PRINTED: 05/12/2016
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055869	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - MODESTO	615 EAST ORANGEBURG AVENUE MODESTO, CA 95350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	#2 POC ACCEPTABLE YES X NO ☐ Reviewed By: Loretta D. Mosher MSN, HFES Name Fax _____ Original _____ Facility Notified Name: Becky Singleton Date: 6/17/16 Time: 3:12pm Notified By: Loretta D. Mosher MSN, HFES Name	

The following reflects the findings of the California Department of Public Health-Licensing and Certification, during a RECERTIFICATION survey.

Representing the California Department of Public Health-Licensing and Certification by Federal Survey ID: # 28531 RN, HFEN and # 36057 RN, HFEN.

Capacity: 70
Census: 9
Sample: 5

F 253 SS=E — 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and administrative document reviews, the facility failed to provide an orderly, comfortable and homelike environment for residents of the facility when the east wing hallway, resident rooms, restrooms, and shower room, were not well maintained.

These failures had the potential to place residents at risk of depression due to poorly kept surroundings and injury due to safety hazards.

Findings:

F 253

F253
a)Maintenance issues identified have been corrected as follows:
-Hallways repainted throughout the facility
-Pillow returned to soiled linen upon identification.
-Tile in shower room repaired
-Cords were secured and new covers placed
-Linoleum in bathroom replaced
-interior of patient rooms repainted following appropriate stripping of old paint
-Bracket for thermostat replaced.
-Plumbing repaired leaks in bathroom.
-Area surrounding south exit door was re-painted following appropriate stripping of old paint.
-Outlet & cords above door secured and covered.
-Missing area of wall repaired following plumbing repairs.
-Bulletin board and tv cabinet were removed and disposed of. Room received terminal cleaning.
-Nails removed from wall upon identification.
-Policy for facility maintenance revised

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Becky Singleton — TITLE: Administrator — (X6) DATE: 6/16/16

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 253	Continued From page 1 On 4/26/16 starting at 9:50 a.m., observations on the initial tour and a concurrent interview with the Interim Director of Nurses (IDON) was conducted. Standing near the nurses station looking down the hall, every wall had multiple areas which had been touched up with paint. The IDON confirmed the observation and stated, "It is unattractive. It looks like they've mixed enamel and flat paints. You shouldn't be able to see every area they repainted." On 4/26/16 at 10:03 a.m., a pillow was observed lying on the shower room floor. Floor tiles were missing in two areas: one area was six inches by one inch and the other area was three inches by 1 inch. The IDON confirmed these observations and stated, "I don't know why the pillow is there, it shouldn't be on the floor. I didn't know there were tiles missing. It needs fixed." On 4/26/16 at 10:05 a.m., Room had covered cords running back and forth, and up and down, on the walls. An uncovered telephone cord was secured to the wall at one end, and the portion that was not secured was partially coiled and dangled from the receptacle. Paint was applied to walls over unpatched and peeling paint, some areas were not covered completely. Paint was allowed to get on the base boards and the cord covers in spots. The IDON confirmed the observations and stated she couldn't explain why the cords were all over the walls. The IDON stated, "The room had not been maintained to industry standards. Paint was applied without any surface prep or patching, and applied on top of peeling paint." On 4/26/16 at 10:10 a.m., the restroom between Room and Room had a two inch triangle	F 253	b) Upon transfer of ownership all resident rooms were assessed by maintenance and construction team to assess any remaining issues within the facility. Additional issues, when found, were repaired promptly. All new housekeeping staff have been oriented to the facility and participated in a facility-wide round conducted with administration to assess for any immediate issues with cleanliness. A deep cleaning was performed on all resident rooms, and each room will undergo deep cleaning once per month going forward. c) Maintenance staff will round on one hallway per week to monitor for any structural, electrical or other issues that fail to meet code, represent a safety risk, or diminishes the facility's aesthetic. Any issues discovered will be scheduled for immediate repair. A written summary of issues identified, and their subsequent repairs will be completed by the maint supervisor and submitted to the administrator at the end of each month. The environmental supervisor will round with housekeeping staff in conjunction with the deep cleaning schedule to assess for compliance with facility policies regarding the cleanliness of resident rooms, showers, and social/common areas.	

