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

PRINTED: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	025025		06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHAB CENTER OF ANCHORAGE	9100 CENTENNIAL DRIVE ANCHORAGE, AK 99504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were noted during an unannounced standard Medicare/Medicaid recertification survey conducted 6/2-5/14. The sample included 15 active residents and 5 closed records. In addition, 8 non-sampled residents were reviewed. In addition, 4 onsite complaint investigations (AK #2533, AK #2535, AK #2536 and AK #2537) were also conducted. One complaint (AK #2535) was substantiated. Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503 Abbreviations used in this document: IDON: Interim Director of Nursing DON: Director of Nursing RCM: Resident Care Coordinator IP: Infection Preventionist LN: License Nurse CNA: Certified Nursing Assistant MAR: Medication Administration Record SS: Social Services CS: Central Supply EVS: Environmental Services PT: Physical Therapist HR: Human Resources BOM: Business Office Manager	F 000		

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

Samantha Pole — Administrator — 7/18/14

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 000	Continued From page 1	F 000		
F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	F 159		

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F 159	Continued From page 2 The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: . Based on interview and record review the facility failed to ensure residents had access to petty cash after business hours. This failed practice had the potential to affect all residents who had a trust fund account managed by the facility. Findings: During an interview on 6/3/14 at 10:15 am, the HR Manager stated that Residents could get money from their accounts at the front desk, 7 days a week during normal business hours. During an interview on 6/3/14 at 11:00 am, Receptionist #1 reviewed the process for a resident to receive money from their account. A Resident would come to the front desk and request funds; the Receptionist would access their account to assure funds were available; and a voucher/receipt would be printed for the Resident to sign and money was retrieved from the cash box and given to the Resident. The Receptionist further stated funds were available 7 days a week, 8:00 am to 4:30 pm. When asked	F 159	Corrective Actions: Staff have been reeducated on our Trust Fund Policy and Procedure. As explained during survey, access is available 24/7. Communication of the P&P made known to all. Residents will be given communication of the procedure at the next resident council meeting. Also, letter explaining P&P will be given/sent to all residents. Others Potentially Affected: We have addressed the issues for all residents and for new residents – a copy of the P&P will be added to the Admit Packet. Measures to ensure compliance: BOM will do questionnaire quarterly to ensure that all residents are aware of the P&P and understand how to access 24/7. Monitoring: When conducting Abaqis interviews at assessments – question to ask for trust fund access will be added. The BOM has been designated to monitor compliance of the corrective action. Corrective Action Date: 7/18/14	7/18/14

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F 159	Continued From page 3 how a resident would get money after 4:30 pm, the Receptionist replied they wouldn't be able to as far as she knew. An interview with the BOM on 6/3/14 at 11:15 am confirmed the process for Residents to access their funds was to see the front desk receptionist, request the amount needed and sign a receipt. She further confirmed access to funds was 7 days a week during business hours. Record review on 6/3/14 of the Resident Handbook, given to Residents upon admission to the facility, revealed a consent for Residents to establish a trust account if they wanted to. There was no other documentation regarding how a resident would access their monies. Record review on 6/4/14 of the Facility Policy and Procedures, "Resident Trust", revised date 07/2011, revealed "Trust Availability", "the Administrator will determine the amount of cash that is to be available during evenings and weekends....cash will be placed in a locked box and located at the nurse's station..."; The charge nurse will be responsible to distributing cash if requested by the residents....".	F 159		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 4 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 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to: 1) provide ostomy care in a dignified manner for 1 Resident (#7) out of 1 resident who required ostomy care; and 2) provide clothing protectors in a manner to maintain and promote dignity for 7 residents (#s 8; 10; 12; 21; 22; 24; and 25) out of 9 residents observed during various mealtimes on the court dining areas. This failed practice had the potential to negatively affect the residents' self-esteem and quality of life in general. Findings: Findings: Ostomy Care Resident #7 was admitted with diagnoses that included cellulitis (skin infection); abscesses (skin wounds) to lower extremities; weakness; and an ileostomy (a surgical procedure where a portion of the intestine is brought through the abdominal wall to carry stool out of the body). During an interview with Resident #7 on 6/3/14 at 7:30 am, the Resident stated his ostomy bag had been off for 1 ½ hours at the time of change of shift on 6/2/14, the previous day. During an interview on 6/3/14 at 7:30 am, while	F 241		

