STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

acceptably POC 7/20/16 KK HS

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. Representing the Department of Public Health: RD/Nutrition Consultant 31472 HFEN 29917 HFEN 29821 HFEN 35598 HFEN 36586 HFEN 36537 The facility census was 97 including one bed hold. The sample size was 20.	F 000	"Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 483 Et seq."	
F 166 SS=E	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 resident interviews and document review, the facility failed to resolve grievances in timely fashion for 11 Confidential Residents. This failure resulted in continued delays in meeting identified resident needs. Findings: During a group interview with 13 residents conducted on 6/8/16 at 10:10 a.m., residents	F 166	F166 1. Resident 1 was discharged on 7/1/2016. Resident 2 call light cable was replaced and working by the Maintenance designee immediately. Employee name tag clips shall be replaced to improve visability to residents by 7/6/2016. 2. A tour of the facility was completed by 6/15/2016, to review resident call light cables and name badges for visability. Areas identified were corrected.	

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

David Miller Administrator 7-8-2016

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 166	Continued From page 1 voiced concerns regarding several issues. Call light response delays up to an hour were identified, especially on evenings and night shifts, which contributed to residents' loss of bowel and/or bladder control and resulted in resident embarrassment. Other group concerns included, but were not limited to, staff speaking with one another in languages, not understood by those residents, during direct resident care, and staff nametags not being visible. Review of the previous four months minutes of Resident Council activity revealed these issues had been previously identified and communicated to the facility's Council representative but lacked resolution. Review of the 5/27/16 "Resident Council Meeting Minutes" taken by the Activity Director (AD) indicated, "No nametags worn. CNAs [Certified Nurse Assistants] do not introduce themselves...Call lights not work [sic] (PM and noc [evening and night shifts])...Call Bell Answering: Timely – No...Mostly morning due to staff is with other resident at the time patient wants assistance [sic]...." Review of the AD's 4/29/16 minutes reflected, "Call Bell Answering: Timely – Sometimes...." The AD's 3/31/16 "Resident Council Meeting Minutes" read, "Call Bell Answering: Timely – No...45 minutes. Have some improvement...Staff's nametags not being worn...Staff not speaking English during patient care...."	F 166	3. A staff in-service was completed by 7/6/2016, by the Director of Staff Development (DSD) regarding use of name badges, speaking english in common areas, and prompt response time to resident call lights. 4. The Maintenance Director or designee shall complete a random check of resident room call light cable functionality monthly for 6 months. The DSD shall monitor staff name badges for visibility and prompt response time to call lights monthly for 6 months. The Maintenance Director or designee and DSD shall review monthly results with the IDT quarterly for quality assurance. 5. Plan of correction completed by 7/8/2016.	

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F 166	Continued From page 2 Review of the AD's 2/25/16 minutes indicated, "Call Bell Answering: Timely - Sometimes...." In a 4:14 p.m. 6/18/16 interview, an alert and oriented Confidential Resident 1 not in attendance at the group meeting stated it took "up to 45 minutes at night to get [her] call light answered." The resident, admitted to the facility within the previous six months, recalled one episode in which she laid in her feces for approximately one hour one night while waiting for her call light to be answered. During the initial tour of the facility on 6/7/16 at 8:50 a.m., an alert and oriented Confidential Resident 2 not in attendance at the group meeting was observed looking anxious and asking for help. The resident stated "I have to go to the bathroom...my call light is not working... I have been waiting for 10 minutes." The surveyor verified the call light was not working and notified nearest Certified Nurse Assistant (CNA) of the resident's needs. The surveyor observed the CNA enter room, check the call light and exit the room in search of assistance. The CNA reentered the room with a new call light cable, replaced the defective one, and left the room again. The resident stated, "I told them yesterday it wasn't working... I still need to go to the bathroom." The surveyor again notified the same CNA of the resident's need to use the bathroom. The CNA was observed entering the room and then leave the room stating to another CNA, "She already wet the bed." The resident then stated, "If someone would have gotten me up, I wouldn't have wet the bed." At 12:30 p.m., 6/9/16, Licensed Nurse (LN) 4's	F 166		

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 166	Continued From page 3 employee identification badge was observed turned backward. In a concurrent interview, LN 4 stated, "The design of the [name badge] clip causes it to flip backward." Review of the facility's undated "Dress and Grooming Policy" reflected, "ID badges are also part of your uniform." Review of the undated "Filing Grievances/Complaints" policy reflected, "The resident or person filing the grievance and/or complaint on behalf of the resident will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator, or his or her designee within ten working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the resident...."	F 166		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	F278 1. a. Resident 1's MDS assessment was corrected to reflect that the resident had no order for hospice or a foley catheter by 7/7/2016. b. The MDS was corrected to reflect resident 2's participation in the RNA program 7/7/2016. c. The MDS coordinator corrected resident 18's MDS assessment to reflect impairment of speech by 7/7/2016.	

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F 278	Continued From page 4 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record and document review, the facility failed to complete Minimum Data Sets (MDSs, comprehensive assessment tools) which accurately reflected the conditions for 3 of 20 sampled residents, Residents 1, 2, and 18. This failure had the potential to prevent plans of care from meeting resident needs. Findings: 1a) Review of 1/8/16 and 4/8/16 MDSs reflected Resident 1's receipt of hospice care (multidisciplinary care focused on symptom management of the terminally ill) in previous 14-day periods. No physician order for hospice care was found in Resident 1's medical record. A 5/27/16 physician progress note read, "Patient and significant other met with hospice and patient decided she was not	F 278	2. a. MDS Coodinator completed a random review of hospice residents and residents with foley catheters with to ensure orders are in place. b. MDS Coordinator completed a random sample comparison of residents on RNA and accuracy of the MDS assessment. c. MDS Coordinator completed a random sample of residents to review and correct any inaccurate findings related to speech by 7/7/2016. 3. a. The MDS Coordinator shall review telephone orders for any changes of orders related to hospice or catheter orders so that the MDS assessment shall reflect accuracy. MDS Coordinator shall keep a log to reflect current status of resident on hospice and with a foley catheter. b. MDS Coordinator shall monitor and consult with the Director of Nursing monthly to review residents on the RNA program to accurately update the MDS assessment. c. The MDS Coordinator shall monitor each MDS assessment by interviewing resident for speech impairment prior to submission.	