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F 253	Continued From page 2 shaped piece of linoleum missing in the doorway; the door jam at the floor was scuffed,and cracked; uneven and discolored caulking filled a half inch to one inch gap between the sink and the wall; and three pieces of wadded up paper towel were on the floor. The IDON confirmed these observations. The IDON stated, "The maintenance is not up to par." The IDON stated the area where the linoleum was missing and the door jam was cracked appear to be "dirty". The IDON stated, "There is no excuse for the paper towels to be on the floor." On 4/26/16 at 10:15 a.m., the south exit door leading to the patio, had covered cord at both sides and around the top of the door. The cord cover was not continuous. Cord and unpainted areas were observed where the cord cover was interrupted. A two by two inch plug was permanently secured to the electric outlet with a bent metal bracket screwed to the wall. There was peeling paint above the door which exposed black and pink flowered wall paper. The IDON stated, "The building maintenance leaves a lot to be desired. I don't know how or why this kind of work is tolerated. It sloppy and it looks bad." On 4/26/16 at 10:18 a.m., a thermostat on the wall near Room was observed. A metal bracket attached it to the wall and there was approximately one inch of play that allowed the four by four by two inch box to fall forward and not sit flush with the wall. The IDON confirmed the observation and stated, "I don't know who did that or anyone that would think that is okay." On 4/26/16 at 10:21 a.m., an observation and concurrent interview with the Registered Nurse on duty, Licensed Nurse (LN) 1 was conducted.	F 253	d) Reports detailing any issues discovered during detailed in © will be submitted to the admin. monthly. Administrator will compile statistical data regarding repairs, structural issues, and the status of the facility's cleanliness at quarterly QA/CQI committee meetings. This report will be a permanent component of the CQI process. Any trends identified with any of these areas will be tracked monthly with subsequent action plans to be submitted by ESS & Maint with reports on resolution to the committee. e) Completed 5/19/16	

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F 253	Continued From page 3	F 253		

LN 1 stated the toilet did not work. An eight by eight inch area of wall behind the toilet was missing. LN 1 confirmed these observations and stated the toilet had "not worked well for awhile," and had required multiple repairs.

On 4/27/16 at 9 a.m., an observation and concurrent interview were conducted with the IDON in unoccupied Room The bulletin board was covered with wrinkled, blue paper with holes and white marks on it. The TV cabinet had a four inch round hole, with nail holes in the front of the cabinet. The base board was scuffed, had darkened areas, and the paint was not uniform. A mat was on the floor and a bed alarm remained on the bed. The window blind had broken and bent slats. There were two thin panels, approximately 2 feet wide, fastened to the wall under the window with a screw every three inches. The IDON confirmed these observations and stated, "This room was terminally cleaned (deep cleaning between residents) they should have removed and replaced the bulletin board cover and removed the floor mat and bed alarm. Those items were the previous resident's and should not still be in the room after terminal cleaning." The IDON stated she did not know why this room and others had the panels fastened to the walls. The IDON stated the TV cabinet needed thrown away.
On 4/27/16 at 9:20 a.m., an observation and concurrent interview was conducted with the Maintenance Man (MM) 1, (borrowed from another facility) in unoccupied Room He also stated he did not know why the panels were attached to the wall.

On 4/27/16 at 9:10 a.m., observation and concurrent interview was conducted with the

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F 253	Continued From page 4 IDON in unoccupied Room . The dresser was scratched, and had chipped and missing laminate veneer. The IDON stated the dresser was in poor condition and looked "very bad." On 4/26/16 at 7 a.m., an observation and concurrent interview with Resident 2 was conducted in Room Room had covered cords running back and forth, and up and down, on the walls, and across the top and down both sides of the closet. Three feet of cord cover was broken and wire hung and draped below the window. (A broken prong remained inside an electrical outlet which was not identified until after the survey). One electric outlet was not secured to the wall and paint was chipped and peeling around the outlet. The cover on another outlet had been screwed down excessively which caused the lower right corner to lift. Inside the clothes closet, on the floor, there was a two to three inch area which was moist and water damaged. Resident 2 confirmed these observations and stated, "I can't believe a building inspector approved this work." On 4/28/16 at 7:30 a.m., an observation and concurrent interview with the Administrator (Admin) was conducted. The Admin confirmed the observations in Room as indicated above. On 4/28/16 at 7:40 a.m., an observation and concurrent interview with the Admin was conducted in Room . There were two nails which protruded on the wall, above and behind the head board. Two more nail were protruding higher up on the wall. Yellow paint showed through the beige paint in an area near the light switch. The Admin confirmed theses observations and stated, "What nails?" as he	F 253		

