriately even with his RP and was unable to follow commands or instructions. The notes indicated a fall mat was at bedside, skid proof socks were worn and call bell was in reach but Resident #20 did not demonstrate use of it.

A review of a PA note dated 09/26/16 revealed Resident #20 was combative at times and had received IM Ativan which caused him to have ataxia (loss of full control of body movements). The note further revealed Resident #20 had fallen on a couple of occasions and was sent out to the hospital for evaluation and had a Computerized Tomography (CT) scan which was negative for any acute findings but he had a superficial laceration of the scalp which was treated with a

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dressing. The notes indicated this morning he was lying in bed and at this time and was not responding verbally and was gotten up by a couple of NAs but was very unstable on his feet. The notes indicated to refer to psychiatry for evaluation and treatment of dementia with behavioral disturbance and continue Ativan 0.5 mg IM every 6 hours when necessary for anxiety and agitation and monitor closely for any problems with ataxia and continue measures for fall prevention.

A review of a nurse's note dated 09/26/16 at 2:15 PM by Nurse #1 revealed a NA observed Resident #20 was lying on his back on the floor with his feet toward the bed and his head toward the television stand. The notes further revealed a skin tear on the left side of Resident #20's head had reopened and he had 2 protrusions on the left side of his forehead and left side of the top of his head. The notes indicated bleeding was stopped and steri-strips were applied and Resident #20 moved all extremities spontaneously but did not follow commands. The notes also indicated 1 staff stabilized Resident #20's head while 2 staff stabilized his body and 1 staff checked his pupils which were equal and reactive to light and Resident #20 had bit his lower lip during the fall. The notes revealed orders were received from a PA to send Resident #20 to the hospital for evaluation and treatment.

A review of an incident report dated 09/26/16 at 2:15 PM revealed staff passed by Resident #20's room and saw him lying on the floor on his back with his feet toward the bed and his head toward a television stand. The notes further revealed a skin tear on the left side of his head from a previous fall had reopened and there were 2

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protrusions on the left side of his forehead and on the top of his head on the left side and steri strips were applied and Resident #20 had bit his lip when he fell. The report indicated Resident #20 was ambulating unassisted when he fell.

A review of a nurse's note dated 09/26/16 at 2:50 PM by Nurse #1 indicated EMS was in the facility to transport Resident #20 to the emergency room for evaluation and treatment.

A review of a nurse's note dated 09/26/16 at 7:50 PM by a second shift Nursing Supervisor revealed Resident #20 returned to facility and was placed in bed but was non-responsive to voices.

A review of a nurse's note dated 09/26/16 at 10:00 PM by a second shift Nursing Supervisor revealed Resident #20 was found on the floor with profuse bleeding from his head and had a hematoma at his right temporal lobe with a laceration. The notes indicated bleeding was finally controlled and his blood pressure was 146/100, pulse 96, respiration 18 and oxygen saturation was 98 percent. The note also indicated Resident #20 had been lying in bed prior to the fall and his fall was unwitnessed.

A review of an incident report dated 09/26/16 at 10:00 PM by a second shift Nursing Supervisor revealed Resident #20 was found in the floor with a laceration to his right temporal lobe with a hematoma growing. The notes indicated 911 was called and Resident #20 was sent to the emergency room and staff would need to do one on one supervision to prevent falls.

A review of a hospital History and Physical dated

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09/26/16 revealed Resident #20 had a head injury after multiple falls. The report indicate Resident #20 had fallen as many at 5 times according to family and was sent to the emergency room multiple times in the last 48 hours and each time received a CT of the head. The report further indicated the last CT revealed an acute subdural hematoma of approximately 3 millimeters in width.

A review of a hospital Discharge Summary dated 09/29/16 indicated a repeat CT scan completed on 09/28/16 was stable.

During an interview on 10/04/16 at 12:55 PM with Nurse #5 she stated Resident #20 had severe dementia and would not stay in his room. She explained when he first came to the facility his gait was steady and he needed no assistance with ambulation but the more he walked the more unsteady he got and staff encouraged him to sit down when his gait was unsteady. She stated she was working when Resident #20 had a fall on 09/25/16 at 9:30 AM and a NA came and got her and when she walked in Resident #20's room another NA was in the room. She explained Resident #20 had a gash in the middle of his forehead and she cleaned it and called the on call physician and got an order to send him to the emergency room. She stated she did not know anything about fall precautions for Resident #20 but they had tried to keep him in common areas where staff could watch him but he would not stay in the areas because he could not stay still.

During an interview on 10/04/16 at 1:43 PM with the PA who had examined Resident #20 on 09/26/16 he explained the Medical Director had resigned from his duties at the facility within the

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last couple of weeks and a new Medical Director would be coming to the facility tomorrow. He stated staff had access to on call physician's 24 hours a day but he was the only medical provider who had seen Resident #20 at the facility and was aware he had fallen several times. He further stated he had told facility staff if Resident #20 continued to fall that eventually he would have a subdural hematoma and confirmed that had happened with his last fall on 09/26/16 at 10:00 PM. He explained he thought Resident #20 had balance problems before he came to the facility and was agitated and was uncooperative with staff. He further explained he had ordered a psychiatric consult because he thought Resident #20 needed a psychiatric evaluation and his medications reviewed but was not sure if that was done since Resident #20 had been sent out to the hospital on 09/26/16 and had not returned to the facility.

During an interview on 10/04/16 at 2:38 PM with Nurse #9 she confirmed she completed some of Resident #20's admission nursing assessment and had interviewed family to get information because Resident #20 was unable to answer her questions. She explained she documented Resident #20 had falls at home and was very uncooperative. She stated he could not follow directions because he had comprehension and communication problems, was disoriented to person, place and time at all times and was severely impaired in cognition for daily decision making. She explained she was working when Resident #20 had the last fall on 09/26/16 at 10:00 PM and it was a bad fall. She stated prior to his fall Resident #20 had been in the bed and then a NA came screaming for the second shift Nursing Supervisor and she went with her to

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Resident #20's room. She explained Resident #20 was on the floor and there was a lot of blood in the floor and his whole face was bloody but when they cleaned the area on his head the cut was not that big. She stated Resident #20 had his eyes open but did not say anything and it was not a surprise to her that he fell because he had already fallen 3 or 4 times because he would just get up and go as he pleased. She stated she did not feel they were equipped to take care of Resident #20 because they could not watch him constantly.

During an interview on 10/04/16 at 3:32 PM with Nurse #1 she explained Resident #20 kept falling and he hit his head every time he fell. She stated she was working on 09/26/16 at 2:15 PM and NA #1 was walking by his room and saw him lying on the floor on his back with his feet toward the bed and his head toward a television stand and NA #1 called her to the room. She explained the skin tear he had gotten on his head from a previous fall had reopened and was bleeding and he had 1 protrusion near his forehead and another protrusion on the left side on the top of his head and both areas were near the skin tear on the left side of his head. She stated she stopped the bleeding and put steri-strips on it and Resident #20 was moving his extremities but he did not follow commands. She explained she called the PA and received orders to send Resident #20 to the emergency room for evaluation and treatment. She stated staff were expected to assess his needs every 2 hours during routine rounds. She further stated she guessed there should have been a discussion about options to prevent Resident #20's falls but she did not see how they could have prevented his falls since he couldn't communicate.