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F 278	Continued From page 5 ready for it." In a 9:20 a.m., 6/10/16 interview, the Director of Nursing (DON) indicated Resident 1 decided she did not want hospice services after a 12/4/15 meeting. The DON stated that Resident 1, "was never on hospice." b) Review of Resident 1's 1/8/16 and 4/8/16 MDSs reflected "Rejection of Care...Behavior of this type occurred daily." During a 2:06 p.m., 6/10/16 meeting, the DON stated that staff document details of residents' care rejection in nursing weekly summaries. Concurrent review of the 4/7/16 summary did not reflect what care Resident 1 had declined. The DON indicated Resident 1 was generally accepting of care. The 5/27/16 physician note read, "Has made significant progress." c) Review of the 4/8/16 MDS also reflected Resident 1 had a urinary catheter (tube to drain the bladder) in place. During the 2:06 p.m., 6/10/16, the DON stated Resident 1's catheter was removed on 2/29/16. A 2/29/16 physician order read, "DC [discontinue] Foley [urinary catheter] tomorrow a.m...." 2) Review of the 5/12/16 MDS reflected Resident 2 was not receiving Restorative Nurse Assistant (RNA) care (nurse assistant care specifically intended to achieve and maintain optimal physical, mental, and psychosocial functioning).	F 278	a. The MDS Coordinator was in-serviced on 7/7/2016, by the Administrator or designee to maintain a log for monitoring weekly to update the MDS assessment to reflect accuracy. b. The MDS Coordinator was in-serviced by the Administrator or designee on 7/7/2016, regarding accuracy of MDS related to RNA program. MDS Coordinator shall monitor monthly and coordinate with the Director of Nursing to review resident participating in RNA to update MDS accuracy. c. The MDS Coordinator was in-serviced by the Administrator or designee on 7/7/2016, regarding MDS assessment accuracy for resident speech . The MDS Coordinator shall monitor monthly by random review of residents to reflect speech assessment accuracy. 4. The MDS Coordinator shall review findings of residents on hospice, having foley catheters, RNA, and speech impairment quarterly with the quality assurance committee for 6 months for quality assurance. 5. Date of completion is 7/8/2016.	

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F 278	Continued From page 6 Review of the May 2016 "Restorative Charting Record," however, indicated Resident 2 had a referral to the program and had participated on 5/2/16 through 5/5/16 and 5/9/16 through 5/12/16. In a 4:30 p.m., 6/7/16 interview, the DON stated the MDS should have reflected that Resident 2 received three days' of RNA care during the previous seven days. 3) Resident 18 (R18) was admitted in 2016 with a diagnosis of dysphagia, muscle wasting,malignant neoplasm (cancer) of the tongue. The resident stated that a portion of his tongue had been surgically removed due the cancer. Review of the 5/11/16 MDS Assessment reflected R18 had clear speech and the ability to express his ideas and wants in a manner that was understood. During an interview on 6/7/16 R18 had slurred, garbled speech and needed to repeat himself occasionally to make himself understood. In a 3 p.m. on 6/9/16 interview with MDS Coordinator (MDSC) regarding the MDS assessment, he stated, "Yes, that could have been a one (an assessment code indicating unclear speech)...he's been here three or four times...I understand him just fine."	F 278		
F 323 SS=E	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.	F 323	F323 1. Resident #9 was assessed by DON and ADON and License Nurse and Lap buddy order was discontinued due to resident no longer need it, but still has current order for tab alarm in place.	

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, document review and staff interviews, the facility failed to provide and utilize the required assistive devices for one resident (Resident 9) to prevent accidents. This failure placed the resident at increased risk for injury and/or falls. Findings: During the initial tour of the facility, conducted on 6/7/16 at 8:50 a.m., Resident 9 was observed to be out of bed and sitting in a wheelchair. The resident appeared uncomfortable, sitting awkwardly and leaning to one side while in the wheelchair. When a Licensed Nurse (LN 2) was asked to come and see the resident to see if she was comfortable sitting in this manner, he attempted to straighten her up and reposition her. Review of Resident 9's medical record revealed physician's orders for a "Lap buddy" (a padded cushion used as a positioning device). The Lap buddy was to be used, "...while up in wheelchair for proper positioning." Another order was for a Tab alarm, which was to be used when the resident was in bed or in wheelchair to alert staff of unassisted transfer." The Fall Risk Care Plan assessed the problem with falls and indicated that the resident had poor safety awareness, attempted to get out of bed without assistance and forgets to lock breaks on wheelchair. The goal was for resident not to have any falls or injuries resulting from a fall. Approaches used to meet this goal was to use a Tab Alarm when in	F 323	2. Any resident with current or existing orders for Lap Buddy or Tab Alarm will be assessed by DON, ADON or License Nurse for continued need for the assistive device. 3. License Nurses and CNA'S were in-serviced on 6/23/2016 and 7/6/2016 on providing and utilizing the required assistive device's for residents to prevent accidents. CNA'S in-serviced on proper positioning of residents when up in their wheelchairs. 4. Daily Checks by License nurse on Physician orders to ensure resident's orders for Lap Buddy or Tab alarm are implemented. At Quarterly Care Conference MDS, Social Service Director and Nursing will review current Lap buddy and Tab alarm orders for continued need. QA Committee will be notified and will review Quarterly for compliance of orders for 6 months.	

