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F 000	INITIAL COMMENTS	F 000		
F 157 SS=G	Annual Certification Survey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

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by:
Based on record review and interview, the facility failed to notify the physician, residents legal representative and/or interested family member in a timely manner of a change in condition, and/or of a pharmacy consult drug interaction concern for 3 of 15 residents (R3, R5, R15) reviewed for physician notification in the sample of 15. This failure resulted in R15 being transferred to local hospital.

The findings are:

1. R15's Vital Summary for March 2016 for 3/17/16 at 2:31 AM shows R15's pulse was 56 (irregular-New onset). No documentation could be found that R15's doctor, Power of Attorney or family was made aware of new onset of irregular, low heart rate.

R15's Health Status note on 3/18/16 at 2:30 AM shows resident was having wet sounding cough and complained of hard time breathing and was experiencing chest pain that was continuous and non-radiating and in the center of her chest and held her right hand in a fist over the area at mid-neck line between her breast. R15 stated she felt like she should go to the hospital. Nurse did not send R15 to hospital at that time but gave R15 an antacid and informed R15 that chest pain may subside in a few minutes. R15's documents go on to show that the nurse went back to the nurse station to resume charting. CNA(Certified Nursing Assistant) went back to check on R15 per nurse request and when CNA entered room came back out and summoned nurse. When nurse arrived R15's eyes were open and her gaze was becoming fixed, weak pulse at 2:50 AM CPR(Cardiopulmonary Resuscitation) and chest

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compressions were started and continued until Emergency Medical Services arrived. This document goes on to state that hospital informed facility of R15's death at 3:44 AM.

There was no documentation found in R15's chart regarding making her doctor, Power of Attorney or family aware of changes in condition and her request to go to the hospital.

R15's mental assessment done on 02/24/16 is a 15 out of 15 which makes her capable of making her needs known and making her own decisions for her care.

On 5/13/16 at 11:00 AM Z1(Primary Care Physician) stated the expectation would be that the staff would notify him or someone from his office if there was a change in the resident and/or if there was a change in the normal status of a resident or their condition. Z1 stated the facility will notify him often of different things by fax and call him but could not remember being made aware of R15's irregular 56 heart rate on 3/17/16. Z1 stated the notification would not have necessarily changed the outcome of R15 having a Cardiac Arrest and subsequent death on the early hours of 3/18/16, because R15 had such a long extensive history of cardiac and pulmonary issues.

On 5/12/16 at 4:00 PM, E4(Corporate Nurse) stated the expectation is that if there's a change in condition in a resident then the nurse should be notifying the doctor and the POA(Power of Attorney). E4 stated the nurse that had taken care of R15 in the early morning of 3/17/16 and 3/18/16 should have called and made the physician aware of R15's condition. E4 stated she

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had spoken to the nurse that had taken care of R15 on the night of 3/17/16 and it was also the same nurse that took care of R15 on 3/18/16. E4 stated she had asked the nurse why she had not notified the doctor of R15's irregular pulse on 3/17/16 and E4 stated the nurse did not have an answer. E4 stated she also asked the nurse if on the early morning of 3/18/16 had she taken vital signs, assessed her lungs, or if the nurse even did a general assessment or why she did not send R15 to the hospital at that time of her request. E4 stated the nurse could not answer any of those questions's when asked. E4 stated this nurse no longer worked for the facility because she was terminated for not following policies and procedures.

2. R3 is a 92 year old resident with diagnoses that include Alzheimer's, Dementia with Behavioral Disturbance and Delusional Disorder, as noted on the May 2016 Medical Review Report. R3's record included 2 documents from the pharmacy, titled "Drug Interaction Information", with dates of 2/9/16 and 3/7/16. Both documents indicate that R3 was receiving Diltiazem which may interact with another medication- Quetiapine Fumarate, that R3 was also taking. The documents indicate that there is a risk for adverse interaction at a Level 2- Severe Interaction, when these two drugs are used concomitantly.

As of 5/12/2016, R3 was continuing to receive these two medications at the same dosage as when the pharmacy addressed the concern. There is no indication in the record that Z3, R3's Primary Care Physician was made aware of this risk as recommended by the consulting pharmacy. On 5/13/2016 at 11:00 am, E2-Interim

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F 157	Continued From page 4 Director of Nurses, verified that Z3 had not been notified of the drug interaction risk, prior to 5/13/2016. 3. R5's Physician's Order Sheet for 5/2016 includes orders for haloperidol (Haldol) 1 mg (milligram) twice daily with a start date of 3/15/2016 and donepezil (Aricept) 10 mg daily with a start date of 8/31/2015. R5's medical record contains a document dated March 15, 2016 with heading of Omnicare Pharmacies Drug Interaction Information and states the following: "R5 is currently receiving Donepezil 10 mg which may interact with the new order for Haloperidol 1mg. Severity Level: 2 Severe Interaction : Action is required to reduce the risk of severe adverse reaction. Please review for appropriate action and place this document in the resident's clinical record. After the surveyor made E2 aware of this issue, a Progress Note dated 5/13/2016 at 9:19 am was presented that states, "Z1's, (R5's physician) office made aware of the potential medication interaction between Aricept and Haldol. Pharmacy recommendations faxed to office for review. Waiting return physician call." R5's Medication Administration Records for the months of March, April, and May, 2016 indicate that R5 is currently receiving both medications and has been since 3/15/2016.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