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During an interview on 10/04/16 at 5:09 PM with NA #2 she stated she remembered Resident #20 got out of bed on his on and he was combative during care. She further stated she was working the day Resident #20 had his first fall on 09/25/16 and she was told to check on him and when she went to his room he was on the floor and was bleeding from his forehead. She stated after he fell there were no changes in interventions for falls that she was aware of and if a resident had increased falls there were no changes that she was told to do to prevent falls.

During an interview on 10/04/16 at 5:23 PM with NA #3 she confirmed she had provided care to Resident #20 and he was very confused, disoriented and combative and would get out of bed on his own and walk around. She explained she was working the day of his first fall on 09/25/16 and he had been sleeping but must have gotten up and was walking toward the window and she thought he had tripped over a bedside table and fell. She explained a nurse checked him to make sure he was alright and they got him up and put him into a wheelchair and then into bed. She stated a floor mat was placed next to his bed and his bed was always in the lowest position but she could not recall any other fall precautions. She further stated it was hard to get Resident #20 redirected or to get him to sit down because he was agitated. She explained she thought being around all the people in the facility had caused increased agitation for Resident #20 and she did not think there was anything they could have done to prevent his falls.

During an interview on 10/04/16 at 5:35 PM with the second shift Nursing Supervisor she

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explained she had helped Nurse #9 complete Resident #20 ' s admission nursing assessment when he was admitted to the facility. She further explained during the first night Resident #20 would lay down for a little while but then got up and started walking and then the next day he was not as responsive as he was the day before. She stated night shift staff had reported to her Resident #20 was combative and he had walked all night. She explained she was working when Resident #20 fell on 09/26/16 at 10:00 PM and it was the worst fall he had with profuse bleeding and a hematoma. She stated she called 911 and the physician on call and Resident #20 was sent to the emergency room for evaluation and treatment. She further stated she felt helpless because Resident #20 just got up and fell and there was nothing she could do to prevent it. She explained Resident #20 could not use his call bell and his dementia was more severe than what they had realized when he was admitted. She explained after the fall on 09/26/16 at 10:00 PM she had written on an incident report that Resident #20 required one on one supervision. She further explained she did not feel the facility was the right place for Resident #20 because the NAs could not stay in the room with him all the time to supervise him. She confirmed the physician would have seen Resident #20 on 09/28/16 for his initial physician assessment but that did not occur since he was sent to the hospital on 09/26/16 and did not return to the facility. She stated she had talked to Administrative staff to have standing orders or steps to follow for residents who had frequent falls but nothing new had been implemented that she was aware of.

During an interview on 10/05/16 at 5:40 AM with

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NA#4 she confirmed she was working on 09/26/16 during second shift when Resident #20 fell. She explained she was next door in another resident ' s room and heard a big bang and she ran out to look to where the noise came from and saw Resident #20 laying with his feet toward the bed and his head was at the door. She stated she and another NA hollered for a nurse and she came to the room and checked Resident #20 and sent him out to the hospital. She explained NAs were expected to make rounds every 2 hours and it was her routine when she worked night shift to do a round after she clocked in at 11:00 PM then her next round was at 1:00 AM, then 3:00 AM and her last round was at 5:00 AM. She stated she did not recall any interventions to check on Resident #20 more frequently than her routine every 2 hour checks.

During an interview on 10/05/16 at 6:05 AM with Nurse #10 she recalled Resident #20 wandered and walked a lot then he started to fall. She explained she was working when Resident #20 fell after 3:00 AM on 09/26/16 and she was aware he had fallen several times on second shift. She explained he had a fall mat beside the bed but that had not helped because he fell in the doorway and his head was partially in the hall and he had a cut on his head. She stated the NA had said she had been in Resident #20's room 10 minutes prior to his fall but after she left the room he got up and fell. She explained she thought frequent monitoring meant for NAs to check on the resident anytime the NA had a few minutes in between their routine rounds.

During an interview on 10/05/16 at 7:59 AM with Nurse #7 she recalled Resident #20's gait was unsteady and he was agitated. She explained

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she came to work on 09/25/16 at 3:00 AM and was told in report Resident #20 had fallen several times and the last fall was at 1:30 AM and as the nurse was reporting to her Resident #20 fell again at 3:45 AM. She stated Resident #20 was sitting in the doorway to his room and he had a skin tear on the right front of his head and they cleaned his head but he was agitated and fighting and didn't want them to touch him. She stated she was not sure how to prevent Resident #20 from falling unless someone sat with him all the time.

During an interview on 10/05/16 at 8:20 AM with the South Wing Unit Manager she explained the only contact she had with Resident #20 was on Monday morning 09/26/16. She stated the NAs who were assigned to Resident #20 came to her in distress because they were so involved with him they couldn't take care of their other residents. She further stated she went to assess Resident #20 and he was agitated and she could not redirect him. She explained she pulled a shower tech to sit with Resident #20 but his RP came in and Resident #20 went to sleep so she sent the shower tech back to her duties. She stated the RP left after lunch while Resident #20 was sleeping but then he woke up and was agitated again and he got up and fell at 2:15 PM. She explained they tried to keep his shoes on but he wouldn't keep them on but he kept his non skid socks on. She stated routine monitoring was done when Resident #20 came back from the emergency room and that meant staff were to check on him at least every 2 hours for turning and toileting and staff were expected to look in on him if they passed by his room. She stated she thought Resident #20 needed to have been evaluated and supervised but they were not equipped to handle his behaviors or prevent him

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from falling. She further stated she was not sure what frequent monitoring meant but would have expected to see parameters for how frequently Resident #20 should have been monitored.

During an interview on 10/05/16 at 9:20 AM the Director of Nursing stated the fall intervention for Resident #20 to monitor frequently was subject to differences in opinion and it was her expectation if a resident required frequent monitoring for it to be defined so staff would know what was expected. She explained the facility was not equipped to provide one on one supervised monitoring for Resident #20 but she expected for staff to increase the frequency of rounds for residents who had frequent falls.

During a follow up interview on 10/05/16 at 11:30 AM with the South Wing Unit Manager she confirmed the psychiatric consult was put in the psychiatrist's book on 09/26/16 after the PA wrote the order but the psychiatrist made his rounds in the facility after 09/26/16 and Resident #20 was in the hospital.

During an interview on 10/06/16 at 10:03 AM with NA #1 she recalled she worked on 09/26/16 when Resident fell at 2:15 AM. She explained she was walking by his room and saw him lying in the floor next to the bed and he had reopened a scab on his head from a previous fall and bit his lip and it was bleeding. She stated she was also working when Resident #20 had a really bad fall on 09/26/16 at 10:00 PM and he was very combative and super agitated and the nurse sent him out to the hospital. She explained Resident #20 could not use his call bell but his room was near the nurse's station. She stated she had no clue how to prevent his falls because he did not understand

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what they told him.