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F 323	Continued From page 8 bed and up in a wheelchair, and a lap buddy while up in the wheelchair for proper positioning. On 6/8/16 at 9:10 a.m., Resident 9 was observed in the hallway, sitting awkwardly and leaning to one side in a wheelchair. As the Activity Director (AD) approached the resident to wheel her to the back dining room for activities, the AD became aware of the resident's awkward sitting positioning. The AD was asked if she had ever seen a lap buddy used on the resident when up in the wheelchair. She replied, "I have never seen a lap buddy on her when in the wheelchair." In a subsequent interview with LN 2 to determine why the lap buddy was not placed on the resident when up in her wheelchair, he said that the order was initially ordered back in October 2013, and by now, felt it may have been "discontinued." After further medical record review and interview with staff of medical records, they confirmed that the orders were still active.	F 323	5. Date of Completion. 7/6/2016.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a physician's order for blood pressure medication was held prior to dialysis (use of a machine to clean the blood and remove fluids) for 1 of 20 sampled residents (Resident 19). This failure had the potential to cause serious side effects or life threatening fluctuations	F 333	F333 1. Resident # 9's MAR concerning Blood Pressure Medication's were reviewed By Director of Nursing (DON), and the Assistant Director of Nursing (ADON). Resident 9 was assessed, dialysis center consulted, and MD notified by the DON regarding an order to hold blood pressure medication prior to to resident receiving dialysis.	

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F 333	Continued From page 9 in blood pressure. Findings: A review of Resident 19's active physician orders included an order from 9/28/2015 stating, "Hold Blood Pressure medications on dialysis days Tuesday/Thursday/Saturday in am". A review of the Medication Administration Record (MAR) for Resident 19 indicated two blood pressure medications (Diltiazem and Furosemide) were to be given daily at 8:00 a.m. and one medication (Carvedilol) was to be given twice daily, morning (8:00 a.m.) and afternoon. The medications were prescribed for hypertension (high blood pressure). During a concurrent interview and record review of the MAR with the Director of Nursing (DON) on 6/10/16 at 2:15 p.m., she acknowledged all three blood pressure medications were not held as ordered, and were given on dialysis days on the following dates: - 4/14/16 and 4/16/16 - 5/7/16, 5/12/16, and 5/28/16 - 6/2/16 and 6/7/16 A review of the dialysis communication form for Resident 19 dated 6/7/16 indicated for "Tolerance to treatment" as completed by the dialysis nurse, "BP [decrease or drop as indicated with a arrow pointing down] during dialysis". A review of the facility policy titled Care of a Resident with End-Stage Renal (Kidney) Disease, revised October 2009, stipulated, "... Education and training of staff includes, specifically:...Timing	F 333	2. Physician orders were reviewed and residents assessed by the DON, ADON, and licensed nurses for residents receiving dialysis and require blood pressure medication held prior to receiving dialysis by 7/6/2016. Physician orders were completed and dialysis center consulted by the DON, ADON, or licensed nurse to reflect medication held prior to dialysis. 3. All residents receiving dialysis shall be assessed for the need for medications to be held prior to dialysis by the DON, ADON, and license nurse. All License Nurse's were in-serviced on 6/23/2016 and 7/6/2016 on the process of holding medications and assessing resident(s) prior to receiving dialysis. The DON/ADON and licensed nurse shall review physician orders daily for follow-up as necessary. An audit shall be completed weekly by the medical record department for physician orders and medication held for residents receiving dialysis.	

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F 333	Continued From page 10 and administration of medications, particularly those before and after dialysis...".	F 333	4. All License nurses shall review Dialysis resident medications per frequency of scheduled visits per week to determine holding of any medication prior to dialysis according to dialysis center and MD recommendations. The DON/ADON shall review and monitor findings for residents receiving dialysis monthly. Trends identified shall be reviewed for any changes with the quality assurance committee quarterly for 6 months for compliance. 5. Date of completion 7/6/2016.	
F 371 SS=F	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, interviews and document review, the facility failed to ensure food was stored, prepared and served under sanitary conditions for 95 of 96 residents who received their food from the kitchen when: 1. A maintenance employee touched ice with his bare hands, that potentially would be consumed by residents 2. A kitchen employee failed to follow hand washing procedures, 3. A kitchen employee touched food contact surfaces with their bare hands, 4. Unlabeled food was stored in the refrigerator and freezer, and 5. The ice machine was not maintained in a clean	F 371		

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F 371	Continued From page 11 and sanitary condition. These failures had the potential to increase the risk of food contamination and food-borne illness among the resident populations that consume food prepared and served by the facility's dietary service. Findings: 1. During an observation of the kitchen on 6/8/16 at 11:25 a.m., Maintenance Worker 1 (MW1) entered the kitchen through a rear, outside door. He went directly to the ice machine, opened the door and placed his personal cup inside the ice machine with his bare, unwashed hands. He then picked up the ice scoop and proceeded to pour ice in his cup. Some of the ice spilled over the top of his cup onto his hands, then back into the ice storage bin. During a concurrent interview with MW1 he stated "It's ok for me to do that...I just washed my hands before I came in." During a concurrent interview with Registered Dietitian (RD), she stated, "That's not ok." Review of policy titled "Sanitation", dated 2015, revealed, "Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner." The Food Code, written by the United States Food and Drug Administration (FDA) and published in 2013, indicated: "1. The person in charge of the kitchen shall ensure that:	F 371	F371 1. The ice machine was shut down immediately and a sign was placed on the ice machine door alerting staff not to use the ice for consumption. The ice machine was then emptied, cleaned and sanitized. New ice was purchased from outside source. Maintenance worker 1 was counseled and in-serviced regarding sanitary ice machine practices and appropriate entry to the kitchen area. The kitchen employee was counseled on following hand washing practices on 6/9/2016. The contaminated portion cups were discarded immediately and the related kitchen employee was counseled by the Dietary Supervisor (DS) regarding hand washing and use of gloves when handling portion cups. The unlabeled items in the refrigerator and freezer were thrown away. Upon the identification of the black substance found on the upper door of the ice machine, the ice machine was cleaned and sanitized immediately.	