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F 241	Continued From page 5 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provided a dignified dining experience for 1 of 13 residents (R10) reviewed for dignity in the sample of 15 and 1 resident (R17) in the supplemental sample. Findings Include: On 5/10/16 from 12:05 PM to 12:35 PM in large dinning room, during lunch meal R10 and R17, on multiple occasions were seen eating their food with their fingers. R10 and R17 were also provided no silverware to eat with at the beginning of the meal. During the lunch meal different CNA's (Certified Nursing Assistants) (E14, E15, E16) came over to the table multiple times during this period. No staff prompted R10 and R17 to not eat with fingers. Staff did not provide R10 and R17 any silverware until there meal trays were served. It Should be noted that staff gave R10 and R17 their desserts prior to their actual meal tray. Once R10 and R17 were served their meal tray and silverware, staff did not unwrap the silverware from the napkins so R10 and R17 continued to eat food with their fingers. R10 was also noted to take R18's dessert and proceed to eat over 3/4 of it with her fingers before any staff intervened and removed it. Staff still did not prompt or cue the resident to not use fingers or provide any silverware at that time. On 5/11/16 at 12:00 PM in large dining room during lunch meal R10 and R17 were at a table that E14 CNA was helping R18 to eat and was	F 241		

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F 241	Continued From page 6 later replaced by E18 CNA. E19 was assisting R22 to eat at this same table . Over the course of the meal there were multiple times both R10 and R17 used their fingers to eat their food. E14, E18 and E19 CNA's did not attempt to prevent this from occurring on multiple occasions. These same CNA's did not consistently cue residents to use silverware or assist residents when necessary. R10's Plan of Care with admission date of 2/10/16 shows resident eats in large dining room, sits at a Feeding table and is prompted and fed by staff when needed. On 5/13/16 at 10 AM, E13 ADON(Assistant Director of Nursing) stated residents should not be eating with their fingers and silverware should be provided. E13 did state some residents will still try to eat with their fingers even if silverware is provided but if staff are present then they should be prompting the resident to use the silverware instead of their fingers.	F 241		
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	F 278		

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that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to accurately complete resident assessments for 2 of 15 (R11, R13) residents reviewed for accurate minimum data assessments in the sample of 15.

The findings include:

1. R11"s Significant Change MDS dated 2/1/16 did not have Section F for assessment of customary routines and activities preferences completed. This was verified by E2 on 5/13/16 at 10:00 am.

2. R13's Initial MDS 3/7/16 did not include coding of the use of an antipsychotic medication, in Section N- Medication Use, by R13. Section N did document that R13 was taking an anti-anxiety medication. R13's admission orders for 2/29/16,

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F 278	Continued From page 8 and the Medication Administration Record for March 2016 documented that R13 was admitted on the antipsychotic medication Seroquel and did not document any use of an anti-anxiety medication for that time frame. This was verified by E2 on 5/13/16 at 10:00 am.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to update Care Plans with information regarding the potential for severe medication interactions, and failed to invite a resident's family to a Care Plan meeting for 3 of 15 residents (R3,	F 280		

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R5, R9) reviewed for Care Plans in the sample of 15.

The findings include:

1. R3 is a 92 year old resident with diagnoses including Alzheimer's, Dementia with Behavioral Disturbance and Delusional Disorder, as noted on the May 2016 Medical Review Report. R3's record included 2 documents from the pharmacy, titled "Drug Interaction Information", with dates of 2/9/16 and 3/7/16. Both documents indicate that R3 was receiving Diltiazem which may interact with another medication- Quetiapine Fumarate, that R3 was also taking. The documents indicate that there is a risk for adverse interaction at a Level 2- Severe Interaction, when these two drugs are used concomitantly.
R3's current Care Plan with a review date of 3/16/2016 failed to address the potential risk for a drug interaction when using both of these medications.. On 5/13/2016 at 11:00 am, E2-Interim Director of Nurses, verified that R3's Current Care Plan was not updated with this concern area prior to 5/13/2016.
2. During an interview with Z2 (family) on May 10, 2016 regarding R9, Z2 states "I would like to have more meetings with the staff there regarding (R9's) care. I have had a couple of meetings when (R9) was first admitted, but it has been a while and I would like to have more."

The staff scored R9's Brief Interview for Mental Status score as severely impaired cognitive function on the Minimum Data Sets (MDS) dated May 10, 2016.

An interview with E20, Minimum Data Set / Care Plan Coordinator on May 12, 2016 at 11:30 AM