During an interview on 10/06/16 at 10:14 AM with NA #7 he stated Resident #20 was constantly in motion and would not lay in bed unless he was asleep and the only way he kept him in bed was to stand with him because Resident #20 did not realize what was going on around him. He stated he worked on 09/26/16 when Resident #20 fell at 10:00 PM. He stated he was nearby Resident #20's room and heard him hit the floor and when he got to the room it was the worst fall he had seen. He explained he was not sure what Resident #20's head hit but it was either the floor or his head hit the kick plate on the bottom of the door to his room. He stated he and another NA ran to the room as fast as they could and Resident #20 had a cut on the top of his head on the right side and it was swelling. He stated the second shift Nursing Supervisor assessed him and sent him out to the emergency room.

During a follow up interview on 10/06/16 at 11:10 AM the DON explained she heard about Resident #20's falls on 09/25/16 during her morning rounds on 09/26/16 and they had discussed them during the morning meeting on 09/26/16. She stated she was called on 09/26/16 after the 10:00 PM fall because the nurse was sending him to the emergency room and when she came to work the next morning it was reported to her that a nurse had called the hospital and found out Resident #20 had a subdural hematoma as a result of his fall.

During an interview on 10/06/16 at 12:17 PM the Administrator explained she was aware of Resident #20's falls because they had discussed them in the morning meeting on 09/26/16. She

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F 323	Continued From page 39 further explained after the morning meeting on 09/26/16 she didn't have a good feeling so she went with the Social Worker and talked with his RP. She stated she told the RP they were trying to not let Resident #20 fall but they could not provide one on one supervision for him because it was already a challenge to keep the floors covered in order to provide care to other residents. She explained the DON called her on 09/26/16 after the 10:00 PM fall and Resident #20 did not return to the facility.	F 323		
F 329 SS=D	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.	F 329		11/1/16

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This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews the facility failed to notify the physician of PT/INR (prothrombin time/international normalized ration) test results for residents on Coumadin (a blood thinner medication) and failed to obtain lab results in a timely manner and as ordered by the physician for 2 of 5 sampled residents. (Residents #4 and #5).
The findings included:

1a. Resident #5 was admitted to the facility 08/29/16 (after hospitalization 08/16/16-08/29/16) with diagnoses which included respiratory failure, chronic obstructive pulmonary disease and atrial fibrillation. Review of admission physician orders noted Resident #5 took 1.5 milligrams of Coumadin every day.

The initial care plan for Resident #5 included the following problem areas: 1. Resident is at risk for abnormal bleeding or hemorrhage because of anticoagulation usage. Approaches to this problem area included:
-schedule lab tests as ordered by the physician.

Review of physician orders in the medical record of Resident #5 noted an order written on 09/02/16 to "Check CBC (complete blood count) and BMP (basic metabolic panel) 09/06/16." A nurses note in the medical record of Resident #5 which was written by Nurse #4 included, Check BMP and CBC on 09/06/16.

Review of lab results in the medical record of Resident #5 noted a BMP done 09/06/16 however

1. Resident #4 had a stat PT/INR drawn on 8/29/16 with MD notification on 8/29/16. Resident #5 was discharged to the hospital on 9/13/16.

2. All residents have the potential to be affected. Medical records for residents currently residing in the facility were reviewed to ensure that labs were drawn per MD order, that results were on the chart, and that MD notification had occurred.

3. Education by the Director of Clinical Support/Designee to be completed by 10/28/16 with Licensed Nurses regarding MD notification of lab results, labs that are unable to be obtained and if redraw orders were needed. MD orders received for labs will be reviewed by the DON/Designee/Unit Managers to ensure lab is placed on lab log, lab is drawn and that facility has received the results on the day the lab is completed, depending on the type of lab ordered. In the event results are not received, the DON/Designee/Unit Managers will contact the lab/hospital (as appropriate) to obtain lab results.

4. Audits will be conducted 5 times weekly of lab logs and new orders for labs to ensure lab was obtained as appropriate, that facility has results and results have been communicated to the

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F 329	Continued From page 41 there were no CBC lab results from 09/06/16. On 09/20/16 at 11:15 AM the Director of Nursing (DON) discussed the facility process for obtaining lab work. The DON stated when lab work was ordered the nurse that processed the order was responsible for recording the order on the lab calendar and lab book. The DON stated third shift nursing staff filled out the individual lab requisition slips based on what was recorded in the lab book. The DON stated routine lab work ordered to be done Monday-Friday was drawn on third shift by the contract lab service and STAT (short turn around time; urgent) or weekend lab work was done by facility staff. On 09/20/16 at 1:11 PM the DON verified with the lab that the CBC had not been done on 09/06/16 for Resident #5. The DON stated new physician orders were reviewed every morning in the morning meeting. The DON stated the unit managers were a part of the morning meeting and were responsible for making sure any new lab orders were documented on the lab book. The DON reviewed the lab book for 09/06/16 and it had the name of Resident #5 listed with lab tests requested noted as a BMP and magnesium level. The DON stated the CBC was not noted on the lab book which was why it was not done as ordered. On 09/20/16 at 2:00 PM the unit manager (over the unit Resident #5 resided) reviewed the 09/02/16 order for Resident #5 and noted it was processed at 2:00 PM. The unit manager stated new orders on a Friday (09/02/16) would be reviewed in the morning meeting on the following Monday (09/05/16). The unit manager stated she did not work on 09/05/16 and wasn't sure who	F 329	MD 5 X weekly by the DON/Designee/Unit Managers. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	

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would have reviewed the order in her absence. The unit manager stated the facility practice did not include documentation on the order by staff that did the second verification so she could not tell who reviewed the order at the morning meeting on 09/05/16. After review of the medical record of Resident #5 the unit manager stated the need of the BMP and magnesium had been recorded on the lab book from discharge orders from the hospital on 08/29/16.

In a follow-up interview on 09/21/16 at 10:30 AM the DON and Staff Development Coordinator (SDC) indicated they were present on 09/05/16. The DON reviewed the morning meeting minutes from the 09/05/16 meeting and stated she didn't have anything recorded about the 09/02/16 lab work ordered for Resident #5. The DON stated she and the SDC would have reviewed the new orders and could not recall who reviewed the specific order for Resident #5 dated 09/02/16 or checked the lab book to ensure the BMP and CBC were transcribed on the book as ordered. The SDC stated she could not recall who reviewed the specific order for Resident #5 dated 09/02/16 or checked the lab book to ensure the BMP and CBC were transcribed on the book as ordered.

On 09/21/16 at 12:00 PM the physician of Resident #5 stated he would have expected lab work to be done as ordered, including the CBC which was ordered to be done on 09/06/16 for Resident #5.

On 09/21/16 at 2:50 PM Nurse #4 verified she was on duty 09/02/16, worked with Resident #5 and processed the order for the BMP/CBC lab work and wrote the nurses note regarding the

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new order. Nurse #4 it would have been her responsibility to put the BMP and CBC for Resident #5 on the lab calendar and lab book. Nurse #4 stated she could not explain what happened.

1b. Resident #5 was admitted to the facility 08/29/16 (after hospitalization 08/16/16-08/29/16) with diagnoses which included respiratory failure, chronic obstructive pulmonary disease and atrial fibrillation.

The initial care plan for Resident #5 included the following problem areas: 1. Resident is at risk for abnormal bleeding or hemorrhage because of anticoagulation usage. Approaches to this problem area included:
-monitor and report to the physician signs/symptoms of abnormal bleeding and/or hemorrhage.
-schedule lab tests as ordered by the physician.