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F 241	Continued From page 5 CNA #4 was cleaning up fecal matter from on the wall and on the Resident's shoe from the previous shift, she stated this is not the first time the Resident had complained about long waits in the evening/night shift for ostomy care. Clothing Protectors Spruce Court An observation on 6/3/14 at 7:35 am during meal time on Spruce Court, revealed 3 Residents (#s 10, 12, and 22) sitting in the dining area. Each resident had white hand towels across the front of their clothes to protect their clothing while eating their breakfast. Willow Court During an observation on 6/4/14 at 8:50 am on Willow Court, Resident #8 requested a clothing protector before breakfast. LN #2 went to the linen closet to get one and then told Resident #8, "We don't have any right now." The LN then offered the Resident a white hand towel to use as a clothing protector. Alder Court An observation on 6/5/14 at 8:00 am, during meal time on Alder Court, revealed 2 residents sitting at the dining table wearing clothing protectors and	F 241	F-241 Corrective Action: Staff has been educated to always provide care in a professional dignified manner. All nursing care staff has been re-training specifically addressing resident #7's specific ostomy care. Others Potentially Affected: All staff has been trained to ask all residents if they desire to wear a clothing protector. Measures to Ensure Compliance: An adequate volume of clothing protects have been ordered to meet the needs of the community. Resident Council is aware of the ordering of clothing protectors. DNS will delegate checks during meal times. Monitoring: Central Supply will keep inventory controls for adequate supply. Visual checks in dining areas. The director of nursing will assure compliance. Corrective Action date: 7/18/14	7/18/14

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F 241	Continued From page 6 one resident (Resident #21), who was sitting outside of their room, had a white towel laid over their clothing. Cedar Court An observation on 6/5/14 at 8:15 am, during meal time, revealed staff used two hand towels as a clothing protector for Resident #24 in the Cedar Court dining room. At 8:45 am, Resident #25 was also given a hand towel as a clothing protector in the Cedar dining room. During the group interview with the Resident Council on 6/3/14 at 1:00 pm, concerns were expressed by several residents regarding the lack of clothing protectors. The statements that were made were: "They don't have enough for those that want them." "They aren't laundered fast enough." "Some people take them to their rooms." "Many have broken snaps." When the Residents were asked what they were given to use as an alternative, they stated, "Towels." During an interview on 6/4/14 at 7:50 am, the	F 241		

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F 241	Continued From page 7 Activity Director stated the facility does run out of the clothing protectors and towels are used. During an interview on 6/4/14 at 12:45 pm, CNA #5 stated the facility did not have enough clothing protectors so hand and bath towels had to be used for the Residents during meal times.	F 241	F244 Corrective Action: A new procedure has been put in place to follow up on all resident concerns voiced at resident council. Minutes are sent to the Administrator who will then create a grievance and assign to appropriate director for follow-up. Follow up and completed action will be submitted to the resident council for an update at each meeting. Items addressed in survey are being completed and will be resolved. Others Potentially Affected: Addressed for all residents. Above detail for all resident council issues and any grievance outside of resident council will be handled the same way. Compliance measures: The Activities Director will be assigned to monitor delivery of the concerns to the Administrator. Administrator will be responsible for follow-up. Monitoring: Will review during QA meetings for any trends. Review log to ensure all concerns are addressed and closed. Corrective Action Date: 7/18/14	7/18/14
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to communicate, respond, or act upon all of the Resident Council concerns and/or suggestions that were brought forth during the past five months of Resident Council meetings. This failed practice denied the residents the right to have their concerns validated. Findings: A review of Resident Council meeting minutes for	F 244		

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F 244	Continued From page 8 12/17/13 through 5/20/14 revealed the following resident concerns which either had no documented follow up or the response was inadequate: · 1/21/14 dietary concerns regarding food choices; laundry concerns and a request for a laundry bag; concerns with long waits for care due to staffing; · 2/2014 dietary concerns regarding food choices with the note "this issue was addressed and resolved"; loud noise from the vacuum cleaners with the note" [Administrator] will talk to Housekeeping director and see what can be done"; concerns with not enough staffing with note "[Administrator] explained that we are hiring new staff as fast as we can"; · 3/18/14 dietary concerns regarding food choices and long waits before food was served. The Resident Council held a vote to hire a dining room attendant; concerns about loud noise from vacuum cleaners with the note "[staff] have been researching vacuums and still have not found industrial strength vacuums that are quiet"; and · 4/15/14 request for quieter vacuum cleaners with the note "Administration may have found a quieter vacuum and will be testing one soon"; concern regarding bathroom sinks draining slow and tub not working with note "while the tub is being repaired [Resident] could use a tub on either Alder or Poplar court [leave their own court to go to another court for bathing]"; concern about still not having a dining room attendant; dining concerns regarding too much pepper in food; concerns that CNA staff do not listen to Resident's requests in regards to positioning.	F 244		

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F 244	Continued From page 9 During the Resident Council Group Interview on 6/3/14 at 1:00 pm, multiple residents expressed concerns regarding the following: · Staffing, "not enough staff"; · long waits in response to call lights; · wanting more food choices; · there wasn't a dining room attendant to help open ketchup packets, etc; · meals were not served when scheduled; · one tub not working, and Residents have to go to another court to bathe; · noise of the vacuum and the interruption in the dining experience due to a loud vacuum; · CNA staff do not listen to Resident's requests in regards to positioning; · clothing missing from the laundry; and · the Residents did not always get a response as a group from Administration regarding concerns brought forward. Residents stated Administration would say they are "working on it" but did not see any resolution. During an interview on 6/5/14 at 11:00 am, the Administrator confirmed that not all the Resident Council concerns brought forward during the Resident Council have a documented follow up and may have not been communicated back to the residents.	F 244		