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F 280	Continued From page 10 states "I send out letters to family members to attend Care Plan meetings, but R9's was omitted. I will make sure R9's family gets an invitation to the next one." R9's MDS dated May 10, 2016 lists family or significant other involvement in care decisions as important to R9. On May 13, 2016 at 11:00 AM E2, Interim Director of Nursing brought in a letter inviting R9's family to a Care Plan Meeting on May 19, 2016, that was going to be mailed on May 13, 2016. 3. R5's Physician's Order Sheet for 5/2016 includes orders for haloperidol (Haldol) 1 mg (milligram) twice daily with a start date of 3/15/2016 and donepezil (Aricept) 10 mg daily with a start date of 8/31/2015. R5's medical record contains a document dated March 15, 2016 with heading of Omnicare Pharmacies Drug Interaction Information and states the following: "R5 is currently receiving Donepezil 10 mg which may interact with the new order for Haloperidol 1mg. Severity Level: 2 Severe Interaction : Action is required to reduce the risk of severe adverse reaction. Please review for appropriate action and place this document in the resident's clinical record. As of 5/12/ 2016, R5's current Care Plan did not include this information. On 5/13/2016 E2, Director of Nursing (interim), stated that R5's Care Plan has now been updated to include this information.	F 280		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 11 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow physician orders and plans of care for 1 of 15 residents (R15) reviewed for physician orders and care plans in the sample of 15. Findings include: 1. R15's Health Status note on 3/18/16 at 2:30 AM shows resident was having wet sounding cough and complained of hard time breathing and was experiencing chest pain that was continuous and non-radiating and in the center of her chest and held her right hand in a fist over the area at mid-neck line between her breast. R15 stated she felt like she should go to the hospital. Nurse did not send R15 to hospital at that time but gave R15 an antacid and informed R15 that chest pain may subside in a few minutes. R15's documents go on to show that the nurse went back to the nurse station to resume charting. CNA(Certified Nursing Assistant) went back to check on R15 per nurse request and when CNA entered room came back out and summoned nurse. When nurse arrived R15's eyes were open and her gaze was becoming fixed, weak pulse at 2:50 AM CPR(Cardiopulmonary Resuscitation) and chest compressions were started and continued until Emergency Medical Services arrived. This	F 282		

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document goes on to state that hospital informed facility of R15's death at 3:44 AM.

R15's Brief Mental Health Assessment shows a score of 15 out of 15 and is able to make her own decisions.

R15's Medication Review for March 2016 shows she is a full code; orders for DuoNeb Solution 0.5-2.5 (3) mg(milligram)/3 ml(milliliter) (ipratropium-albuterol) 1 vial inhale orally every 6 hours as needed for congestion; Nitroglycerin tablet sublingual 0.4 mg-Give 1 tablet sublingually every 5 minutes as needed for Chest pain X 3 doses. If no relief , call MD; Proventil HFA Aerosol Solution (Albuterol Sulfate HFA)-2 puff inhale orally every six hours as needed for COPD(Cardio Pulmonary Disease).

Review of R15's Medication Administration and progress notes shows she was not sent to the hospital upon her request. R15 was not given Nitroglycerin per physician orders for chest pains. R15 was not given either DuoNeb Solution or Provental HFA Aerosol Solution even though she "had a wet sounding cough" and "hard time breathing".

On 5/12/16 at 4:05 PM E4(Corporate Nurse) stated she had questioned the nurse who had taken care of R15 on the early morning shift of 3/18/16 because there were concerns. E4 stated she was a nurse and she had asked the nurse why the Nitroglycerin or Nebulizer treatments had not been given or why R15 had not been sent to the hospital when requested. E4 stated the nurse in question could not provide E4 any answers to these questions.

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F 282	Continued From page 13 On 5/12/16 at 4:10 PM, E13 ADON(Assistant Director of Nursing) stated she had been on call the night/early morning or 3/18/16 when the nurse on duty had called her to make her aware R15 had been to sent to the hospital and expired. E13 stated she had reviewed the incident and stated as RN(Registered Nurse) she was not sure why R15 had not been sent out or why the nitroglycerine were not given. E13 stated R15 could tell you what she needed and wanted.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to educate residents, family and representatives regarding the Food and Drug Administration (FDA) black box warnings for 2 of 5 residents (R2, R3) reviewed for antipsychotic medications in a sample of 15. In addition, the facility also failed to provide identified nursing services for one resident (R15) reviewed for nursing services in the sample of 15. This failure resulted in R15 being transferred to local hospital. The findings include: 1. According to the Admission Record, R2 is 74	F 309		

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F 309	Continued From page 14 years old, indicating she is geriatric, and has diagnosis of Dementia without Behavioral Disturbance, and Hallucinations. R2 is prescribed Risperidone, an antipsychotic, 0.25 milligrams (mg) one tablet BID (twice a day) on October 23, 2015 for a diagnosis of "Hallucinations" with indications for use as agitation according to R2's Physician Orders for April, 2016. This medication has a FDA (Federal Drug Administration) Black Box Warning which includes the information that this medication, when used in dementia related psychosis is not an indicated use and is associated with an increased risk of death. R2's Consent for Psychoactive Medication Therapy form for Risperdal 0.25 mg indicates R2's Power of Attorney for Healthcare gave phone verbal approval on October 30, 2016 however, does not list any of the above FDA's Black Box Warning information. There was no education noted in R2's record regarding potential risks/side effects of the use of these medications being discussed with R2's family or R2. E2, Interim Director of Nurses, verified on 5/13/2016 at 10:00 am that there was no evidence that the FDA Black Box Warning education was shared with residents/next of kin/POA or documented on the Consent forms. 2. According to the Admission Record, R3 is 92 years old, indicating she is a geriatric, and has diagnosis of Dementia without Behavioral Disturbance, and Delusional Disorder.	F 309		

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F 309	Continued From page 15 R3 is prescribed Seroquel, an antipsychotic, 25 milligrams (mg) one tablet TID (three a day) on 3-7-16 as noted on R3's Physician Orders for April, 2016. This medication has a FDA (Federal Drug Administration) Black Box Warning which includes the information that this medication, when used in dementia related psychosis is not an indicated use and is associated with an increased risk of death. R3's Consent for Psychoactive Medication Therapy form for the Seroquel indicates R3's Power of Attorney for Healthcare gave phone verbal approval on 3-10 2016 however, it does not list any of the above FDA's Black Box Warning information. E2, Interim Director of Nurses, verified on 5/13/2016 at 10:00 am that there was no evidence that the FDA Black Box Warning education was shared with residents/next of kin/POA or documented on the Consent forms. 3.R15's Vital Summary for March 2016 for 3/17/16 at 2:31 AM shows her pulse was 56 (irregular-New onset). No documentation could be found that R15's doctor, Power of Attorney or family was made aware of new onset of irregular, low heart rate. R15's Health Status note on 3/18/16 shows "at approximately 2:30 AM resident turned on her call light. A CNA(Certified Nursing Assistant) answered the call light immediately. The CNA reported to this nurse that the resident not feeling	F 309		