Review of admission physician orders noted Resident #5 took 1.5 milligrams of Coumadin every day. A physician's order was written on 08/30/16 for a PT/INR (a laboratory test used to dose Coumadin) to be done on 09/02/16.

A nurses progress note written 09/02/16 at 3:15 AM noted "to have PT/INR drawn this morning." Documentation on the 24 hour nurses shift report for 09/02/16 noted "PT/INR drawn this morning."

PT/INR lab results from 09/02/16 were not located on the medical record of Resident #5. On 09/20/16 at 1:11 PM the Director of Nursing (DON) verified there were no PT/INR lab results from 09/02/16 on the medical record of Resident #5. In a follow-up interview on 09/21/16 at 10:30

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AM the DON stated routine lab work was drawn by the contract lab during third shift. The DON stated typically the PT/INR results would be back that same day, no later than second shift. The DON stated if the results were not back, second shift nursing staff were expected to call the lab about the results. The DON stated the system used by the facility to ensure lab work was completed as ordered was the 24 hour nursing shift report. The DON stated nursing staff was expected to document on the 24 hour nursing report when the lab was drawn up through the results being sent to the facility. The DON stated documentation on the 24 hour nursing report should be a flag to the nurse on duty of pending labs and their receipt.

On 09/20/16 at 2:00 PM the unit manager (over the unit Resident #5 resided) stated it was the responsibility of the nurse on duty to ensure lab results were received from the contract lab. The unit manager reviewed the medical record of Resident #5 and noted although the 09/02/16 PT/INR results were not on the record there had been a PT/INR done on 09/05/16 and those results were reviewed by the physician. The unit manager stated although there was not a physician's order she thought the PT/INR on 09/05/16 had been done because Resident #5 was admitted on Coumadin and an antibiotic. The unit manager stated typically the PT/INR was checked every 3 days if a resident was on Coumadin and an antibiotic.

In a follow-up interview on 09/21/16 at 10:30 AM the DON stated Nurse #4 worked on 09/02/16 from 7AM-7PM and would have been responsible for ensuring the PT/INR results drawn earlier that morning had returned. The DON stated if the

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results were not back by the end of the shift for Nurse #4 then it should have been reported to Nurse #8 who worked from 7PM-6:30 AM (09/02/16-09/03/16). The DON stated she was not aware the 09/02/16 PT/INR results had not been received by the facility or reviewed by the physician for Resident #5. The DON provided a copy of the 09/02/16 PT/INR lab results for Resident #5 which had been requested by the lab on 09/20/16. The PT/INR results read 31.7/2.47 with .8-3.5 the therapeutic INR reference range.

On 09/21/16 at 2:50 PM Nurse #4 verified she worked with Resident #5 on 09/02/16. Nurse #4 reviewed the 24 hour nursing report and stated the notation "PT/INR" written by the name of Resident #5 was a trigger for her to be looking for the lab results. Nurse #4 stated she did not recall anything about the results to know if the PT/INR came back or if she notified Nurse #8 at the end of the shift that the results had not been received.

On 09/21/16 at 12:00 PM the physician of Resident #5 stated he was dependent on nursing staff to inform him of PT/INR results and used the results to assess any need to change the dosing of Coumadin and to order subsequent PT/INR tests. The physician stated he was not aware the 09/02/16 PT/INR results for Resident #5 had not been received for review. In a follow-up interview on 09/21/16 at 4:55 PM the physician of Resident #5 reviewed the 09/02/16 PT/INR test results and noted the results were within therapeutic range and no changes would have been made to the Coumadin dosing.

On 09/21/16 at 5:30 PM Nurse #8 verified she worked on 09/02/16 from 7:00 PM-7:00 AM with Resident #5. Nurse #8 stated she usually worked

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11:00 PM-7:00 AM but came in early on 09/02/16 to assist with staffing needs. Nurse #8 stated her typical role with labs was to fill out the requisition slips for the lab work needing to be done and write what labs were done beside the individual residents name on the 24 hour nursing report. Nurse #8 stated she could not recall anything about the PT/INR for Resident #5 on 09/02/16 including anything that might have been passed on during report by Nurse #4.

2. Resident #4 was admitted to the facility on 07/28/16 with diagnoses that included heart disease, kidney disease, and peripheral vascular disease. Review of the admission Minimum Data Set dated 08/04/16 revealed Resident #4 was cognitively intact and received anticoagulant medications 7 days a week.

The prothrombin time (PT) is a lab test used to help diagnose the cause of unexplained bleeding or inappropriate blood clots. The international normalized ratio (INR) is a calculation based on results of a PT and is used to monitor individuals who are being treated with the blood-thinning medication Coumadin.

Review of the medical record indicated Resident #4 had physician orders that originated on 08/22/16 that indicated the following lab to be drawn: PT with INR on 08/25/16. Resident #4 also had orders to take Coumadin 3.5 mg. on 08/23/16 and 8/24/16, and Coumadin 2.5 mg. on 08/25/16. No further Coumadin orders were noted.

Further review of the medical record revealed Resident #4 did not have a PT with INR drawn on 08/25/16. Review of nurse's notes dated 08/26/16 indicated the lab was drawn at 5:20 PM on 08/26/16 and sent to the hospital laboratory for evaluation. Review of the 24 hour nursing report revealed the PT with INR for Resident #4 was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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redrawn on 08/27/16 at 7:15 AM due to an insufficient specimen for testing. Review of the lab reports from the hospital noted the lab was received at 9:40 AM. Review of the nurse's notes dated 08/28/16 at 10:00 PM, indicated the on-call physician was not notified of the results of the PT with INR until that time. The on-call physician instructed staff that no further orders would be added to Resident #4 until he was evaluated by his primary care providers.

The medical record revealed on 08/29/16 at 10:50 AM, Nurse #1 called the Nurse Practitioner (NP) and an order was received to begin Coumadin 3.0 mg daily and re-check PT with INR on 09/06/16. On 08/29/16 at 11:15 AM another order was received from the NP to have a stat (short turn around time; urgent) PT with INR drawn and give Coumadin 5 mg now and start Coumadin 3.0 mg daily on 08/30/16. Resident #4 had his last dose of Coumadin on 08/24/16 and Coumadin was not restarted until 08/29/16.