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F 247	Continued From page 11 agreed to move but the report did not provide any information on a moving timeline. Record review of the email sent from SS #1 to SS #2 on 5/16/14 at 10:26 am, "[Resident #19], Spruce 101, has agreed to move to Birch 205B...please facilitate moves as soon as possible." Record review of a nursing note, dated 5/17/14 at 7:36 pm, revealed "Resident stated her fibromyalgia was acting up. Resident slept in today and woke up at 1140 [11:40 am]. This nurse notified that resident must clear from room at 1600 [4:00 pm]. Resident upset about short notice and asked why did the social worker not call in the am [morning] time. Resident left court at 1840 [6:40 pm] and moved to Birch after packing up belongings." During an interview with the Administrator on 6/5/14 at 12:00 pm, the Administrator stated she would expect social work to write a progress note about the move and would expect the Resident to be provided with adequate time to move. Record Review on 6/5/14 of the handout "Resident's Rights" given to residents as part of the admission packet revealed, "9. To not be reassigned to a new room within the facility without cause and without adequate preparation for the move in order to avoid harmful effects" and "21. To be fully informed of any changes during their stay in the facility."	F 247	F-247 Corrective Action: Staff have been re-educated to Prestige Policy and Procedures regarding room changes and the timing of room changes. All staff will follow the Prestige Policy for room changes which will afford resident care and services will exceed standards. When a resident agrees or requests to move, adequate timing and a schedule of actual move time will be provided to resident and family. Staff will adhere to schedule and conduct move in its entirety per p&p. Others Potentially Affected: The P&P will be implemented for all residents. Compliance Measures: The lead Social Worker will monitor for 90 days for compliance and will be responsible for compliance. Review at QA meetings for next Monitoring: Lead Social Workers will monitor daily and Administrator will review and audit per month. Monthly QA meetings will include a review of all room moves. Corrective Action Date: 7/18/14	7/18/14
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=E	Continued From page 12 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to ensure residents were provided with an environment that was functional and in good repair. Specifically, the facility failed to: (1) provide a functioning window blind for 1 resident (#19) of 20 sampled residents; (2) provide a functioning closet for 1 resident (#19) of 20 sampled residents; and (3) provide a well maintained Tub Room floor in the Willow Court for all residents that used the Tub Room. These failed practices have the potential to deny the residents the opportunity to have a functioning and well maintained home. Findings: Window Blind During an interview on 6/3/14 at 10:00 am, Resident #19 stated the window blind in their room was broken and was being held together with tape. The Resident stated they were unable to open or close the blind without the blind falling apart. Resident #19 stated they had complained about the blind and that was when staff came in and taped it up. An observation on 6/3/14 at 10:00 am, revealed a window blind in Resident #19's room that had tape holding the blinds to the wall mounts.	F 253	**F 253** **Corrective Action** Prestige Care Anchorage is purchasing Miele S7280 Jazz Commercial Vacuums that will reduce noise pollution to under 70db. Each Vacuum costs $550, ordered through Bed, Bath, and Beyond, Delivery is within 5 Business days. All Resident rooms have been inspected for broken or unserviceable window blinds. 11 broken blinds were found and all have been replaced by Maintenance. All Resident closet wardrobes have been inspected and the large 18" hangers have been removed. The closets are 16 ½ "in depth and Laundry has been directed to only use 16" clothing hangers to ensue the closet doors fully close. All court tub rooms and tile surfaces have been inspected and Maintenance has repaired all cracked or broken tiles using a specialized grout. Thick Layer of Grease and dirt on fire detection line and kitchen hood was cleaned immediately. Contract in place for quarterly deep cleaning in addition to daily cleaning schedule. **Others Potentially Affected** All resident rooms have been inspected for broken blinds, closet doors able to close. All court tub rooms and tiled surfaces have been inspected by Maintenance	7/18/14

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F 253	Continued From page 13 During an environmental tour on 6/4/14 with the Administrator, Maintenance Director, and Maintenance Assistant, it was confirmed the bracket holding the blind was broken and needed to be replaced. Closet During an interview on 6/3/14 at 10:00 am, Resident #19 stated the closet wardrobe was not deep enough to hold standard hangers. An observation on 6/3/14 at 10:00 am of Resident's built in wardrobe revealed the closet was not large enough for the hangers that were provided by the facility to hang the clothes and did not allow the door of the wardrobe to close. During an environmental tour on 6/4/14 with the Administrator, Maintenance Director, and Maintenance Assistant it was confirmed the closet was not large enough for the clothes hangers. Floor Tile An observation during the initial tour of Willow Court on 6/2/14 at 7:00 am, revealed a cracked, broken tile in the Tub Room. During an environmental tour on 6/5/14 of the Tub Room on Willow Court, the Maintenance Director confirmed the floor tile was broken and called staff to repair it.	F 253	**Measures to Ensure Compliance** Prestige staff has been directed to immediately create a Maintenance work order when a broken or unserviceable blind has been discovered. Maintenance will conduct weekly spot inspections to ensure compliance Laundry staff has been directed to use only 16" hangers for residents clothing to ensure all closet doors fully close. Maintenance has been directed to conduct a weekly spot inspection on tub room tile surfaces to ensure compliance. Contracted Vendor to conduct audit. Kitchen staff and maintenance will ensure that the kitchen is free of grease and dirt. Maintenance will conduct a weekly cleaning of kitchen ansuls and fire suppression lines as well as a general clean of appliances. Monitoring: Weekly rounds to check. Maintenance has been given oversight for compliance with reporting to the Administrator . Review during scheduled QA meetings. Corrective Action Date: 7/18/14	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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	025026		06/05/2014