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	555673	A. BUILDING _____ B. WING _____	06/10/2016

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F 371	Continued From page 12 a. Persons unnecessary to the food operation are not allowed in the food preparation areas, and Persons entering the food preparation areas comply with the Code." "2. Multi-use containers returned to the kitchen may be refilled if: a. they are properly cleaned and sanitized before refilling, and b. They are refilled by a kitchen employee" 2. During kitchen observation on 6/8/16 at 11:59 a.m., Dietary Aide 2 (DA2) was observed placing portion control cups on a tray by removing individual cups from a stack one at a time. She was observed placing her fingers directly inside the cups without wearing gloves. During a concurrent interview, she stated, "It's not ok to do that....I'll throw them away." During a concurrent interview with the Dietary Supervisor (DS), she stated, "It's not ok...she should be wearing gloves...sometimes they forget." Review of the Policy and Procedure titled "Sanitation" revealed, "Dishes are to be handled on the rim of the plates, sauce dishes, etc. Hands must not contact the food surface." 3. During an observation on 6/8/16 at 11:20 a.m., Dietary Aide 1 (DA1) was observed washing his hands, then donning his hair net and his apron. He then left the kitchen and returned without re-washing his hands. During a concurrent interview with Registered Dietitian she stated, "That is not how he was trained...that's not ok." Review of the facility policy and procedure titled "Hand Washing Procedure," dated 3/13, indicated, "Hands need to be washed after going to the toilet, after sneezing, after using a handkerchief or tissue, or after touching your hair	F 371	2. No residents were identified to be affected by the deficiency. The DS in-serviced kitchen staff on 6/9/2016, regarding proper handwashing, glove use, and food labeling. The frequency of the cleaning and sanitizing of the ice machine will be done every month (more frequently than the printed manufacturer's recommendations of every 6 months) by the environmental services director (ESD) or designee. An all staff in-service was conducted by 7/8/2016, regarding designated persons allowed in the kitchen, proper procedures for reusing multi-use containers returned to the kitchen, and designated employees allowed to scoop ice. 3. The ESD or designee shall review frequency of cleaning and sanitizing of the ice machine monthly for compliance. A random audit shall be conducted by the dietary supervisor and /or registered dietitian weekly for kitchen staff hand washing, glove use, food labeling, and ice machine maintenance.	

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F 371	Continued From page 13 or face." Review of Hand washing Dietary In-Service indicated hands should be washed, "after returning to the kitchen from any other area, and after touching face or hair." The attendance record, dated 4/21/16, indicated that DA1 had attended and successfully passed the in-service post test. According to the Food Code: "1. Food employees shall keep their hands and exposed portions of their arms clean: a. After touching bare human body parts other than clean hands and clean, exposed portions of arms, and, b. After engaging in other activities that contaminate the hands." 4. During an observation on 6/7/16 at 8:15 a.m., two bags of an unlabeled substance were found in the walk-in refrigerator. During a concurrent interview, Dietary Supervisor (DS) stated the bags contained bread crumbs, and they had been removed from their original container. During an observation on 6/7/16 at 8:30 a.m., five brown bags of unlabeled frozen food were noted in the walk-in freezer. During a concurrent interview with DS, she stated that the bags contained french fries. Review of the policy titled "Procedure for Refrigerated Food," dated 3/13, indicated, "Individual packages of refrigerated or frozen food taken from the original packing box need to be labeled and dated." 5. During an observation on 6/7/16 at 8:35 a.m., a black substance was found on the upper door near the hinges of the ice machines. During a	F 371	4. The ESD or designee shall review results monthly regarding ice machine cleaning and sanitizing frequency. The DS and/or registered dietician shall review weekly results of the random audit monthly for trends. Trends identified shall be reviewed for any changes with the quality assurance committee quarterly for 6 months for compliance. 5. Plan of correction shall be completed by 7/8/2016.	

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F 371	Continued From page 14 concurrent interview with DS, when asked about the black substance, she stated, "It shouldn't be like that." Review of the facility policy "Sanitation," dated 2015, indicated, "All utensils, counters, shelves and equipment shall be maintained in good repair." The policy further states, "Ice which is used in connection with food or drink shall be from a sanitary source."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	F 431 1. Keys for Controlled medications for both nurse stations were removed by DON and placed in the medication cart for 1A hall and 2A hall immediately. 2. An audit was completed by the DON/ADON immediately regarding safe storage of controlled medication in each medication room with no findings noted. License Nurses were in-serviced by the DON on 6/23/2016 and 7/6/2016 on Keys for Controlled medication to be stored in 1A and 2A hall medication carts drawer. Also no unauthorized staff in medication room without License Nurse present.	

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F 431	Continued From page 15 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, the facility failed to: 1. Restrict unauthorized access to the medication room and subsequent access to the keys to the controlled drug supply and 2. Remove expired protein supplements and medications from supply for resident use. These failures had the potential for drug diversion by staff and expired supplements or medications to be ineffective if administered. Findings: 1. During an concurrent interview and observation of the medication storage room at the front nursing station on 6/7/16 at 11:35 a.m., Licensed Nurse (LN) 1 stated the keys hanging on the wall inside the room were for the locked box in the refrigerator, the locked cabinet containing the emergency medication kit, and the locked cabinet containing discontinued medications. She stated only nurses have keys and have access to the medication room. During a concurrent observation and interview	F 431	3. During Q shift report the License Nurse shall check to ensure no unauthorized staff in medication room. Controlled medication keys shall be kept in medication cart drawer for 1A hall and 2A hall and shall be documented on the controlled count sheet daily by the licensed nurse to ensure no access to medications and entry into the medication room except license nurses. 4. The DON/ADON shall review the controlled count sheet monthly for any trends. Areas identified shall be reviewed and revised as necessary with the quality assurance committee quarterly for 6 months for compliance. 5. Date of completion 7/6/2016.	