On 09/21/16 at 12:00 noon an interview was conducted with the Medical Director (MD) and Resident #4's primary care physician. The MD stated Resident #4 had difficulty metabolizing Coumadin and this led to numerous changes in his Coumadin orders and repeated PT with INR levels. The MD indicated the medical staff should have been notified when the labs were initially missed on 08/25/16, and additional orders could have been made regarding Coumadin orders and lab work. The MD noted that the medical staff depended on facility staff to perform Coumadin lab work as ordered and report Coumadin levels to medical staff immediately so adjustments to dosages could be made as needed. The MD revealed he did not believe the resident suffered from ill effects due to his lack of Coumadin for several days because his lab results showed little

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change from when he was taking the medication. The MD noted Resident #4 had since been changed to a different anticoagulant medication due to his inability to metabolize Coumadin.
On 09/21/16 at 1:30 PM an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated Resident #4's PT with INR was missed on 8/25/16 and was discovered by Nurse #1 on 08/26/16 and was redrawn that afternoon and sent to the hospital laboratory. The SDC stated the facility received a fax later that evening that indicated an insufficient specimen to perform the test. The SDC indicated the lab test was redrawn on the morning of 08/27/16, sent to the hospital laboratory, and the lab result was sent back to the facility sometime that day on first or second shift. Neither the facility nor the lab could confirm the exact time the result was returned, but it was faxed back to the facility on 08/27/16. The SDC further acknowledged from the time the lab results were faxed back to the facility on 08/27/16 and the on-call MD was notified of the results at 10:00 PM on 8/28/16, there was poor communication between the nursing staff. She stated she expected the MD to be notified of the results as soon as they were obtained.
On 09/21/16 at 3:45 PM an interview was conducted with Nurse #2. He stated he was the nurse on duty on second shift on 08/27/16 when the lab results for Resident #4's PT with INR was available. He revealed he may have missed the results when they returned from the lab, and stated he had not been informed of a pending lab. Nurse #2 acknowledged the lab results should have been called to the MD as soon as they were available.
On 09/21/16 at 2:45 PM an interview was conducted the Director of Nursing (DON). She

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F 329	Continued From page 49 stated when the lab had been ordered on 08/22/16 to be completed on 08/25/16, the nurse failed to complete a requisition and put the order in the lab book. She indicated it was her expectation that that both of those tasks would have been completed by the nurse at the time the order was taken off. The DON indicated the error led to the lab not being completed. She revealed it was her expectation that once the staff realized the PT with INR had been missed, the MD would have been notified and new lab orders and medication orders would have been obtained. She stated the lab could not confirm when the results for the PT with INR were returned to the facility, but it was either on first or second shift on 08/27/16. The DON indicated it was her expectation that the results would have been called to the on call medical staff immediately. She stated it was poor communication that led to the delay in the notification of the lab results to the MD on 08/28/16 at 10:00 PM.	F 329		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to notify and obtain a physician's order for a lab test for 1 of 5 sampled residents (Resident #4). The findings included: Resident #4 was admitted to the facility on 07/28/16 with diagnoses that included heart	F 504	1. Resident #4 had a stat PT/INR drawn on 8/29/16 with MD notification on 8/29/16. Resident #5 was discharged to the hospital on 9/13/16. 2. All residents have the potential to be affected. Medical records for residents	11/1/16

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F 504	Continued From page 50 disease, kidney disease, and peripheral vascular disease. Review of his admission Minimum Data Set dated 08/04/16 revealed Resident #4 was cognitively intact and received anticoagulant medications 7 days a week The prothrombin time (PT) is a lab test used to help diagnose the cause of unexplained bleeding or inappropriate blood clots. The international normalized ratio (INR) is a calculation based on results of a PT and is used to monitor individuals who are being treated with the blood-thinning medication Coumadin. Review of the medical record indicated Resident #4 had physician orders that originated on 08/22/16 that indicated the following lab to be drawn: PT with INR on 08/25/16. Resident #4 also had orders to take Coumadin 3.5 mg. on 08/23/16 and 8/24/16, and Coumadin 2.5 mg. on 08/25/16. No further Coumadin orders were noted. Further review of the medical record revealed Resident #4 did not have a PT with INR drawn on 08/25/16. Review of nurse's notes dated 08/26/16 indicated the lab was drawn at 5:20 PM on 08/26/16 and sent to the hospital laboratory for evaluation. Review of the 24 hour nursing report revealed the PT with INR for Resident #4 was redrawn on 08/27/16 at 7:15 AM due to an insufficient specimen for testing. On 09/21/16 at 12:00 noon an interview was conducted with the Medical Director (MD) and Resident #4's primary care physician. The MD stated Resident #4 had difficulty metabolizing Coumadin and this led to numerous changes in his Coumadin orders and repeated PT with INR levels. He indicated the medical staff should have been notified when the labs were initially missed on 08/25/16, and additional orders could have been made regarding Coumadin orders and lab	F 504	currently residing in the facility were reviewed to ensure that labs were drawn per MD order, that results were on the chart, and that MD notification had occurred. 3. Education to be completed by 10/28/16 with Licensed Nurses regarding MD notification of lab results, labs that are unable to be obtained and if redraw orders were needed. 4. Audits will be conducted 5 times weekly of lab logs with follow up as indicated and new MD orders for labs to ensure obtained as appropriate completed 5 X weekly by the DON/Designee/Unit Managers. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	

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F 504	Continued From page 51 work. The MD noted that the medical staff depends on facility staff to perform Coumadin lab work as ordered and report Coumadin levels to medical staff immediately so adjustments to dosages and additional labs can be made as needed. On 09/22/16 at 11:15 AM an interview was conducted with Nurse #1. She stated she picked up on the missed PT with INR for Resident #4 on 08/26/16 by reviewing the labs that were due on her unit. She revealed she drew the lab on 8/26/16 for the PT with INR. Nurse #1 indicated she did not call the physician to let him know the original lab order had been missed, and she did not get a new order for lab work. She stated that she always called the MD to request additional lab, but in this case she did not. Nurse #1 acknowledged she should have called the MD to get a new lab order before drawing the PT with INR. On 09/22/16 at 11:55 AM an interview was conducted with the DON. She stated when the PT with INR order for Resident #4 was missed and not drawn on 08/25/16, it was her expectation that the nurse who identified the mistake would have notified the physician and obtained new orders for labs and medication if needed. She stated she expected all labs to have a physician order before they were drawn.	F 504		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by:	F 505		11/1/16

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F 505	Continued From page 52 Based on medical record review and staff interviews the facility failed to notify the physician of PT/INR (prothrombin time/international normalized ration) test results for 2 of 4 sampled residents on Coumadin (a blood thinner medication). (Residents #4 and #5) The findings included: 1. Resident #5 was admitted to the facility 08/29/16 (after hospitalization 08/16/16-08/29/16) with diagnoses which included respiratory failure, chronic obstructive pulmonary disease and atrial fibrillation. The initial care plan for Resident #5 included the following problem areas: 1. Resident is at risk for abnormal bleeding or hemorrhage because of anticoagulation usage. Approaches to this problem area included: -monitor and report to the physician signs/symptoms of abnormal bleeding and/or hemorrhage. -schedule lab tests as ordered by the physician. Review of admission physician orders noted Resident #5 took 1.5 milligrams of Coumadin every day. A physician's order was written on 08/30/16 for a PT/INR (a laboratory test used to dose Coumadin) to be done on 09/02/16. A nurses progress note written 09/02/16 at 3:15 AM noted "to have PT/INR drawn this morning." Documentation on the 24 hour nurses shift report for 09/02/16 noted "PT/INR drawn this morning." PT/INR lab results from 09/02/16 were not located on the medical record of Resident #5. On 09/20/16 at 1:11 PM the Director of Nursing	F 505	1. Resident #4 had a stat PT/INR drawn on 8/29/16 with MD notification on 8/29/16. Resident #5 was discharged to the hospital on 9/13/16. 2. All residents have the potential to be affected. Medical records for residents currently residing in the facility were reviewed to ensure that labs were drawn per MD order, that results were on the chart, and that MD notification had occurred. 3.Education by the Director of Clinical Support/Designee to be completed by 10/28/16 with Licensed Nurses regarding MD notification of lab results, labs that are unable to be obtained and if redraw orders were needed. MD orders received for labs will be reviewed by the DON/Designee/Unit Managers to ensure lab is placed on lab log, lab is drawn and that facility has received the results on the day the lab is completed, depending on the type of lab ordered. In the event results are not received, the DON/Designee/Unit Managers will contact the lab/hospital (as appropriate) to obtain lab results. 4. Audits will be conducted 5 times weekly of lab logs and new orders for labs to ensure lab was obtained as appropriate, that facility has results and results have been communicated to the MD 5 X weekly by the DON/Designee/Unit Managers. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing	