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F 278	Continued From page 14 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. 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, observation, and interview the facility failed to ensure the risk and benefits of devices (lap belt) was assessed for 1 resident (#1) out of 20 sampled residents.The failure to ensure assessments were accurate placed the resident at risk for ineffective care planning and potential harm. Findings:	F 278	F-278 Corrective Action: All residents participating in the use of enablers have been reassessed for their use, new orders will be been attained, new consents and order if necessary will also be attained. Staff has been educated to the Prestige Policy and Procedure for enablers, orders for enables, and all assessment related to enablers, and care planning for use of an enablers. Others Potentially Affected: All residents have been assessed and reviewed. Compliance Measures: These will be monitored and updated quarterly in IDT for any changes in resident needs. Monitoring: The Director of Nursing will assure compliance. Corrective Action Date: 7/18/14	7/18/14

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	025025		06/05/2014

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F 278	Continued From page 15 Record review from 6/2-5/14 revealed Resident #1 was admitted with diagnoses that included cerebral palsy (a disorder of movement, muscle tone or posture that is caused by an insult to the immature, developing brain, most often before birth); rheumatoid arthritis (a chronic, inflammatory, destructive and sometimes deforming collagen disease that has an autoimmune component); and chronic pain. Random observations from 6/2-5/14 revealed the Resident had a seat belt in place while seated in a wheelchair. The Resident was unable to demonstrate the ability to release the seat belt and staff were observed releasing the seat belt to transfer the Resident into a recliner chair. Record review of the Resident's care plan on 6/2-5/14 revealed the problem "resident uses non restraint wheelchair seat belt for positioning and for safety d/t (due to) Cerebral Palsy" with a goal of "Resident will maintain his ability to release seatbelt at will or on command" and an approach to "continue to assess resident's need for use of non-restraint seat belt in wheelchair." During an interview on 6/4/14 at 8:35 am, CNA #4 stated that she usually unbuckled Resident #1's seat belt for transfers. During an interview on 6/4/14 at 8:45 am, LN #6 stated that PT performed the assessment on whether or not Resident #1 could unbuckle the seat belt. Record review of the annual and last quarterly Minimum Data Set (a federally required	F 278		

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F 278	Continued From page 16 assessment tool), dated 12/1/13 and 3/2/14, revealed the Resident was assessed as requiring extensive assistance with dressing, eating, and personal hygiene. During an interview on 6/4/14 at 2:40 pm, the PT stated physical therapy had not seen Resident #1 since 2010 and if the Resident had a seat belt device, it was not a physical therapy recommendation. The PT stated that if physical therapy recommends a device, they usually check it to see that resident is able to release and that device fits resident appropriately. Record review revealed the last assessment of seat belt device was completed 9/12/11 and the original adaptive device assessment and consent was completed in 2007. During an interview on 6/4/14 at 10:30 am, the IDON verified there was no documentation of the Resident's ability to release seat belt and no current annual completed assessment. Record review on 6/5/14 of the facility's policy, "Physical restraints and enablers", revealed a physical restraint defined as "any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts the freedom of movement or normal access to one's body". The policy included the instructions "...if it is determined that a resident has symptom necessitating the use of a physical or mechanical device, the Enabler/Physical Restraint Assessment will be completed when the device is first initiated, annually and on change of condition." The policy further stated, "The Effect not the Intent will be	F 278		

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F 278	Continued From page 17 evaluated in order to determine if the device used is a restraint or an enabler."	F 278	F-280 Corrective Action: Staff have been re-educated to Prestige Policy and Procedures as well as CMS Regulations and will have quarterly IDT meetings as required.	7/18/14
F 280 SS=E	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 record review, interview, and observation the facility failed to ensure an	F 280	Resident #2 - Staff have been re-educated to standard precautions as-well-as transmission based precautions to meet infection control needs. Resident #3 , #7, #9 are addressed under the IDT meeting statement in this Plan of Correction. Resident #11 is addressed under both the IDT paragraph and the statements above for Resident #2 above. Others Potentially Affected: Complete review of system processes was conducted to ensure compliance. Monitoring: The Director of Nursing will monitor and assure compliance. Corrective Action Date: 7/18/14	