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well. This nurse went in to residents room and discovered resident was lying flat in bed in supine position with her head upon a pillow. Nurse noticed wet sounding cough and resident was holding a trash can and spitting into it. At this time resident was alert and speaking to nurse describing how she felt. Resident reported to nurse that she was having a hard time breathing due to cough. Nurse adjusted resident with the assistance of 2 CNA's who came into the room at this time. HOB (Head of bed) was elevated. Resident described experiencing chest pain that was continuous and non-radiating. She described location "in the center" of her chest and held her right hand in a fist over the area of mid-neck line between her breast. She stated she felt like she should go to hospital. This nurse went to med.(medication) cart and obtained a antacid and gave it to resident. Nurse instructed resident to chew antacid up in her mouth and swallow it. Resident nodded her head in understanding. Nurse informed resident that her chest pain may subside in a few minutes and that nurse was going to leave the room for just a minute. Resident nodded. Nurse came to nurses station and resumed charting on another resident, nurse also asked CNA at nurse station to go check on resident and to ask her if she was feeling any better. CNA went to resident room and stepped back out into hallway and said, "I can't understand her, come like now!" Within seconds, nurse was heading to resident's room. Upon arrival, resident had her eyes open and her gaze was becoming fixed. This nurse called out residents name and resident attempted a vocal response. A Weak pulse was noted. Nurses stepped out of room to call 911, and another nurse to aid in CPR if necessary. Continued to get a response from resident. Two nurses met in

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resident's room and find resident unresponsive to CNA attempts to keep alert. Apnec breathing noted at this time. Sternal rub elicited a response from resident 2 possibly 3 times. Nurses begin CPR with chest compressions starting at 2:50 AM and continued until EMS(Emergency Medical Services) arrived. CNA obtained oxygen and it was started at 4 liters per nasal cannula. Blood sugar was 191. This nurse spoke with local hospital around 4:00 AM and was informed that official time of death was 3:44 AM. On Call nurse notified, as well as family and MD."

There was no documentation found in R15's chart indicating that her doctor, Power of Attorney or family were made aware of changes in condition and her request to go to the hospital.

R15's mental assessment done on 02/24/ 16 is a 15 out of 15 which makes her capable of making her needs know and making her own decisions for her care.

On 5/13/16 at 11:00 AM Z1(Primary Care Physician) stated the expectation would be that the staff would notify him or someone from his office if there was a change in the resident or if there was a change in a normal status of a resident or their condition. Z1 stated the facility will notify him often of different things by fax and call him but could not remember being made aware of R15's irregular 56 heart rate on 3/17/16. Z1 stated the notification would not have necessarily changed the outcome of R15 having a Cardiac Arrest and subsequent death on the early hours of 3/18/16 because R15 had such a long extensive history of cardiac and pulmonary issues.

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F 309	Continued From page 18 On 5/12/16 at 4:00 PM, E4(Corporate Nurse) stated the expectation is that if there's a change in condition of a resident then the nurse should be notifying the doctor and the POA(Power of Attorney). E4 stated the nurse that had taken care of R15 in the early morning of 3/17/16 and 3/18/16 should have called and made the physician aware of R15's condition. On 5/12/16 at 4:00 PM, E4(Corporate Nurse) stated the expectation is that if there's a change in condition of a resident then the nurse should be notifying the doctor and the POA(Power of Attorney). E4 stated the nurse that had taken care of R15 in the early morning of 3/17/16 and 3/18/16 should have called and made the physician aware of R15's condition. E4 stated she had spoken to the nurse that had taken care of R15 on the night of 3/17/16 and it was also the same nurse that took care of R15 on 3/18/16. E4 stated she had asked the nurse why she had not notified the doctor of R15's irregular pulse on 3/17/16 and E4 stated the nurse did not have an answer. E4 stated she also asked the nurse if on the early morning of 3/18/16 if she had taken vital signs, assessed her lungs, or if the nurse even did a general assessment or why she did not send R15 to the hospital at that time of her request. R15's Brief Mental Health Assessment shows a score of 15 out of 15 and is able to make her own decisions. R15's Medication Review for March 2016 shows she is a full code; orders for DuoNeb Solution 0.5-2.5 (3) mg(milligram)/3 ml(milliliter) (ipratropium-Albuterol) 1 vial inhale orally every 6 hours as needed for congestion; Nitroglycerin tablet sublingual 0.4 mg-Give 1 tablet sublingually	F 309		

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every 5 minutes as needed for Chest pain X 3 doses. If no relief , call MD; Proventil HFA Aerosol Solution (Albuterol Sulfate HFA)-2 puff inhale orally every six hours as needed for COPD(Cardio Pulmonary Disease).

Review of R15's Medication Administration and progress notes shows she was not sent to the hospital upon her request. R15 was not given Nitroglycerin per physician orders for chest pains. R15 was not given either DuoNeb Solution or Provental HFA Aerosol Solution even though she "had a wet sounding cough" and "hard time breathing".