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(DON) verified there were no PT/INR lab results from 09/02/16 on the medical record of Resident #5. In a follow-up interview on 09/21/16 at 10:30 AM the DON stated routine lab work was drawn by the contract lab during third shift. The DON stated typically the PT/INR results would be back that same day, no later than second shift. The DON stated if the results were not back, second shift nursing staff were expected to call the lab about the results. The DON stated the system used by the facility to ensure lab work was completed as ordered was the 24 hour nursing shift report. The DON stated nursing staff was expected to document on the 24 hour nursing report when the lab was drawn up through the results being sent to the facility. The DON stated documentation on the 24 hour nursing report should be a flag to the nurse on duty of pending labs and their receipt.

On 09/20/16 at 2:00 PM the unit manager (over the unit Resident #5 resided) stated it was the responsibility of the nurse on duty to ensure lab results were received from the contract lab. The unit manager reviewed the medical record of Resident #5 and noted although the 09/02/16 PT/INR results were not on the record there had been a PT/INR done on 09/05/16 and those results were reviewed by the physician. The unit manager stated although there was not a physician's order she thought the PT/INR on 09/05/16 had been done because Resident #5 was admitted on Coumadin and an antibiotic. The unit manager stated typically the PT/INR was checked every 3 days if a resident was on Coumadin and an antibiotic.

In a follow-up interview on 09/21/16 at 10:30 AM the DON stated Nurse #4 worked on 09/02/16

substantial compliance.

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F 505	Continued From page 54	F 505		

from 7AM-7PM and would have been responsible for ensuring the PT/INR results drawn earlier that morning had returned. The DON stated if the results were not back by the end of the shift for Nurse #4 then it should have been reported to Nurse #8 who worked from 7PM-6:30 AM (09/02/16-09/03/16). The DON stated she was not aware the 09/02/16 PT/INR results had not been received by the facility or reviewed by the physician for Resident #5. The DON provided a copy of the 09/02/16 PT/INR lab results for Resident #5 which had been requested by the lab on 09/20/16. The PT/INR results read 31.7/2.47 with .8-3.5 the therapeutic INR reference range.

On 09/21/16 at 2:50 PM Nurse #4 verified she worked with Resident #5 on 09/02/16. Nurse #4 reviewed the 24 hour nursing report and stated the notation "PT/INR" written by the name of Resident #5 was a trigger for her to be looking for the lab results. Nurse #4 stated she did not recall anything about the results to know if the PT/INR came back or if she notified Nurse #8 at the end of the shift that the results had not been received.

On 09/21/16 at 12:00 PM the physician of Resident #5 stated he was dependent on nursing staff to inform him of PT/INR results and used the results to assess any need to change the dosing of Coumadin and to order subsequent PT/INR tests. The physician stated he was not aware the 09/02/16 PT/INR results for Resident #5 had not been received for review. In a follow-up interview on 09/21/16 at 4:55 PM the physician of Resident #5 reviewed the 09/02/16 PT/INR test results and noted the results were within therapeutic range and no changes would have been made to the Coumadin dosing.

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On 09/21/16 at 5:30 PM Nurse #8 verified she worked on 09/02/16 from 7:00 PM-7:00 AM with Resident #5. Nurse #8 stated she usually worked 11:00 PM-7:00 AM but came in early on 09/02/16 to assist with staffing needs. Nurse #8 stated her typical role with labs was to fill out the requisition slips for the lab work needing to be done and write what labs were done beside the individual residents name on the 24 hour nursing report. Nurse #8 stated she could not recall anything about the PT/INR for Resident #5 on 09/02/16 including anything that might have been passed on during report by Nurse #4.

2. Resident #4 was admitted to the facility on 07/28/16 with diagnoses that included heart disease, kidney disease, and peripheral vascular disease. Review of the admission Minimum Data Set dated 08/04/16 revealed Resident #4 was cognitively intact and received anticoagulant medications 7 days a week.
The prothrombin time (PT) is a lab test used to help diagnose the cause of unexplained bleeding or inappropriate blood clots. The international normalized ratio (INR) is a calculation based on results of a PT and is used to monitor individuals who are being treated with the blood-thinning medication Coumadin.
Review of the medical record indicated Resident #4 had physician orders that originated on 08/22/16 that indicated the following lab to be drawn: PT with INR on 08/25/16. Resident #4 also had orders to take Coumadin 3.5 mg. on 08/23/16 and 8/24/16, and Coumadin 2.5 mg. on 08/25/16. No further Coumadin orders were noted.
Further review of the medical record revealed

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Resident #4 did not have a PT with INR drawn on 08/25/16. Review of nurse's notes dated 08/26/16 indicated the lab was drawn at 5:20 PM on 08/26/16 and sent to the hospital laboratory for evaluation. Review of the 24 hour nursing report revealed the PT with INR for Resident #4 was redrawn on 08/27/16 at 7:15 AM due to an insufficient specimen for testing. Review of the lab reports from the hospital noted the lab was received at 9:40 AM. Review of the nurse's notes dated 08/28/16 at 10:00 PM, indicated the on-call physician was not notified of the results of the PT with INR until that time.

On 09/21/16 at 12:00 noon an interview was conducted with the Medical Director (MD) and Resident #4's primary care physician. The MD stated Resident #4 had difficulty metabolizing Coumadin and this led to numerous changes in his Coumadin orders and repeated PT with INR levels. The MD indicated the medical staff should have been notified when the labs were initially missed on 08/25/16, and additional orders could have been made regarding Coumadin orders and lab work. The MD noted the medical staff depended on facility staff to perform Coumadin lab work as ordered and report Coumadin levels to medical staff immediately so adjustments to dosages could be made as needed.