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F 431	Continued From page 16 with LN 2 on 6/7/16 at 12:25 p.m., he stated the keys hanging inside the medication room at the back nursing station opened the locked box in the refrigerator and the cabinet containing the emergency medication kit. He stated only nurses have keys to enter the medication room. During a concurrent observation and interview with the Environmental Services Director (ESD) on 6/8/16 at 3:10 p.m., he stated he kept keys for the both medication rooms at the front and back nursing stations. He was observed opening the medication room at the back nursing station. He stated he could enter the room "anytime" unescorted, and did not need a nurse to be present. In an interview with the Director of Nursing (DON) on 6/9/16 at 8:00 a.m., she acknowledged keys for unlocking controlled drugs from the refrigerator and for cabinets containing controlled drugs were hung inside the medication rooms at both nursing stations. She was observed using these keys to access the locked cabinets in medication room at the front nursing station. She further stated that the ESD also had keys to access the room as needed for repairs. A review of facility policy titled Storage of Medication, dated 2007, stipulated, "...Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access...". A review of facility policy titled Controlled Medication Storage, dated 2007, specified, "...Only authorized licensed nursing and pharmacy personnel have access to controlled medications. The medication nurse on duty	F 431	F431 1. 6 bottles of Liquid Protein, 1 bottle of ASA, and 1 bottle of 1000ml Sterile saline were removed by DON and ADON and discarded appropriately from Station 1 and Station 2. 2. All OTC'S in both Medication room's were checked by DON and ADON immediately for current expiration dates with no findings. License Nurse's were in-serviced on 6/23/2016 and 7/6/2016, by the DON and ADON on checking expiration dates on any OTC'S stored in the medication rooms License Nurse's to check weekly and as necessary for any expired medication and OTC'S and will discard them accordingly. 3.All OTC'S will be checked weekly in both medication rooms by License Nurse's for expired dates and removed accordingly at both stations. The DON or the designee shall review findings monthly to identify concerns or trends. 4. The DON or designee shall review monthly trends and changes quarterly with the quality assurance committee for 6 months.	

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F 431	Continued From page 17 maintains possession of the key to controlled medication storage areas..." and "...the access system (key, security codes) used to lock controlled medications and other medications subject to abuse cannot be the same access system used to obtain the non-scheduled medications...". 2. During an observation on 6/7/16 at 11:35 a.m., six bottles of liquid protein supplement were stored on a shelf in the medication storage room at the front nursing station. All six bottles had an expiration date of 4/24/2016. Upon further inspection, 1 bottle of aspirin in the storage room at the front nursing station had an expiration date of "4/16". During an interview with LN 1 on 6/7/16 at 11:35 a.m., she stated they should not have been there. She then placed the expired items in the locked cabinet labeled for discontinued medications. A concurrent observation and interview was conducted with LN 2 on 6/7/16 at 12:25 p.m. in the medication storage room at the back nursing station. One bottle of 1000 mL (milliliter- a unit of measure) sterile saline solution was observed with the seal removed and a date, 6/3/16, was written on the bottle. LN 2 stated this was the, "open date". LN 2 consulted with the pharmacy by telephone whom stated the solution expired after 24 hours of being opened. A review of the facility policy titled Storage of Medication, dated 2007, specified, "...Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are	F 431	5. Date of completion 7/6/2016.	

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F 431	Continued From page 18 immediately removed from stock...".	F 431		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain dietary equipment in proper working order when: 1. The Wolf [brand] range ovens were not operational and were in disrepair, 2. The lower Lang [brand] oven door was in disrepair, and 3. The Freezer door gasket was torn and frayed. These failures had potential to interrupt food service for 95 of 96 residents. Findings: 1. During kitchen observation on 6/7/16 at 8:30 a.m., the lower Lang oven door was found to be in disrepair; an improvised latch was attached to the exterior of the door to keep it closed. The door would not stay closed without the latch. The bottom of the door protruded from the framework making it difficult to open and close. Screws that held the door in place were missing. During trayline observation on 6/8/16 at 11:05 a.m., Cook 1 was seen kicking the bottom of the lower oven to open it on six separate occasions.	F 456	F456 1. The Environmental Services Director (ESD) or designee completed repairs on the Wolf range ovens immediately after notification; The lower Lang oven door was repaired by 6/13/2016; and the freezer door gasket was replaced on 6/16/2016. 2. The ESD or designee shall provide an in-service with dietary and environmental services staff to ensure effective communication when areas are in need of repair by 7/8/2016 3. The ESD or designee shall monitor the kitchen area monthly for 6 months regarding any concerns regarding repair needs. 4. The ESD or designee shall review findings quarterly with the IDT for quality assurance. 5. Plan of correction completed by 7/8/2016.	

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F 456	Continued From page 19 At 12:00 p.m. Cook 1 was unable to open the oven door while kicking it; another employee helped her open the door. She stated, "I burn my hands on the latch all the time." During an interview with Maintenance and Environmental Services Director (ESD) on 6/7/16 at 3:35 P.M., he stated, "We can no longer get parts for the [Lang] ovens...they need to be replaced." During an interview regarding the Wolf ovens on 6/7/16 at 9:30 a.m., the Administrator, stated, "We'll replace them down the road." During a subsequent interview on 6/7/16 at 2:30 p.m., he stated, "They [Lang ovens] work....one is enough." 2. During kitchen observation on 6/7/16 at 8:30 a.m., the Wolf range left side oven door handle was missing. During a concurrent interview with Dietary Supervisor (DS), she stated, "These ovens don't work. We haven't used them in a long time...we don't need them...we're in the process of getting a new range sometime...we don't know when yet, but we have started the process." At 2:40 p.m., when asked why they were not in use, DS commented, "The pilot lights won't stay lit....when the door to the outside opens or the swamp cooler comes on, the pilot flame goes out...the range ovens have not been used for about two years." Review of the facility document "Maintenance Work Order" revealed an entry by the Registered Dietitian (RD) dated 3/14/16 requesting, "Oven (below range) pilot light goes out when hood fan turned on...so we can't use. Please fix. We need the oven space."	F 456		