On 5/12/16 at 4:05 PM E4(Corporate Nurse) stated she had questioned the nurse who had taken care of R15 on the early morning shift of 3/18/16 because there were concerns. E4 stated she was a nurse and she had asked the nurse why the Nitroglycerin or Nebulizer treatments had not been given or why R15 had not been sent to the hospital when request. E4 stated the nurse in question could not provide E4 with any answers to these questions. When asked E4 if the nurse that provided care to R15 on both of these occasion was still working at the facility, E4 stated no. When questioned E4 why the nurse no longer worked at the facility, E4 stated the nurse was terminated for not following facility policy and procedures. E4 stated the nurse should have assessed R15 when she saw her having issues with Shortness of breath. E4 stated it was not the CNA's responsibility to follow up after the nurse had given the antacid and the nurse should have followed up because the CNA's are not qualified to do this. E4 stated if a resident is having problems with shortness of breath then the nurse should listen to their lungs. E4 stated if a resident

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is complaining of chest pain then a more thorough assessment needs to be done.

On 5/12/16 at 4:10 PM, E13 ADON(Assistant Director of Nursing) stated she had been on call the night/early morning or 3/18/16 when the nurse on duty had called her to make her aware R15 had been sent to the hospital and expired. E13 stated she had reviewed the incident and stated as a RN(Registered Nurse) she was not sure why R15 had not been sent out or why the nitroglycerine were not given. E13 stated R15 could tell you what she needed and wanted.

Review of R15's pulse summary from 8/11/15 to 3/17/16 shows no issues with R15's pulse until 3/17/16 at 2:30AM of the irregular 56.

Review of R15's Respiration Summary from 8/11/15 to 3/18/16 shows no issues with R15's respirations being higher than normal until 3/18/16 at 2:31 AM when it was 24.

R15's Plan of Care with initiation date of 8/21/15 shows resident has altered cardiovascular status related to Congestive Heart Failure, Hypertension, Peripheral Vascular Disease and the goal is resident will be free from sign/symptoms of complications of cardiac problems through the next review date of 5/18/16. Interventions include Assess for shortness of breath and cyanosis every shift; Monitor and report to MD changes in lung sounds on auscultation, shortness of breath; monitor and report to MD as needed any sign/symptom of Coronary Artery Disease: Chest pain or pressure especially with activity, heartburn nausea and vomiting, shortness of breath; monitor pedal

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F 309	Continued From page 21 pulse to right foot as needed with care and concerns; Vital signs as needed. Notify physician of any abnormal readings. According to same plan of care, R15 had history of asthma and Cardiopulmonary Disease and the goal was resident will display optimal breathing pattern daily. Noted interventions are: Give aerosol or bronchodialators as ordered. Monitor/document any side effects and effectiveness; Monitor and report to MD as needed any sign/symptoms of respiratory infection: increase sputum (document the amount, color and consistency), chest pain, increased difficulty breathing, increased coughing and wheezing; Monitor for signs/symptoms of acute respiratory insufficiency: Anxiety, confusion, restlessness, shortness of breath at rest, Cyanosis, Somnolence	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a restorative nursing program for 1 of 4 residents (R13) reviewed for restorative nursing programs in the sample of 15. The findings include: 1. R13 was admitted to the facility on 2/29/16 for skilled therapies related to Generalized Muscle Weakness and Difficulty in Walking, as noted on the Physical Therapy (PT) Progress and	F 311		

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F 311	Continued From page 22 Discharge Summary dated 4/1/16. The summary notes that goals were not met for ambulation and balance, transfers and strength, though some progress was made. The therapy note states that R13 was "discharged to facility with Restorative Program." E21-Certified Nurse Aide, was asked on 5/12/16 at 10:35 am if R13 was in a restorative program. E21 stated that sometimes "we will do passive range of motion when dressing or toileting." E21 checked the computer record for R13 and stated that there was no restorative program noted for R13. This was verified with E2, Interim Director of Nurses on 5/13/16 at 10:00 am.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to consistently provide Passive Range of Motion for one of nine residents (R9) reviewed for range of motion in a sample of 15. Findings include: 1. During a Range of Motion observation for R9 on May 12 2016 at 11:00 AM, E14, Restorative	F 318		

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Aide stated "I don't really know what to do for her, I have not done this in three months, we have been short of staff and I haven's done this in so long." and further stated "I don't do anything with her neck. I start with her shoulders" and preceded to move R9's arm in an up and down motion (flexion and extension) 5 times on the right side then repeated the up and down motion to the left arm. E14 then moved to R9's hands, washed them with a wet cloth and moved R9's fingers in abduction and abduction motions for each finger. E14 then started moving R9's left knee in an up and down motion 5 times and then right knee 5 times, then proceeded to the ankles and stated "her ankles will not move at all" while attempting to turn her ankle in a circular motion. E14 made no attempts to perform Passive Range of Motion on R9's elbow, hips, knee, or toes.

According to the Minimum Data Sets (MDS) for R9 dated May 10, 2016 lists R9 as receiving Passive Range of Motion 2 days out of the 7 day look back period for the assessment.

R9's Care Plan with a revision dare of February 20, 2016 lists under Interventions "Restorative Program - Passive Range of Motion: R9 will tolerate PROM exercises to all 4 extremities with no resistance or pain. 5 reps (repetitions) each joint. Date initiated March 2, 2016."