On 09/21/16 at 1:30 PM an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated Resident #4's PT with INR was missed on 8/25/16 and was discovered by Nurse #1 on 08/26/16 and was redrawn that afternoon and sent to the hospital laboratory. The SDC stated the facility received a fax later that evening that indicated an insufficient specimen to perform the test. The SDC indicated the lab test was redrawn on the morning of 08/27/16, sent to the hospital laboratory, and the

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F 505	Continued From page 57 lab result was sent back to the facility sometime that day on first or second shift. Neither the facility nor the lab could confirm the exact time the result was returned, but it was faxed back to the facility on 08/27/16. She further acknowledged from the time the lab results were faxed back to the facility on 08/27/16 and the on-call MD was notified of the results at 10:00 PM on 8/28/16, there was poor communication between the nursing staff. She stated she expected the MD to be notified of the results as soon as they were obtained. On 09/21/16 at 3:45 PM an interview was conducted with Nurse #2. He stated he was the nurse on duty on second shift on 08/27/16 when the lab results for Resident #4's PT with INR was available. He revealed he may have missed the results when they returned from the lab, and stated he had not been informed of a pending lab. Nurse #2 acknowledged the lab results should have been called to the MD as soon as they were available. On 09/21/16 at 2:45 PM an interview was conducted with the DON. She stated the lab could not confirm when the results for the PT with INR were returned to the facility, but it was either on first or second shift on 08/27/16. The DON indicated it was her expectation that the results would have been called to the on call medical staff immediately. She stated it was poor communication that led to the delay in the notification of the lab results to the MD on 08/28/16 at 10:00 PM.	F 505		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		11/1/16

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F 514	Continued From page 58 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to document neurological checks after falls with lacerations and hematomas for 1 of 3 residents sampled for supervision to prevent accidents (Resident #20) and failed to document a nursing assessment for 1 resident (Resident #15) who reported his roommate hit him in the leg with a wheelchair for 1 of 3 residents sampled for abuse. The findings included: 1. Resident #20 was admitted to the facility on 09/22/16 from home and was discharged to the hospital on 09/26/16 and did not return to the facility. A review of diagnoses revealed Resident #20 had thyroid disease, high blood pressure, osteoarthritis, amnesia, dementia and Alzheimer's disease. A review of an admission Nursing Evaluation dated 09/22/16 at 12:35 PM indicated Resident #20 was alert but confused and was uncooperative. A section labeled Fall Risk Evaluation revealed Resident #20 was	F 514	1. Resident #20 was discharged to the hospital on 9/26/16. Resident #15 will continue to have documented nursing assessments. 2. All residents have the potential to be affected. Incident reports from the last 90 days were reviewed to ensure notification of MD/RP has occurred and that interventions are care planned as appropriate. Fall risk assessments/evaluations have been completed for residents currently residing in the facility. 3. Education by the Director of Clinical Support/Designee to be completed by 10/28/16 with Licensed Nurses regarding notification of MD/RP related to incident reports, to include refusal of neurological checks, agitation, combative behaviors, and resident behaviors, and the documentation of such in the medical record. DON/Designee/Unit Managers will review incident reports and other clinical	

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F 514	Continued From page 59 disoriented to person, place and time at all times and had 3 or more falls in the past 3 months. The Nursing Evaluation revealed Resident #20 was ambulatory but was frequently incontinent of bladder and bowel. A review of a nurse's note dated 09/25/16 at 9:30 AM by Nurse #5 indicated a staff member came to let her know Resident #20 was in the floor. The notes revealed Resident #20 was sitting in the floor in front of a closet and had a laceration to his mid forehead and bleeding was controlled with gauze pads. The notes further revealed the physician on call was notified and orders were received to send Resident #20 to the hospital for treatment and evaluation and emergency medical services was in the facility on 09/25/16 at 9:55 AM to transport Resident #20 to hospital. A review of a nurse's note dated 09/25/16 at 12:40 PM revealed Resident #20 was back in the facility from the hospital. A review of a Neurological Evaluation Flow Sheet dated 09/25/16 indicated instructions at the top of the form and a handwritten check mark was in a box for suggested frequency of Neurological (neuro) checks every 15 minutes for 1 hour then every 30 minutes for 3 hours then every 1 hour for 4 hours then every 4 hours for 16 hours and then every 8 hours for 48 hours. A review of handwritten notes on the form revealed there were no neuro checks documented and there were no nurse ' s initials every 30 minutes from 1:00 PM until 3:00 PM or for every hour from 3:00 PM until 8:00 PM and there was no neuro check documented at 12:00 AM or after 12:00 AM. A review of a nurse's note dated 09/26/16 at 1:10	F 514	communication tools for items such as behaviors or disagreements between residents and then will review the medical records to ensure documentation of identified resident events is present, to include documentation that neurologic checks have been completed as appropriate. 4. Audits of incident reports for MD/RP notification, new interventions after incidents, review of neurological checks (as appropriate) and documentation in medical records will be completed 5 X weekly by the DON/Designee/Unit Managers. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	

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AM by Nurse #6 revealed Resident #20 was found on the floor sitting up in front of his bed. The notes indicated a superficial abrasion on the top of his head was cleaned with normal saline and gauze. The notes further indicated Resident #20 refused vital signs and neuro checks from a previous fall, was confused and combative with staff and refused to stay in bed.

A review of a Neurological Evaluation Flow Sheet dated 09/26/16 revealed there was no documentation of neuro checks after Resident #20 ' s fall at 1:10 AM.

A review of a nurse's note dated 09/26/16 at 3:45 AM by Nurse #7 indicated Resident #20 was found in the floor when she "heard his head hit floor." The notes revealed Resident #20 had a bruise near the center of his right ear and a skin tear to the top of his head on the right side. The notes indicated the skin tear was cleaned with normal saline and a wet to dry dressing was applied and Resident #20 refused vital signs and was fighting staff when they tried to help him to bed.

A review of a Neurological Evaluation Flow Sheet dated 09/26/16 revealed a check mark in a box at the top of the form which indicated unwitnessed fall, alert and oriented and reports no head injury and to complete checks every 15 minutes for 1 hour, then every 30 minutes for 3 hours and then every hour for 4 hours. A review of hand written documentation indicated there were no nurse's initials or neuro checks documented from 3:45 AM until 4:45 AM or for every 30 minutes from 5:15 AM until 6:15 AM and there was no documentation of neuro checks after 6:15 AM.

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During an interview on 10/04/16 at 12:55 PM with Nurse #5 she stated she provided care to Resident #20 on 09/25/16 after he returned from the hospital. She explained nurses were expected to do neuro checks after an unwitnessed fall every 15 minutes for the first hour and then check them every 30 minutes for 3 hours then every hour for 4 hours and they should document neuro checks for at least 72 hours on the Neurological Evaluation Flow Sheet. She stated if a resident hit their head they were usually sent to the hospital for evaluation but neuro checks should be continued when the resident returned to the facility according to the instructions on the Neurological Evaluation Flow Sheet or according to the physician's orders. She explained she had attempted to check Resident #20's vital signs and neuro checks but he was agitated and combative and she had forgotten to put her initials of the form and did not complete the documentation on the Neurological Evaluation Flow Sheet.

During an interview on 10/04/16 at 3:32 PM with Nurse #1 she explained she provided care for Resident #20 on day shift on 09/26/16 and they were doing neuro checks from a previous fall he had. She explained she recalled he was combative and she had not documented his neuro checks due to his agitation.

During an interview on 10/04/16 at 5:35 PM with a second shift Nursing Supervisor she explained she had provided care to Resident #20 and she had attempted to check his vital signs and do neuro checks but he was combative and agitated and she had not documented any neuro checks for him.