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F 253	Continued From page 5 pulled nails out of the wall with his hand. On 4/28/16 at 10 a.m., the Admin stated the Maintenance Assistant (MA) assumed responsibility for maintenance to the facility on 1/6/16, and that the Admin was ultimately responsible for the facility and it's oversight. The "Maintenance Assistant" job description, dated 5/11/14, indicated, "Assist the Maintenance Supervisor in ensuring the building(s), equipment and utilities are maintained in good working order and facility grounds are properly maintained in accordance with facility policies." On 4/28/16 at 11 a.m., the Admin stated, "We do not have a policy and procedure that covers building maintenance."	F 253		
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	F 329	F329 a) All residents with orders for psychotropics were assessed for the appropriateness of dose reduction in conference with resident, their physician, and family members. Where medically and behaviorally appropriate, dose reduction trials were enacted, and continue. b) Upon transfer of ownership a reassessment of all psychotropic orders in-house was completed and any additional residents appropriate for dose reduction trials were placed on one, following consultation with the resident and their physician.	

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F 329	Continued From page 6 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and administrative document review, the facility failed to ensure residents were free of unnecessary drugs when one of four residents (Resident 4), had no documented evidence a gradual dose reduction (GDR) had been attempted for an antipsychotic medication (medication used to control mental disorder) since the original order date, one year and four months ago. This failure had the potential to result in adverse effects from an unnecessary medication. Findings: Resident 4's physician orders, dated 7/23/16, indicated an order for Trifluoperazine (antipsychotic medication) 20 milligrams to be administered every night at bedtime. The physician's original order was dated 12/15/14, for the treatment of Schizophrenia (mental illness with loss of reality) manifested as angry outbursts of unprovoked anger with abusive language to others. On 4/28/16 at 12:30 p.m., during a concurrent interview and clinical record review, the Interim Director of Nursing (IDON) stated there was no documented evidence of a GDR attempt for Resident 4's Trifluoperazine or a clinical rationale	F 329	c) MDS has drafted a schedule to alert IDT when each resident with orders for psychotropic medication are due for consideration of a routine dose reduction trial. All new psychotropic orders are forwarded to the DNS for immediate review, if on-site, or within 24hrs otherwise. A monthly report on current psychotropic orders, by class, will be prepared by the DNS, including statistics on the number of attempted dose reductions/eliminations specifying how many were successful during the report period. d) The report outlined in c) will be submitted by the DNS to the QA/CQI committee quarterly for monitoring of trends. Any identified will require an action plan submitted by the DNS detailing steps for immediate resolution of the trend identified. e) Completed 5/16/16	

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F 329	Continued From page 7 by the physician which would have explained the absence of a GDR. The IDON stated no GDR was done for Resident 4 and she did not know why. The IDON stated there was no documented clinical rationale from the physician to support and explain the benefit of continued use on the resident's functional stability in these medication reviews. Resident 4's "Consultant Pharmacist's Recommendation To Inter-Disciplinary Team" dated 1/5/16, indicated, "Please ask MD (medical doctor) to evaluating risk/benefits of the Trifluoperazine, as reduction may precipitate previous behaviors...The IDT [InterDisciplinary Team] evaluation and response: Resident has the same behaviors and we agree with the above recommendations." The IDT and the MD signed and dated the form on 1/11/16. On 4/28/16 at 3:10 p.m., during a telephone interview, the facility's consultant pharmacist read the statement off the "Consultant Pharmacist's Recommendation To Inter-Disciplinary Team" form dated 1/5/16, (above). The Consultant Pharmacist stated, "There is no statement of risks versus benefits. The statement could have been stronger." Review of the facility's policy and procedure titled, "Psychoactive Medication Informed Consent, Dose reduction and Behavior Monitoring," dated 1/2010, indicated, "...5. The facility will attempt gradual dose redactions (GDR) or dose tapering unless clinically contraindicated in accordance with applicable state and federal regulation ... 6. If it is the determination of the physician that gradual dose redaction/dose tapering is clinically	F 329		