The Admission MDS completed on August 17, 2015 for R2 lists no impairment on R9's Functional Limitations on Range of Motion. The Quarterly MDS assessment for R2 dated May 10, 2016 on Functional Limitations on Range of Motion lists impairment on both sides of R9's upper and lower extremities.

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F 323	Continued From page 24	F 323		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the facility failed to ensure a safe environment free of hazards for 1 of 13 residents (R12) in the sample of 15. Findings Include: 1. On 5/12/16 at 1:00 PM a space heater was observed in R12's room set at 74 degrees Fahrenheit (F). the external surface of this heater was warm to the touch at this time The heater had a warning label placed on the back of the heater. The label states "Risk of fire. Keep combustible materials such as furniture, papers, clothing and curtains at least 3 feet away from the sides and rear." Also, a caution label stating "High temperature, risk of fire. Keep electrical cords, drapery, furnishings, and other combustibles at least 3 feet from the front of the heater and away from the sides and rear." E11 (Maintenance Supervisor) stated in an interview that the facility provides these heaters to residents who are cold, and that he believes that they are safe because they do not heat in excess of 97 degrees F and automatically shut off if knocked over.	F 323		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide an acceptable indication for use of antipsychotic medication, implement behavior tracking and interventions, address identified adverse drug interaction risks, and address identified concerns regarding noted side effects for 3 (R2, R3, R5) of 5 residents reviewed for antipsychotics in a sample of 15.	F 329		

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The findings include:

1. 1. R3 is a 92 year old resident with diagnosis of Dementia with Behavioral Disturbance and Delusional Disorder, as noted on the Admission form. R3's record included 2 documents from the pharmacy, titled "Drug Interaction Information", with dates of 2/9/16 and 3/7/16. Both documents indicate that R3 was receiving Diltiazem which may interact with another medication- Quetiapine Fumarate, that R3 was also taking. The documents indicate that there is a risk for adverse interaction at a Level 2- Severe Interaction, when these two drugs are used concomitantly.

As of 5/12/2016, R3 was continuing to receive these two medications at the same dosage as when the pharmacy, in two consecutive months, addressed the concern.

In addition, a 3/24/2016 pharmacy Consultant Report notes that R3 was started on Seroquel and developed significant movement disorders. The report recommends that R3's dosage of Seroquel be decreased back to a previous dose. The Medication Review Report for March 2016 indicates that R3's dose of Seroquel was increased from 25 milligrams twice daily to 25 milligrams three times a day.

The facility completed an Abnormal Involuntary Movement Scale (AIMS) in December 2015 when R3 was taking Haldol- an antipsychotic medication. At this time the AIMS test scored R3 a 0 for no movement disorder. On March 12, 2016 another AIMS was completed and it showed a "positive" AIMS, and noted that R3 had developed some minimal facial movement in two

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F 329	Continued From page 27 or more areas. There is no indication in the record that Z3, (R3's Primary Care Physician) was made aware of the potential for adverse drug interaction between the Seroquel and the Diltiazem as recommended by the consulting pharmacy. A Nurses Note dated 3/15/16 documents that Z3 was notified of the 3/24/16 pharmacy concern regarding the development of the facial movement and the pharmacy recommendation to decrease the Seroquel. However, there was nothing in the record to indicate that a response was ever received from Z3. On 5/13/2016 at 11:00 am, E2-Interim Director of Nurses, verified that Z3 had not been notified of the drug interaction risk prior to 5/13/2016, and verified that no follow up occurred to ensure that Z3 addressed the change in the AIMS scoring. A 4/27/2016 Physician Progress Note did not address AIMS scoring, facial movement or pharmacy recommendations. Review of R3's medical record revealed no documentation of a rationale to continue these medications despite the noted adverse interaction risk or noted side effects, or a recommendation to attempt a gradual dose reduction. 2. R5's Physician's Order Sheet for 5/2016 includes orders for haloperidol (Haldol) 1 mg (milligram) twice daily with a start date of 3/15/2016 and donepezil (Aricept) 10 mg daily with a start date of 8/31/2015. R5's medical record contains a document dated March 15, 2016 with heading of Omnicare Pharmacies Drug Interaction Information and states the following: "R5 is currently receiving Donepezil 10 mg which may interact with the new order for Haloperidol 1mg. Severity Level: 2 Severe Interaction : Action is required to reduce the risk of severe	F 329		

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adverse reaction. Please review for appropriate action and place this document in the resident's clinical record. Review of R5's medical record revealed no documentation of a rationale to continue these medications despite the noted adverse interaction risk, or a recommendation to attempt a gradual dose reduction.

After the surveyor made E2 aware of this issue, a Progress Note dated 5/13/2016 at 9:19am was presented that states, "Z1's, (R5's physician) office made aware of the potential medication interaction between Aricept and Haldol. Pharmacy recommendations faxed to office for review. Waiting return physician call."

R5's Medication Administration Records for the months of March, April, and May, 2016 indicate that R5 is currently receiving both medications and has been since 3/15/2016.

3. According to the Admission Record, R2 is 74 years old, indicating she is geriatric, and has diagnosis of Dementia with Behavioral Disturbance, and Hallucinations.

R2 is prescribed Risperidone, an antipsychotic, 0.25 milligrams (mg) one tablet BID (twice a day) on October 23, 2015 for a diagnosis of "Hallucinations" with indications for use as "agitation" according to R2's Physician Orders for April, 2016.