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F 280	Continued From page 18 interdisciplinary team of appropriate staff met quarterly, or more often if needed, to review and revise resident care plans after each assessment for 5 (#s 2;3;7;9; and 11) of 16 sampled residents. This had the potential for these residents to not receive appropriate or necessary care and services. Findings: Resident #2 Record review from 6/2-5/14 revealed Resident #2 was admitted to the facility with diagnosis that included leg cellulitis/abscess (an acute inflammation of the connective tissue of the skin). The Resident had an indwelling urinary catheter. The Resident was on contact isolation [precautions for MRSA] (methicillin-resistant Staphylococcus aureus, a type of bacteria resistant to certain antibiotics that survives on skin and objects in the environment). Review of the most recent comprehensive care plan and in-room care plan revealed no problem, goal, or approach related to contact precautions. There were no specific instructions for staff to care for this Resident who was on contact precautions. Review of the Resident's medical record revealed there had been no interdisciplinary care conferences held from October 2013 to April 2014. Resident #3 Record review from 6/2-5/14 revealed Resident #3 was admitted to the facility with diagnoses that included diabetes and dementia (a decline in intellectual functioning, including problems with	F 280		

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F 280	Continued From page 19 memory, reasoning and thinking). In addition, the record revealed from 9/13/13 to 6/5/14 the resident had documented behaviors, a new anti-psychotic medication, wandering, falls, and pressure ulcers. Review of the Resident's medical record revealed the last interdisciplinary care conference report was dated 9/19/13. During an interview on 6/5/14 at 8:35 am, the IDON confirmed the medical record had no documentation of an interdisciplinary team conference since 9/13/13. Resident #7 Record review from 6/2-5/14 revealed Resident #7 was admitted with diagnoses that included urinary tract infection; cellulitis (skin infection); ileostomy (a surgical procedure where a portion of the intestine is brought through the abdominal wall to carry stool out of the body); and kidney disease. Record review of the most recent comprehensive care plan revealed "Last Care Conference: N/A" and "Next Care Conference: N/A" for care conference dates. During an interview on 6/4/14 at 11:15 am, RCM #1 confirmed that no quarterly care conferences had been completed since the Resident's admission on 12/13/13. Resident #9 Record review from 6/2-5/14 revealed Resident	F 280		

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F 280	Continued From page 20 #9 was admitted with diagnoses that included hip fracture and pain. The Resident's drug regimen included Norco, a narcotic pain medication. Review of the physician's order and the MAR, dated 3/1/14, revealed the Norco was discontinued. Review of the most current comprehensive care plan, edited 3/17/14, revealed "...Approach...Administer medications: Norco Q [every] 4 hours PRN [as needed]..." Review of the Resident's medical record revealed the Resident was admitted to the facility 6/2013. The first interdisciplinary care conference was 12/30/13 and the next care conference was held 4/3/14. Resident #11 Record review on 6/2-5/14 revealed Resident #11 was admitted to the facility on 2/18/14 and readmitted to the facility on 5/15/14. The Resident's diagnoses included C-Diff (Clostridium difficile, a spore forming toxin that can develop in the intestines after antibiotic use and causes watery diarrhea). An interview with CNA #1 on 6/2/14 at 11:10 am, revealed Resident #11 was on contact precautions for C-Diff. The CNA stated the nurse told staff to wear a gown and gloves whenever they would change the Resident's brief. Record review on 6/2-5/14 of the Resident's most current comprehensive are plan and in-room care plan revealed no specific instructions for staff to care for the Resident while on contact	F 280		

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F 280	Continued From page 21 precautions. During an interview on 6/5/14 RCM #1 stated contact precautions not was added to the care plan since they may not be on it [contact precautions] that long. During an interview on 6/5/14 at 9:00 am the IP stated she would expect contact isolation [precautions] to be on the Resident's care plan and stated the RCM is responsible for the care plan. Review of the facility policy "Care Conference", dated 1/14, revealed "It is the policy of the facility to hold care conference to validate completion of all components of the MDS process, review care plans developed and discuss current care plan goals and interventions with the resident and/or responsible party." Review of the Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0, most current version dated October 2013, revealed, "...Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g. customary routine, vision, and continence"). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care."	F 280		

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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHAB CENTER OF ANCHORAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 9100 CENTENNIAL DRIVE ANCHORAGE, AK 99504	

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F 280	Continued From page 22	F 280	F-281	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to ensure that care was provided according to professional standards for 2 sampled resident (#s 2 and 17) out of 12 sampled residents whose medical records were reviewed; specifically, the facility failed to follow physician's orders for wound care and pain medication was not given to the Resident prior to physical therapy. Professional standards are developed to maximize quality of care. When professional standards are not followed, residents are at greater risk for poor outcomes. Findings: Resident #2 Record review from 6/2-5/14 revealed Resident #2 was admitted to the facility with a diagnosis that included leg cellulitis/abscess (an acute inflammation of the connective tissue of the skin). The Resident's drug regimen included Silver Sulfadiazine Cream (Silvadene), a topical cream used to treat wounds. Record review from 6/2-5/14 revealed Resident #2 went to a Podiatrist (a physician who treats feet), outside the facility, on 4/23/14. The	F 281	Corrective Action: Licensed staff has been in-serviced to proper medication and treatment transcription to provide care as ordered by physicians. All new physician orders will be transcribed by the licensed nurse and then reviewed by the registered nurse supervisor/RCM to assure accuracy. The community has contracted with a local pharmacy to assure medications are received in a timely manner. Licensed Nursing staff has been in-serviced regarding medication errors and engaged in preparing a QAPI for related to aforementioned errors. Others Potentially Affected: Review includes QAPI prep for all errors. Compliance Measures: Daily checks during MACC meeting with RCMs and RN supervisor. Monitoring: QA review for next year in addition to the daily MACC meeting and review. The Director of Nursing will assure compliance. Corrective Action Date: 7/18/14	7/18/14