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F 329	Continued From page 8 contraindicated, the facility will request that the physician document his/her rational in the resident record ..."	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and administrative document review, the facility failed to store food under sanitary conditions when the following food items were refrigerated beyond the expiration dates: 1. Approximately two quarts of egg salad with an expiration date of 4/25/16. 2. Two ounces of whipped topping in a 16 ounce pastry bag with an expiration date of 4/14/16. 3. Half of a 40 ounce pack of sliced oven roasted turkey breast, stored in the original zip lock bag, was marked with an expiration date of 4/24/16. These failures placed residents at risk of foodborne illness from consumption of expired foods.	F 371	**F371** **a) Outdated food disposed of immediately upon identification.** **b) All perishable foods were checked to ensure they had not been kept past their appropriate date. Kitchen staff were on the dangers of serving food that has been kept past its' specified date. Staff demonstrated proper review and dating of perishable foods as part of the inservice.** **c) Dietary supervisor will complete daily rounds on all storage areas containing perishable foods to determine if compliance with dating and disposal is occurring, correcting any issues discovered at the time of discovery. A report pertaining to the ongoing compliancde of kitchen staff on the facility's policy on the dating and disposal of perishable foods will be prepared monthly by the DSS and submitted to the administrator.** **d) Administrator and/or DSS will report to the QA/CQI committee on the ongoing compliance with the perishable foods policy and tracking for any trends related to this compliance will be done by the committee. Any trends identified will require an immediate action plan from the DSS with follow-up of resolution at the subsequent meeting.** **e) Completed 5/16/19**	

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F 371	Continued From page 9	F 371		

Findings:

1. On 4/26/16 at 9:20 a.m., a walk-in refrigerator observation and a concurrent interview with the Regional Nutritional Manager (RNM) was conducted. An egg salad container was observed with a hand written date of 4/23/16. The RNM stated, "The salad was good for three days and the first day counts." The RNM stated the egg salad expired on 4/25/16. The RNM stated the kitchen management was responsible to monitor expiration dates. The RNM stated it should be thrown out.

On 4/26/16 at 9:27 a.m., during an interview, the Dietary Assistant Manager (DAM) stated it was her responsibility to monitor expired foods but she missed the egg salad. The DAM stated the egg salad had expired and should be tossed out.

On 4/26/16 at 3:55 p.m., during an interview, the Clinical Dietitian (CD) stated the egg salad had expired and should be thrown away.

2. On 4/26/16 at 9:22 a.m., a concurrent kitchen walk-in refrigerator observation and interview with the RNM was conducted. A bag of whipped topping was observed hand labeled with an open date of 4/9/16, and the a "use by" date of 4/14/16. The RNM stated per manufactory recommendation, whipped topping was good to use for two weeks after initial open date, this package had exceeded that and should be thrown away.

On 4/26/16 at 9:27 a.m., during an interview, the DAM stated it was her responsibility to monitor expired foods but she missed it. DAM stated the

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F 371	Continued From page 10	F 371		

whipped topping was expired and should be tossed out.

On 4/26/16 at 3:55 p.m., during an interview, the Clinical Dietitian (CD) stated the whipped topping was expired and should be thrown away.

Per original package, manufacturer recommended storage for whipped topping is two weeks thawed and refrigerated.

3. On 4/26/16 at 9:26 a.m., during a concurrent kitchen walk-in refrigerator observation and interview, sliced oven roasted turkey breast dated only with a hand written "use by" date of 4/24/16. The RNM stated she did not know how long the sliced oven roasted turkey had been in the walk in refrigerator. The RNM stated it should be thrown out.

On 4/26/16 at 9:27 a.m., during an interview, the DAM stated it was her responsibility to monitor expired foods but she missed it. The DAM stated the sliced oven roasted turkey was expired and should be tossed.

On 4/26/16 at 3:55 p.m., during an interview, the CD stated the sliced oven roasted turkey was expired and should be thrown away.

The facility policy and procedure (P&P) titled, "DIETARY GUIDELINES MANUAL: LABELING AND DATING OF FOOD" revised and dated 2013, indicated, "...one dietary position should be assigned the regular task of discarding opened food products which have past their "use by" or expiration dates.