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F 456	Continued From page 20 3. During kitchen observation on 6/7/16 at 8:30 a.m. the gasket to the walk-in freezer was found to be torn and in disrepair. During a concurrent interview, Dietary Supervisor (DS) stated, "I have a request in." Review of the facility document "Maintenance Work Order," revealed a request by RD dated 2/26/16, "Kitchen Refrig and freezer needs new gaskets installed." An additional entry by DS on 6/3/16 showed, "Freezer gasket needs repair." During an interview on 6/7/16 at 2:05 P.M., ESD stated, "The freezer gasket was ordered by phone on Tuesday after I heard it was a problem." Requested supporting documentation was not provided. Review of the facility policy and procedure dated 2015 "Sanitation," indicates: 1. All equipment shall be maintained as necessary and kept in working order. 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair. According to the Food Code 2013: "Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding potentially hazardous (time/temperature control for safety) foods at safe temperature."	F 456		

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F 460	Continued From page 21	F 460		
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to assure full visual privacy to over 50% of its residents, in 30 of 48 resident rooms. Some multiple resident rooms were missing either 1 or 2 privacy curtains around resident beds. The failure to provide full visual privacy to each resident by not having adequate number of privacy curtains in resident rooms, contributed to residents feeling exposed and embarrassed when getting dressed. Findings: During the Resident Group Interview, conducted on 6/8/16 at 10 a.m., one of the residents at the group, expressed feeling very uncomfortable whenever she would undress in her room. She said that privacy curtains were missing and/or they were too short to go completely around her bed to provide her with complete privacy. During the General Observation Tour of the facility, escorted by the facility's Environmental Services Director (ESD), conducted on 6/8/16 at	F 460	F460 1. The Environmental Services Director (ESD) or designee placed privacy curtains in resident rooms as required. 2. The ESD or designee did a random tour of facility rooms and no other rooms were identified needing privacy curtains. The ESD or designee shall in-service environmental service staff on process of ensuring that privacy curtains are installed appropriately as necessary by 7/8/2016. 3. The ESD or designee shall randomly select 10 percent of resident rooms weekly to observe that privacy curtains are installed appropriately. The ESD or designee shall review findings and trends monthly for any changes. 4. The ESD or designee shall review monthly trends identified quarterly with the quality assurance committee for 6 months. 5. Plan of correction completed by 7/8/2016.	

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F 460	Continued From page 22 2 pm, a full inspection of privacy curtains was conducted, in all resident rooms. Residents' rooms, thirty (30) in total, were found to be missing one or two privacy curtains. When the ESD was questioned about the missing curtains, he said, they could have been washed, but not yet been put back up. However, he did acknowledged not knowing that so many curtains were missing in so many resident rooms.	F 460		
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to ensure resident call light systems for both nurses' stations were able to receive resident calls through a communication system from resident rooms when: 1. The call bell was checked and was not functioning for one bed on Station 1 and 2. The central call system on Station 2 alarmed continuously during all days of the survey, with no corresponding light. These failures had the potential to cause harm by preventing the residents from directly contacting their care givers during a medical emergency or asking for assistance when needed.	F 463	F463 1. The Environmental Services Director (ESD) or designee checked all resident rooms for Station 1 and did not identify any concerns. The central call system on Station 2 was tested and related alarm was repaired by 7/8/2016. 2. No residents were identified to be affected by the deficiency. A staff inservice was conducted by 7/6/2016, regarding reporting any concerns verbally and placing the concern in the maintenance log immediately related to central call systems for station 1 and station 2. 3. The ESD or designee shall check the station 1 and station 2 central call systems daily for any concerns. The ESD or designee shall review findings monthly for trends identified.	

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F 463	Continued From page 23 Findings: 1. During the initial tour of the facility on 6/7/16 at 8:50 a.m., an alert and oriented Confidential Resident 2, not in attendance at the group meeting, was observed looking anxious and asking for help. The resident stated "I have to go to the bathroom...my call light is not working... I have been waiting for 10 minutes." The surveyor verified the call light was not working and notified nearest Certified Nurse Assistant (CNA) of the resident's needs. The surveyor observed the CNA enter room, check the call light and exit the room in search of assistance, without attending to the resident's needs. The CNA reentered the room with a new call light cable, replaced the defective one, and left the room again, without attending to the resident's needs. The resident stated, "I told them yesterday it wasn't working... I still need to go to the bathroom." The surveyor again notified the same CNA of the resident's need to use the bathroom. The CNA was observed entering the room and then leave the room stating to another CNA, "She already wet the bed." The resident then stated, "If someone would have gotten me up, I wouldn't have wet the bed." 2. On 6/9/16 at 3:15 p.m. during a concurrent observation and interview with LN 6, the Station 2 call light system was alarming all days of the survey with a continuous intermittent beep, with no corresponding light on the main module or over resident room doors. LN 6 stated the module "always beeps... Some lights work, others don't." LN 6 further stated, "We've asked maintenance to fix it." The continuous intermittent	F 463	4. The ESD or designee shall review monthly trends and changes made quarterly with the quality assurance committee for 6 months. 5. Plan of correction completed by 7/8/2016.	