Upon review of R2's medical record, no behavior tracking was found, and when discussing behavior tracking and gradual dose reduction May 12, 2016 at 11:25 AM, E2, Interim Director of Nursing states "There has been no gradual dose reduction for (R2) and the behaviors are

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F 329	Continued From page 29 documented in the nursing notes so I will have to look and put something together for the justification for continued use."	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, and record review the facility failed to administer medications as ordered by the physician. There were 31 opportunities with 3 errors resulting in a 9.67 % medication error rate. The errors involved 1 resident (R13) in the sample of 15 and one residents (R16) in the supplemental sample. Findings include: 1. During a medication pass observation on May 11, 2016 at 8:03 AM, E6, Licensed Practical Nurse handed R13 a Proair HFA 90 micrograms (mcg) inhaler 8.5 Grams and R13 pushed the plunger and inhaled, twice within a 5 second period. R13's physician order lists, Proair HFA 90 mcg inhaler 8.5 Grams, prescribed on March 3, 2016 lists one inhalation four times a day. 2. During a medication pass observation on May 11, 2016 at 8:25 AM, E 7, Registered Nurse provided Magnesium Oxide 500 mg one tablet to R16. The physician orders for R16 lists Magnesium Oxide 400 mg one tablet orally three times a day prescribed on February 4, 2016.	F 332		

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F 332	Continued From page 30 During that same medication pass observation, R16 was injected with 10 units of Lantus insulin 100 units per milliter subcutaneous in the left side of R16's abdomen. R16's physician order lists "Lantus 100 unit per milliter give 25 units every AM (morning) and IHS (hour of sleep)", prescribed on February 4, 2016.	F 332		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334		

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F 334	Continued From page 31 that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to offer the flu and pneumonia vaccine to 7	F 334		

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F 334	Continued From page 32 of 15 residents (R1, R2, R5, R6, R8, R11, R13) reviewed for vaccination administration in the sample of 15. Findings Include: 1. The review of the medical record for R1, R8, R11, did not indicate that the flu vaccine was administered or refused, nor if these residents received education regarding the flu vaccine. 2. The review of the medical record for R5 did not indicate the pneumonia vaccine was administered, refused, or if the resident was educated regarding the vaccination. 3. The review of the medical record for R2, R6, R13 did not indicate that the flu or pneumonia vaccine was administered, refused, or if the residents received education regarding the flu and pneumonia vaccine. An interview with E13 (Assistant Director of Nursing) on 10/11/16 at 1:30 PM confirmed that the facility has no verification that the consents were returned, or that the flu and pneumonia vaccine's were offered/administered/refused to the above mentioned residents.	F 334		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by:	F 365		

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F 365	Continued From page 33 Based on observation, interview and record review the facility failed to provide an ordered pureed diet for one out of five residents (R10) reviewed for pureed diets in the sample of 15 and one resident (R18) in the supplemental sample. Findings include: According to the list of Purred diets provided on 5/13/16 by E13 ADON(Assistant Director of Nursing), R10 and R18 are to receive a pureed diet. On 5/10/16 at 12:05 PM, E16 CNA(Certified Nursing Assistant) gave both R10 and R18 a whole slice of a brown cake served in a brown bowl for dessert. R10 proceeded to eat all of hers and then took R18's dessert and had eaten 3/4 of its content. On 5/10/16 at 12:20 PM, E14 CNA came over to the table that R10 and R18 were at and took the bowl R10 had been eating R18's dessert out of and took it away and said to E16 CNA that they (R10 and R18) can't have the breaded pudding they're pureed diets. E14 then proceeded to get both R10 and R18 a clear small dessert bowl of a light yellow pudding like substance. On 5/10/16 at 12:30 PM E15 stated that the stuff in the brown bowls was a breaded pudding cake square and the stuff in the clear smaller clear bowls was pudding. E15 stated the pureed diets were the ones that were supposed to get the clear cups of pudding.	F 365		
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 34 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, record review and interview the facility failed to prepare food in a sanitary manner to prevent potential contamination. This had the potential to affect all 63 residents in the facility. The Findings Include: 1. On 5/10/16 at 9:50 AM during the initial tour of the kitchen the microwave on the counter next to the electric slicer had dried splattered food debris on all surfaces inside the microwave. 2. On 5/11/16 at 12:15 PM E9 (Cook) was observed to place oven mitts on over her latex gloves. E9 then removed a hot pizza pan from the oven and placed the pan on the counter. E9 then removed her oven mitts, and without changing her rubber gloves cut the pizza with a pizza slicer and transferred the cut slices of pizza from the pan to the steam table using her gloved hand. Interview with E8 (Dietary Supervisor) on the expectation of proper hand washing and glove change. He expects hands to be washed and gloves to be changed whenever tasks are performed in the kitchen between preparation and serving.	F 371		

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F 371	Continued From page 35 3. Review of Resident Census and Conditions of Residents Report provided on entrance date of 5/10/16 reported 63 residents.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to address and act upon reported pharmacy concerns for potential drug interactions and development of side effects for 2 of 15 residents (R3, R5) reviewed for medication use in the sample of 15. The findings are: 1. R3 is a 92 year old resident with diagnoses of Dementia with Behavioral Disturbance and Delusional Disorder, as noted on the Admission form. R3's record included 2 documents from the pharmacy, titled "Drug Interaction Information", with dates of 2/9/16 and 3/7/16. Both documents indicate that R3 was receiving Diltiazem which may interact with another medication- Quetiapine	F 428		

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Fumarate, that R3 was also taking. The documents indicate that there is a risk for adverse interaction at a Level 2- Severe Interaction, when these two drugs are used concomitantly.