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F 281	Continued From page 23 Podiatrist ordered Silvadene cream to be used on the Resident's wounds. Record review from 6/2-5/14 of the physician's orders, revealed no written order for Silvadene cream for the Resident until 5/2/14. During a wound care observation on 6/2/14 at 1:55 pm, Resident #2 asked LN #5, "What is that?", when the LN was ready to put the Silvadene on the wounds. The LN said it was Silvadene. The Resident said,"Finally. It took so long [to get it]." During an interview on 6/3/14 at 1:30 pm, when asked why the Silvadene cream was not available for the Resident until 6/2/14 when it was ordered 5/2/14, LN #5 stated they had noticed the physician's signature was missing on the medication order on 5/31/14. The LN called the nursing supervisor who said the physician was in the facility at that time. LN #5 got the order signed by the physician and faxed it to the pharmacy that day. The medication was received and was started on 6/2/14, approximately 31 days after the original order of 5/2/14. Resident #17 The Resident was admitted to the facility on 4/16/14 for rehabilitation therapy with diagnoses that included hip joint replacement and pain. The Resident's drug regimen included Percocet, a pain medication. Record review of Physician's Orders, dated 4/16/14, revealed the following:	F 281		

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F 281	Continued From page 24 · Percocet 5/325 one tab 30-60 minutes prior to PT (physical therapy) Record review of the "Physician's History and Physical", dated 4/16/14, revealed "Pain control - d/w [discuss with] pt [resident], will schedule Percocet am/HS [morning and hour of sleep] and prior to PT". Review of the Medication Administration Record (MAR) dated, 4/16/14-4/30/14, revealed the Resident received one dose of Percocet 5/325 prior to PT on 4/19/14. The MAR reflects the Resident was not given 13 possible doses between 4/17/14 and 4/30/14. Physical Therapy (PT) notes revealed the Resident was seen 14 times for Physical Therapy between 4/17/14 and 5/2/14. .	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED 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: .	F 282		

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F 282	Continued From page 25 Based on record review and interview, the facility failed to provide feeding tube care in accordance with plan of care for 1 resident (#19) out of 20 sampled residents. This failed practice placed the resident at risk for not receiving professional nursing interventions and placed residents at risk for poor outcomes, including the potential for harm. Findings: Resident #19 was admitted with diagnoses that included endocarditis (inflammation of the inner lining of the heart); cerebrovascular disease (damage to blood vessels in the brain); gastric reflux with nausea; and history of feeding tube (tube placed through the wall of the stomach into the abdomen used to provide nutrition). Record review from 6/2-5/14 of the Resident's care plan, revealed "GI [gastrointestinal] distress R/T [related to] history of GERD [gastric reflux], nausea, vomiting and placement of a new G tube [feeding tube]." The care plan included an approach, "Assess for complications reporting any found to physician and as advised by MD if ordered." During an interview on 6/5/14 at 10:00 am, Resident #19 complained that when she had a feeding tube, staff did not regularly perform feeding tube care and did not flush the feeding tube. Resident also stated that eventually mold grew in the feeding tube. At the time of the survey, the feeding tube had already been removed. Resident #19 stated, "I would come back from [an outing] and ask to have my bloody gauze changed [dressing around the feeding tube] and tube flushed. I would wait up as long as I could." Resident further stated she would fall asleep without the care being provided until the	F 282	F-282 Corrective Action: All licensed staff has been educated to care and services required for feeding tubes. This training included, maintained of the tube, proper flushing and dressing changes. Others Potentially Affected: All residents with feeding tubes have been assessed for appropriate care and documentation of said care. Compliance Measures: DNS will delegate audits to ensure compliance. Review during QA for trends and compliance for next year. The Director of Nursing will assure compliance. Monitoring: Review during QA for trends and compliance for the next year. Corrective Action Date: 7/18/14	7/18/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 26 next day. Record review of the 4/1-30/14 medication and treatment records, revealed an order for water flushes through the feeding tube every shift (day, evening, and night). Further review of the record revealed flushes had not been documented 23 times during the 4/1-30/14 time period. Record review 6/5/14 of the facility policy entitled, "Gastrostomy Feeding Tube", revealed instructions "upon admission or initiation the licensed nurse will obtain a specific physician's order including the following...water flushes." The policy also stated "staff should routinely monitor for signs of complications including nausea, vomiting, diarrhea, gastric distension, pain at the tube site, abdominal cramping/discomfort or signs of aspiration."	F 282		
F 309 SS=E	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:	F 309		