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F 463	Continued From page 24 beep was heard on all 4 days of the survey. Review of the maintenance logs on 6/10/16 from Station 1 dated from 2/11/16 through 5/16/16 indicated two requests for call lights not working. Review of Station 2 maintenance log dated 4/16/16 through 6/9/16 indicated 9 requests for call lights not working. There was one request on 4/26/16 indicating "all call lights are not working at Station 2" with a corresponding notation in the comments section as "fixed". Review of the Resident Council Meeting Minutes dated 5/27/16 indicated resident complaints that call lights were not working with a follow up note dated 6/1/16 indicating "All call lights have been checked and working" with ESD signature.	F 463		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide and maintain a safe, clean homelike environment when the exterior of the building was in disrepair, areas of the facility were not clean and furniture was damaged. Findings: During an environmental tour of the facility, escorted by the facility's Maintenance &	F 465	F465 1. The Environmental Services Director (ESD) or designee completed the following by 7/8/2016. The outside left lower corner of resident room 3's window frame was repaired; bids were collected regarding repair of roof tiles with repairs completed by 7/30/2016; repair of the faucet and removal of stain in the back shower stall of shower room 2A Hall; the clean linen closet located on hall 2A floor was cleaned and items removed; the wall in room 26 was repaired and painted; the 1B shower room walls and floor were cleaned; unlabeled clothing items were	

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F 465	Continued From page 25 Environmental Services Director (ESD), conducted on 6/8/16 at 2:20 p.m., the following concurrent observations were made and acknowledged by the ESD: - 2:20 p.m.: The outside left lower corner of resident room 3's window frame was damaged and/or punctured. The area had missing, peeling paint and a hole through the wood. The outside, south east corner of the roof was severely damaged and smashed inward. Roof tiles were damaged, stucco and parts of the corner was cracked and broken off, exposing the inner structure of the building. Some roof tiles were missing from the eaves (part of a roof that overhangs the walls of a building) spider webs and a black substance was noted. What appeared to be spray foam insulation was observed to be sticking out of the damaged areas. Additional areas were observed along the entire east side of the roof line and eaves with damaged areas to the roof tiles, stucco missing and discolored areas. The ESD stated the damage, "...was from delivery trucks hitting it... it happened about 2 months ago...I haven't had time to fix it..." - 2:40 p.m.: The housekeeping closet and clean linen closets on Hall 2B had dirt on the floors with leaves and debris accumulated in the corners. ESD stated he was the supervisor overseeing housekeeping and acknowledged the floors of the storage closets needed to be cleaned. - 3:22 p.m.: A leaky faucet was observed in the back shower stall of the shower room on the 2A Hall. The back shower stall had a brown rust stain down the wall below the faucet and onto floor.	F 465	discarded from closet containing donated items; and the door lock on the room 30 side of a shared bathroom was repaired. 2. The ESD or designee completed a random tour of the facility. No other areas were identified. 3. The ESD or designee shall complete a tour of the facility for signs of needed repair monthly. 4. Trends identified shall be reviewed by the ESD or designee for any changes with the quality assurance committee quarterly for 6 months. 5. Plan of correction completed by 7/8/2016.	

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F 465	Continued From page 26 - 3:25 p.m.: The Clean Linen closet located on Hall 2A had accumulated dirt and debris on the floor. Along with the clean linen, a walker and miscellaneous wheel chair parts were also stored in the closet. - 3:30 p.m.: A 12-14 inch X 5 inch scrape along the wall to the right of the door of Room 26, had large areas of dry wall and paint missing. - 3:38 p.m.: Dirty tiles with dark brown colored grout, and a used adhesive bandage was left on the unclean, half wall of the shower in the shower room on Hall 1B. - 3:40 p.m.: A closet containing donated and unlabeled clothing items had loose clothing items on the dirty floor with dirt and debris. Additional observations were noted on 6/9/16: - 12:00 p.m.: The west side of Physical Therapy Building had damage along the length of the eaves, with additional damage to the south east front corner of this building. The corner had been smashed inward, exposing the the inner structure. Roof tiles were damaged, stucco was cracked and missing from the eaves. - 12:20 p.m.: The bathroom door lock did not work on the room 30 side of a shared bathroom. - 12:30 p.m.: In an interview with the ESD, the findings of 6/8 and 6/9/16, were also observed and acknowledged by the ESD. He added that, portions of the roof were also damaged by delivery trucks.	F 465		
F 468	483.70(h)(3) CORRIDORS HAVE FIRMLY	F 468		

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F 468 SS=E	Continued From page 27 SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain all corridors with firmly secured handrails. This failure had the potential to contribute to falls for ambulatory residents unable to steady themselves to help maintain their balance. Findings: During the general observation tour of the facility, escorted by the facility's Environmental Services Director (ESD), conducted on 6/8/16 at 2 p.m., handrails in the corridors were inspected. Two different hallways (on both nursing stations), were noted to have missing handrails on one side of the corridor. When the length of wall was measured, 15 feet of corridor was missing affixed handrails. When the ESD was questioned about the missing handrails, he confirmed the measurements and responded that they had never had handrails on that portion of the walls, and acknowledged that handrails needed to be installed.	F 468	F468 1. The environmental Services Director (ESD) or designee finished upgrading the handrails and placed handrails back to their original corridor. 2. No other missing handrails were identified. 3. The ESD or designee shall tour the corridors routinely for handrail integrity. 4. The ESD shall review monthly findings quarterly with the IDT for quality assurance. 5. Plan of correction to be completed by 7/8/2016.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