The facility (P&P) titled, "SNF (Skilled Nursing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055869	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - MODESTO	515 EAST ORANGEBURG AVENUE MODESTO, CA 95350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 Facility) MANUALS/NUTRITION GUIDELINES/ SANITATION & FOOD SAFETY / FOOD USE BY DATES," revised and dated 6/2013, indicated, "... In the Refrigerator All leftovers or prepared foods...[should be used in] 3 days THE FIRST DAY COUNTS."	F 371		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional 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 staff interview and clinical record review, the facility failed to maintain accurate clinical records when: The Minimum Data Set (MDS) (an assessment tool for resident's physical assessment and health care needs) assessment had not accurately reflected the health status for 4 of 5 sampled residents (Residents 1, 2, 3 and 4). These failures placed the Resident 1, Resident 2, Resident 3, and Resident 4 at risk for inaccurate	F 514	F514 a) All residents MDS revised to reflect accurate assessment data, and submitted. b) A new, qualified MDS coordinator has been employed and is based in-house as of 5/17/19. Resident assessment schedule has been drafted and IDT provided with a copy. DNS will monitor assessments for new admits as well as quarterly, annual and Significant Change of Condition for accuracy of assessment data with the assistance of the MDS Coordinator. c) A report summarizing any issues related to the ongoing accuracy and timeliness of assessments will be completed monthly by the MDS and submitted to the DNS for review. d) DNS & MDS will report on ongoing compliance with assessment schedule and assessment accuracy to the QA/CQI Committee on a quarterly basis. Any trends identified in this area will require the submission of an immediate action plan from the MDS with clearly defined steps to address the trends identified. e) Completed 5/17/16	

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F 514	Continued From page 12 care plans and not having their care needs met. Findings: For Resident 1: On 4/27/16 at 11:10 a.m., during a clinical record review, Resident 1's MDS assessment dated 2/18/16, indicated Resident 1 was always incontinent (no control) of bowel and his range of motion (ROM) was impaired on both sides, both upper extremity (shoulder, elbow, wrest, hand) and lower extremity (hip, knee, ankle, foot). Registered Nurse (RN) 2 signed the MDS assessment and verified it as complete and accurate. On 4/27/16 at 8 a.m., during a concurrent interview and clinical record review, the Interim Director of Nursing (IDON) stated the MDS nurse incorrectly coded Resident 1's bowel control and ROM. The IDON stated Resident 1 was always continent of stool and his ROM was not impaired on either side, for either upper or lower extremities. For Resident 3: On 4/27/16 at 2:35 p.m., a review of Resident 3's Significant Change MDS, dated 3/7/16, (MDS Nurse 1 signed the assessment as complete) and a concurrent interview with the IDON was conducted. The Brief Interview for Mental Status (BIMS) Summary Score indicated 01 out of 15, indicating the resident was severely cognitively impaired. The IDON stated, "The significant change was done because he needed more help with meals and to toilet." The IDON stated she didn't agree with the BIMS score, "I don't get it... He couldn't answer questions about memory and recall but he could answer questions about	F 514		

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F 514	Continued From page 13	F 514		

behavior." The area G0400, for ROM, indicated impairment on both sides. The IDON stated, "I don't agree with that. That is not correct. There has been no loss of ROM." Section J, 200, asks if a pain assessment interview should be conducted. A dash indicated the response. The IDON stated, "No pain assessment is wrong. Dashes are not appropriate. They should have interviewed staff."

For Resident 2:
On 4/27/16 at 2:55 p.m., a review of Resident 2's Annual MDS dated 4/7/16, (MDS 1 signed the assessment as complete 1) and a concurrent interview with the IDON was conducted. The Brief Interview for Mental Status (BIMS) Summary Score on Resident 2's MDS had dashes filled in the blanks instead of a numerical score. The IDON stated, "I don't agree with that, he was a 15 [indicating the highest score possible] in January and there's been no change. C500 is an error. He has good recall." The Mood section, D0200, H, indicated Resident 2 moved or spoke slowly. The IDON stated, "He doesn't speak slowly, not slower than what is normal for him." The Functional Status, G0110, indicated Resident 2 needed limited assistance for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. The IDON stated, "He is independent. Turning the shower on is all the help he needs from staff. Coding indicating staff is helping is not right. It's an error. He doesn't need help." Under section J, the MDS indicated Resident 2 had not fallen since admission. The IDON stated, "That is an error." The IDON stated Resident 2 fell on 1/13/16, which was not reflected on the MDS assessment.

For Resident 4:

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F 514	Continued From page 14 On 4/28/16 at 8 a.m., during a clinical record review, Resident 4's MDS assessment, dated 3/12/16, indicated Resident 4 was not on a antipsychotic medication during the last 7 days. Resident 4's physician orders dated 7/23/15, indicated an order for Trifluoperazine (an antipsychotic medication) 20 milligrams to be administered every night before bed. The original physician order was dated of 12/15/14. On 4/28/16 at 9 a.m., during a concurrent interview and clinical record review, the IDON stated the MDS nurse incorrectly coded the number of days Resident 4 received antipsychotic medication during the last seven days. The IDON stated it should have indicated Resident 4 received antipsychotic medication seven days out of the last seven days.	F 514		