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	025025		06/05/2014

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F 309	Continued From page 27 Based on record review, interview, and observation the facility failed to: 1) ensure medication error reports were reviewed by the Pharmacist for 1 resident (#2) of 20 sampled residents; 2) communicate from shift to shift concerns for 3 residents (#s 2, 7, and 19) regarding scheduled appointments; provision of ileostomy supplies in a timely manner; and room change timing; and 3) assure medications were available for 4 residents (#1, 2, 20, and 23) when requested and or scheduled. These failed practices placed residents at risk for not receiving necessary care and services to maintain the highest practicable well-being. Findings: Medication Error Resident #2 Record review from 6/2-5/14 revealed the Resident was admitted to the facility with diagnoses that included leg cellulitis/abscess (an acute inflammation of the connective tissue of the skin). The drug regimen included morphine IR, an immediate release narcotic pain medication. Record review from 6/2-5/14 of the "Resident Progress Notes", dated 5/27/14, revealed "Noted that on 5/26/14 resident received morphine [narcotic given for pain] 15 mg extended release instead of the intended morphine 15 mg immediate release." Record review of the investigation report revealed the Pharmacist did not review the medication error. During an interview on 6/5/14 at 10:00 am, the	F 309	F-309 Corrective Action: All licensed staff has been educated to Prestige Policy and procedure for Medication and Treatment order for transcription and administering medications, to alleviate medication errors. Licensed staff has been inserviced that both the floor nurse and one other RN will review all transcriptions onto the MARs and cosign for accuracy. Medical Records will establish a calendar that is updated daily for resident appointments for all key staff to review, allowing for better preparation of resident to meet outside appointments. Staff have been re-educated to Prestige Policy and Procedures regarding room changes and the timing of room changes. All staff will follow the Prestige Policy for room changes which will afford resident care and services which exceed standards. The lead Social Worker will monitor for 90 days for compliance and will be responsible for compliance. Residents #1, #2, #7, #19, #20, #23 have all been addressed with the above implementations. Completed 6/28/14. Others Potentially Affected: All were reviewed. Measures to Ensure Compliance: Pharmacy consultant will review all medication errors in a timely manner and offer consulting/inservicing as needed to all Licensed Staff. A review of the ordering process of supplies was performed with the outcome being that supplies will be ordered more frequently in order to meet the needs of the residents. The community has contracted with a local pharmacy to assure medical supplies are received in a timely manner. Monitoring: The Director of Nursing and lead Social Service worker will assure compliance. Corrective Action Date: 7/18/14	7/18/14

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F 309	Continued From page 28 IDON stated it was the DON's responsibility to review medication errors and not the Pharmacist. Shift to Shift Communication Resident #2 Record review from 6/2-5/14 revealed Resident #2 was admitted to the facility with diagnoses that included leg cellulitis/abscess (an acute inflammation of the connective tissue of the skin) and urinary tract infection (an infection that affects any part of the urinary system - kidneys, ureters, bladder and urethra). During an observation on 6/4/14 at 2:30 pm, LN #1 told the Resident he had a VA (Veterans Administration) appointment today. The Resident stated the appointment was yesterday and not today. During an interview on 6/5/14 at 11:50 am, when asked how appointments were communicated between shifts LN #1 stated appointments were to be passed on from LN to LN at change of shift and that appointments were written on a desk calendar. In addition, LN #1 stated at change of shift today the LN did not talk about the Resident having a VA appointment. Review of the large desk calendar for appointments revealed the Resident had a VA appointment written for 3:00 pm on both 6/3/14 and 6/4/14. Resident #7 Resident #7 was admitted with a diagnosis of Ileostomy (a surgical procedure where a portion	F 309		

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F 309	Continued From page 29 of the intestine is brought through the abdominal wall to carry stool out of the body). During an interview on 6/2/14 at 1:00 pm, Resident #7 stated the facility frequently ran out of ileostomy supplies and substituted different types of bags or adhesives when they ran out which didn't always stay on the skin well and had caused skin breakdown. During an interview on 6/2/14 at 1:45 pm, RCM #1 stated the facility had occasionally run out of the supplies for the ileostomy. During an interview the following day, on 6/3/14 at 7:30 am, Resident #7 stated the facility was again out of ileostomy supplies and complained about the long wait for an ileostomy bag change. During an interview on 6/3/14 at 7:30 am, CNA #4 stated they had reported to the LN at the change of shift last evening that the Resident was out of ileostomy supplies and further stated this was not the first time the facility did not have the correct supplies for the Resident's ileostomy. During an interview on 6/3/14 at 10:20 am, with Central Supply regarding ordering ileostomy supplies, staff verified supplies were usually ordered once a month but they can place rush orders and then those supplies usually arrive in 2 days. Record review on 6/3/14 at 10:20 am of Central Supply ordering information, revealed emergency ileostomy supplies had been rush ordered three times; on 3/13/14, 3/24/14, and 5/28/14. Resident #19	F 309		