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F 502	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on interview, record and document review, the facility failed to obtain an ordered CBC (complete blood count), for 1 of 20 sampled residents (Resident 3). This failure had potential for delayed diagnosis and treatment. Findings: Resident 3 (R3) was admitted to the facility in 2015, with diagnoses of myasthenia gravis (a weakness and rapid fatigue of muscles under voluntary control), Type 2 Diabetes (a chronic condition that affects the way the body processes blood sugar), and anemia (a deficiency of red blood cells). Record review on 6/7/16 revealed a physician's order dated 6/2/16 for a CBC to be drawn on 6/3/16. However, the record did not contain a report for the CBC. Review of the lab transmittal form dated 6/2/16, it failed to include an order for the CBC. During an interview with Licensed Nurse 3 (LN3) on 6/7/16 at 12:30 p.m. he stated, "The CBC was not drawn...it's not in the computer." Review of the facility's Policy and Procedure,"Lab and Diagnostic Test Results - Clinical Protocol," indicated, "The staff will process test requisitions and arrange for tests." The policy further stated, "A nurse will review all results."	F 502	F 502 1. Resident # 3's Labs were addressed by License Nurse and Physician and ordered to be drawn 6/8/2016. 2. Any resident needing Lab's orders the License Nurse will complete the requisition slip correctly upon MD order's, and will place the requisition slip in the binder. 3. All TO'S pertaining to labs will be checked by DON or ADON Mon-Fri to verify that the requisition slip is filled out correctly per MD order's. Sat-Sun Desk Nurse desk nurse will verify labs. All License Nurse's were in-serviced on 6/23/2016 and 7/6/2016 to properly fill out requisition's for labs per MD order's.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	Continued From page 29 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, medical record and document review, the facility failed to maintain medical records which accurately reflected the conditions of Residents 1 and 17. This failure had the potential to prevent nursing care planning from being based on accurate information and/or precluded these residents from receiving needed care based on their current conditions. Findings: 1) Review of Resident 1's 4/8/16 Minimum Data Set (MDS, a comprehensive assessment tool) reflected Resident 1 was "always incontinent" (lacking voluntary control) of her bowel movements. In a 2:10 p.m., 6/10/16 interview with the Director of Nursing (DON), the 4/7/16 weekly "Nurses' Progress Note" was reviewed. The document reflected that Resident 1 was "usually continent" (in control) of her bowel movements. The	F 514	4. When License Nurse's are filling out Lab requisition slips the requisition's will be verified by another License Nurse Daily to ensure lab's correctly ordered per MD. DON and ADON to check all TO'S written for Labs Mon-Fri to ensure accuracy, Sat-Sun Desk Nurse to verify labs for accuracy. QA committee to review Labs Quarterly for 6 months to assure compliance. 5. Date of completion. 7/6/2016.	

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F 514	Continued From page 30 3/31/16 weekly summary reflected similar information. In a 2:10 p.m., 6/10/16 medical record review and concurrent interview with the DON and the MDS Coordinator (MDSC), the latter presented the April 2016 Certified Nurse Assistants' (CNAs') "ADL [Activities of Daily Living, daily self care activities including bed mobility, bed-to-wheelchair transfers, dressing, toileting, bathing and hygiene] Flow Record" which reflected, Resident 1 had been incontinent of bowel function every evening and night from 4/1/16 through 4/17/16 and twice on day shift during the same period. In a 10:25 a.m., 6/10/16 interview, the MDSC indicated he takes bowel and bladder activity information for the MDS directly "from the ADL charting... accurate ADLs from CNAs." MDSC further stated he does not typically cross check CNA charting verses nursing charting. He confirmed, " 'Incontinent' is correct." 2) Review of the MDS dated 4/16/16 reflected the ADL assistance required for Resident 17 varied from a self-performance rating of 3 (extensive assist where resident is involved in activity and staff provides weight bearing support) to a level of 4 (total dependence with full staff performance) and the support from staff with a rating of 2 (one person physical assist). Review of the documents titled "Nurse's Note" dated 4/6/16 and 4/13/16 reflected the ADL assistance required for Resident 17 rated a self-performance level of 1 (supervision including oversight, encouragement or cueing) and the support from staff with a level of 2 (one person	F 514	F514 1. Resident #1 and # 17's Weekly Progress note's were reviewed by DON and ADON from 6/12/2016 thru 6/18/2016 for proper documentation of Physical function and continence. 2. A random sample of resident's ADL records and progress notes were reviewed by the DON/ADON on 6/12/2016 thru 6/18/2016 and was determined to match in both Physical Function and continence. 3. License Nurses were in-serviced by the DON/ADON on 6/23/2016 and 7/6/2016 on the use of the CNA'S ADL records for completion of weekly Nurses Progress notes to accurately reflect resident's Physical Function continence. Weekly Progress notes and ADL records will be monitored by the DON or ADON weekly to ensure accuracy that progress notes and ADLs are matching. If incomplete or not accurate the documentation will be given to the License Nurse to correct in order to ensure	

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F 514	Continued From page 31 physical assist). Review of the document titled "ADL Flow Record", completed by the CNA, dated 4/1/16 - 4/15/16, reflected ADL assistance required for Resident 17 from a self-performance level of 3 to a level of 4 and the support from staff with a rating of 2. Additionally, a review of the MDS dated 4/16/16 reflected Resident 17 was "always incontinent" of urine and bowel movements. Review of the documents titled "Nurse's Note" dated 4/13/16 reflected Resident 17 was "continent" of both urine and bowel movements. Review of the document titled "ADL Flow Record" dated 4/1/16 - 4/15/16 reflected Resident 17 was "incontinent" of urine and bowel movement. In an interview on 6/10/16 at 11:30 a.m. LN 5 stated the process for completing the weekly nurses notes was as follows: she reviewed the CNA's ADL charting, RNA (Restorative Nursing Assistants, caregivers who work to achieve and maintain optimal physical, mental, and psychosocial functioning) notes and any recent Physical Therapy notes to complete the ADL section titled "Physical Functioning, "... especially if I don't know the resident very well." In an interview with the DON on 6/10/16 at 1:15 p.m. when presented with the documents 4/1/16 -4/15/16 ADL Flow sheet and the 4/13/16 Nurses Progress Notes, the DON agreed the discrepancy was significant and stated, "There will need to be more in-services on how to complete these."	F 514	accuracy of the documentation. 4. The DON/ADON shall review trends monthly. Trends and changes identified shall be reviewed quarterly with the quality assurance committee for 6 months for compliance and accuracy of license nurse documentation. 5. Date of completion 7/6/2016.	