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During an interview on 10/05/16 at 7:59 AM with Nurse #7 she explained she came to work on 09/26/16 at 3:00 AM and was told in report Resident #20 had fallen several times and his last fall was at 1:30 AM but as the nurse was reporting to her Resident #20 fell again at 3:45 AM. She stated she went to check Resident #20's vital signs and neuro checks but Resident #20 was agitated and combative and she had not completed the Neurological Evaluation Flow Sheet regarding his neuro checks.

During an interview on 10/05/16 at 9:20 AM with the Director of Nursing she stated it was her expectation for the Neurological Evaluation Flow Sheets to be initialed by the nurse who completed the check. She further stated she expected for neuro checks to be completed within the time frames as indicated on the top of the neuro forms or according to physician's orders. She explained if a resident was agitated or combative or refused neuro checks she expected for nurse's to notify the physician or on call for additional orders and document in the nurse's notes.

2. Resident #15 was re-admitted to the facility on 04/10/15 with diagnoses which included diabetes, asthma, congestive heart failure, depression and a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 06/29/16 indicated Resident #15 was cognitively intact for daily decision making and was independent with transfers and locomotion on and off the unit. The MDS further indicated Resident #15 was not coded for behaviors.

A review of a nurse's note dated 09/18/16 at 9:45 AM revealed Resident #15 was alert and verbal, was able to voice needs and used a wheelchair

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and could propel himself.

A review of a 24 hour nurse's report dated 09/18/16 revealed there was no documentation regarding Resident #15.

A review of a 24 hour nurse's report dated 09/19/16 revealed Resident #16 had an altercation with his roommate (Resident #15) on 09/18/16.

During an interview on 09/21/16 at 2:22 PM with Nurse #12 she stated she was standing in the hall and was pulling medicines out of a medication cart and heard Resident #15 yell at his roommate (Resident #16). She explained she told Nurse Aide (NA) #6 to go to the room and as NA #6 ran to the room she reported both residents had been fussing back and forth at each other. She further explained Resident #15 told her his roommate had kicked his wheelchair into his leg and had threatened him. She stated she assessed Resident #15's leg but there was no injury and she could not find a mark on his leg anywhere. She explained she called the North Wing Unit Manager who was the nurse on call and was in the facility and she went to Resident #15's room to talk with him. She confirmed she did not document the incident in Resident #15's medical record and did not document the assessment of his leg because she wasn't sure if she was supposed to document it or where she was supposed to document it and she did not ask the North Wing Unit Manager where to document it. She stated she called the Administrator and was told to write a statement and she put her statement under the Administrator's door on 09/19/16 and that was the only documentation she had done regarding the incident between

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Resident #15 and his roommate.

During an interview on 09/21/16 at 3:31 PM with the North Wing Unit Manager she stated she was the nurse on call on 09/18/16 and Nurse #12 and Nurse Aide (NA) #6 told her Resident #15 was arguing with his roommate (Resident #16). She stated Resident #15 told her his roommate had kicked him and had cursed at him but when she confronted both residents in the room together Resident #15 said his roommate had kicked the wheelchair and the wheelchair rolled into his leg. She explained she looked at Resident #15's leg and there was no redness or marks or bruising of any kind but she did not document anything in the nurse's notes because it was her expectation Nurse #12 should have documented the incident and her nursing assessment of Resident #15's leg and the resident's behaviors in the nurse's notes since she was assigned to care for him.

During an interview on 09/22/16 at 9:20 AM with Resident #15 he explained on 09/18/16 he was sitting on the side of his bed in his room and his roommate (Resident #16) came into the room and cursed at him and pushed a wheelchair into his leg. He stated they exchanged words and then the nurse came into the room to see what was going on.

During an interview on 09/22/16 at 11:11 AM with the Staff Development Coordinator (SDC) she explained when resident ' s exhibited behaviors it was supposed to be documented in the nurse's notes. She explained the nurses had received education they should document altercations and behaviors between residents. She verified there were no nurse's notes regarding the incident between Resident #15 and his roommate

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F 514	Continued From page 65 (Resident #16) on 09/18/16. She stated there should have been nurse's notes documented and follow up regarding behaviors for the following shifts and explained behavior charting was usually done for 14 days but it had not been done for Resident #15. The SDC explained she would have expected to see documentation on the change in condition forms since there was the potential for injury when the wheelchair had hit Resident #15's leg and she would have expected to see the nurse's assessment documented. She confirmed there was no documentation in the nurse's notes or on a change in condition form of the nurse's assessment of Resident #15's leg. During an interview on 09/22/16 and 12:36 PM with the Director of Nursing she stated she would have expected to see a note on the 24 hour nursing report dated 09/18/16 regarding the incident between Resident #15 and his roommate (Resident #16). She confirmed the nurse's notes for Resident #15 on 09/18/26 did not contain any information about the incident between Resident #15 and his roommate to explain what had actually occurred between them. She stated it was also her expectation that a nursing assessment should be documented in the nurse ' s notes anytime there was a potential for injury. She confirmed there was no documentation of the nurse ' s assessment of Resident #15's leg in his medical record.	F 514		
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	F 520		11/1/16

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F 520	Continued From page 66 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 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 facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to a recited deficiency which was originally cited during the facility's 03/17/16 recertification survey and was recited during a complaint survey. The recited deficiency was in the area of accuracy of the medical record. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee during two consecutive federal surveys of record show a pattern of the facility's inability to sustain an	F 520	1. The facility will ensure the QAPI committee maintains and effective plan to monitor continued compliance of deficiencies identified. 2. All residents have the potential to be affected. 3. The facility Quality Assurance Performance Improvement committee members were educated by the Director of Clinical Operations on 10/19/16 regarding the revised QAPI process to include the new forms and format. This includes the facility will identify areas for	

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F 520	Continued From page 67 effective Quality Assurance program. Findings included: This tag is cross referenced to: F 514 Accuracy of the Medical Record. Based on record reviews and resident and staff interviews the facility failed to document neurological checks after falls with lacerations and hematomas for 1 of 3 residents sampled for supervision to prevent accidents (Resident #20) and failed to document a nursing assessment for 1 resident (Resident #15) who reported his roommate hit him in the leg with a wheelchair for 1 of 3 residents sampled for abuse. During the recertification survey of 03/17/16 the facility was cited for failure to have matching documentation on the front and back of the Medication Administration Record (MAR) and the controlled drug record for the administration of Clonazepam (a controlled substance used to treat anxiety) for 1 of 5 residents reviewed. (Resident # 132). On 09/22/16 at 2:30 PM the Administrator reported the Quality Assessment and Assurance Committee monitored orders for three months after the 03/17/16 recertification survey and had nothing ongoing in place to ensure the accuracy of the medical record.	F 520	continuous quality monitoring and the monitoring tools to be used. These monitoring activities should focus on those processes that affect resident outcomes most significantly, to include previous survey deficiencies. This ongoing monitoring is used to establish the facilitys baseline and the predictability of various outcomes. 4. The QAPI Committee will continue to meet on a monthly basis to continue monitoring identified areas of improvement, to include, survey deficiencies for compliance. The QAPI Committee will address the identified area, examine and improved the identified need through improvement (action) plans and monitoring the effectiveness of such plans. The Director of Clinical Operations/Designee will review the facility QAPI Committee meeting minutes monthly until substantial compliance is achieved.	