As of 5/12/2016, R3 was continuing to receive these two medications at the same dosage as when the pharmacy, in two consecutive months, addressed the concern.

In addition, a 3/24/2016 pharmacy Consultant Report notes that R3 was started on Seroquel and developed significant movement disorders. The report recommends that R3's dosage of Seroquel be decreased back to a previous dose. The Medication Review Report for March 2016 indicates that R3's dose of Seroquel was increased from 25 milligrams twice daily to 25 milligrams three times a day.

The facility completed an Abnormal Involuntary Movement Scale (AIMS) in December 2015 when R3 was taking Haldol- an antipsychotic medication. At this time the AIMS test scored R3 a 0 for no movement disorder. On March 12, 2016 another AIMS was completed and it showed a "positive" AIMS, and noted that R3 had developed some minimal facial movement in two or more areas.

There is no indication in the record that Z3, (R3's Primary Care Physician) was made aware of the potential for adverse drug interaction between the Seroquel and the Diltiazem as recommended by the consulting pharmacy. A Nurses Note dated 3/15/16 documents that Z3 was notified of the 3/24/16 pharmacy concern regarding the development of the facial movement and the

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pharmacy recommendation to decrease the Seroquel. However, there was nothing in the record to indicate that a response was ever received from Z3. On 5/13/2016 at 11:00 am, E2-Interim Director of Nurses, verified that Z3 had not been notified of the drug interaction risk prior to 5/13/2016, and verified that no follow up occurred to ensure that Z3 addressed the change in the AIMS scoring.

R3 was observed at 12:15 pm, during the lunch meals on 5/10/16 and 5/11/16 as well as in her room after lunch on those same days and at other random times throughout the survey. No abnormal facial movement was able to be identified at any of these times. A 4/27/2016 Physician Progress Note did not address AIMS scoring, facial movement or pharmacy recommendations.

2. R5's Physician's Order Sheet for 5/2016 includes orders for haloperidol (Haldol) 1 mg (milligram) twice daily with a start date of 3/15/2016 and donepezil (Aricept) 10 mg daily with a start date of 8/31/2015. R5's medical record contains a document dated March 15, 2016 with heading of Omnicare Pharmacies Drug Interaction Information and states the following: "R5 is currently receiving Donepezil 10 mg which may interact with the new order for Haloperidol 1mg. Severity Level: 2 Severe Interaction : Action is required to reduce the risk of severe adverse reaction. Please review for appropriate action and place this document in the resident's clinical record." Review of R5's medical record revealed no documentation of a rationale to continue these medications despite the noted adverse interaction risk, or a recommendation to attempt a gradual dose reduction.

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F 428	Continued From page 38 After the surveyor made E2 aware of this issue, a Progress Note dated 5/13/2016 at 9:19am was presented that states, "Z1's, (R5's physician) office made aware of the potential medication interaction between Aricept and Haldol. Pharmacy recommendations faxed to office for review. Waiting return physician call." R5's Medication Administration Records for the months of March, April, and May, 2016 indicate that R5 is currently receiving both medications and has been since 3/15/2016.	F 428		
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, interview, and record review the facility failed to maintain the facility clean and in good repair. This has the potential to affect all 63 residents in the facility Findings include: 1.On 5/10/2016 at 2:30 pm and again on 5/13/2016 at 10:00 am the 300 Hall common shower at the north end of Hall 300 was noted to have built-up grime and stains on the shower room floor, and debris on the floor of the shower room and under a storage cabinet. The toilet located in the bathroom adjacent to this room had	F 465		

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F 465	Continued From page 39 dark stains around the inside perimeter. 2. On 5/11/2016 at 8:30 am, the 300 Hall common shower room floor needed to be swept of debris. The grab bar cover on a mechanical lift device stored in this room was soiled and stained and the base was dirty. At 8:40 am, a second mechanical lift was noted to need cleaning of the base and grab bar. 3. On 5/12/2016 at 9:30 am, the toilet riser in R3's room was noted to have a rusted area in the metal of the cross bar in the front section of the seat. On this same date at 2:00 PM, the toilet in R12's room contained residue in the bowl and needed to be cleaned. On 5/13/2016 at 9:00 am E5, Registered Nurse verified that 300 Hall showers are the only showers in the facility and used by residents from all 4 halls. The Resident Census and Conditions of Residents report dated 5/10/2016 indicates that there are currently 63 residents residing in the facility.	F 465		
F 469 SS=C	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 469		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 62960

(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 469	Continued From page 40 Based on observation, record review and interview the facility failed to ensure an environment free of pests. This has the potential to affect all 63 residents in the facility. Findings include: On 5/12/2016 at 11:00 am, while R4 was in the bathroom in his room, a spider was noted on R4's bed. During the group interview on 5/10/2016 at 11:am, R19 stated that she had seen spiders in her room on occasion. R20 and R21 both reported seeing bugs or insects in their rooms. On 5/13/2016 at 8:30 am, E10, Certified Nurse's Aid stated that she had seen a spider twice in the past month near the 100 Hall Nurse's station. On 5/13/2016 at 8:40 am, E11, (Maintenance Supervisor) stated that he had received a few sporadic reports from residents of spiders in the facility. E11 went on to say that visits are made to the facility monthly by the facility's pest control provider and he alerts them to any reports or concerns of pests. According to the facility's Resident Census and Conditions of Residents report dated 5/10/2016, there are currently 63 residents in the facility.	F 469		