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F 309	Continued From page 30 Record review from 6/2-5/14 revealed Resident #19 was admitted with diagnoses that included hypertension (high blood pressure) and anxiety. During an interview on 6/5/14 at 10:00 am, Resident #19 stated Social Services told her she would have through 5/18/14 to move into a room on Birch Court. However, on 5/17/14 at 12:00 noon, she was told by staff she had only until 5:00 pm on that day to move to her new room. Record review of the "Social Services Observation Report", dated 5/16/14, revealed Resident #19 agreed to move but the report did not provide any information on a moving timeline. Record review of a nursing note, dated 5/17/14 at 7:36 pm, revealed "Resident stated her fibromyalgia was acting up. Resident slept in today and woke up at 1140 [11:40 am]. This nurse notified that resident must clear from room at 1600 [4:00 pm]. Resident upset about the short notice and asked why the social worker was not called in the am [morning] time. Resident left court at 1840 [6:40 pm] and moved to Birch after packing up belongings." During an interview with the Administrator on 6/5/14 at 12:00 pm, the Administrator stated she would expect social work to write a progress note about the move and would expect the Resident to be provided with adequate time to move. Medication Not Available Resident #1 Record review from 6/2-5/14, revealed Resident	F 309		

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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHAB CENTER OF ANCHORAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 9100 CENTENNIAL DRIVE ANCHORAGE, AK 99504	

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F 309	Continued From page 31 #1 was admitted with diagnoses that included rheumatoid arthritis (a chronic, inflammatory, destructive and sometimes deforming collegen disease that has an autoimmune component) and chronic pain. Record review of the MAR revealed, on 5/21/14 at 12:00 am, the prn [as needed] narcotic pain medication (hydrocodone with Tylenol) was not available. Resident #2 Record review from 6/2-5/14 revealed Resident #2 was admitted to the facility with diagnoses that included leg cellulitis/abscess (an acute inflammation of the connective tissue of the skin) and below the knee amputation. The Resident's drug regimen included morphine IR (immediate release)15 mg, a pain medication. Record review from 6/2-5/14 of the "Resident Progress Notes", dated 5/27/14, revealed: · "14:43 [2:43 pm]...grumpy today with staff. Requested morphine PRN [as needed] 15 mg short acting. No morphine 15 mg IR available...staff pharmacy stated no medication was send [sent] to facility because resident prescription was expired and MD have not renewed it." · "22:09 [10:09 pm] Patient [Resident] was grumpy because he was in pain most of the day. The patient [resident] IR morphine 15 mg script [prescription] was expired and needed to be renewed by physician." During an interview on 6/3/14 at 10:00 am, when	F 309		

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F 309	Continued From page 32 the Resident was asked if the facility ever ran out of any medication he was taking he stated, "They ran out of the instant (immediate) release morphine." He further stated the morphine IR taken with the prescribed Tylenol really helped his pain. During an interview on 6/3/14 at 1:30 pm, LN #5 reviewed the medication administration record for the Resident and confirmed that the facility had been out of the Resident #2's morphine IR and the Resident was given plain Tylenol. Resident #20 Record review from 6/2-5/14 revealed Resident #20 was admitted to the facility on 5/29/14 with diagnoses that included diabetes and a tissue infection. The Resident's drug regimen included verapamil (a heart medication) and insulin. During an interview on 6/4/14 at 9:45 am, the Resident stated last night the facility ran out of verapamil and the evening dose had not been given on 6/3/14. In addition, the Resident stated the heart medication and the insulin are the only 2 medications the Physician said to "never run out of." During an interview on 6/4/14 at 10:05 am, LN #8 reviewed the Resident's MAR and confirmed the verapamil had not been available on 6/3/14 and the Resident had not received the medication. During an interview on 6/2/14 at 11:10 am LN #6 stated the LN on duty was to alert the Nursing Supervisor when the medication card was down to the last 5-6 medications and that Residents should not run out of medications.	F 309		

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F 309	Continued From page 33 Resident #23 Record review from 6/2-5/14 revealed Resident #23 was admitted with diagnoses that included recovery from a motor vehicle accident; fractured tibia; rib fracture; muscle weakness; and high blood pressure. The Resident's drug regimen included a pain medication and amlodipine (used to treat high blood pressure). During an interview on 6/2/14 at 8:00 am, Resident #23 stated the facility ran out of her pain pill and her "heart pill." During an interview with LN #4 on 6/2/14 at 8:30 am, LN #4 reviewed the MAR and verified the Resident had not received the amlodipine for blood pressure, and a pain medication was given from the emergency medication supplies. Record review on 6/5/14 at 3:00 pm, of the facility policy "Shift Reports", dated 1/14, revealed "It is the policy of this facility to communicate information re: resident condition changes to appropriate nursing staff in order to provide the necessary care and service to each resident."	F 309		
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	F 371		

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F 371	Continued From page 34 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure: 1) the kitchen hood and high horizontal surfaces were clean and free of dust and grease; and 2) resident courts were free of expired and unlabeled/undated foods. These failed practices had the potential to place all residents eating food from the kitchen at risk for food borne illness or contamination of food stuffs. Findings: Kitchen Observation during the initial kitchen tour on 6/2/14 at 6:15 am, revealed the fire detection line with the fusible links under the kitchen hood system and the top of the oven, also under the hood, had a thick layer of grease and dust. During an interview on 6/2/14 at 6:35 am, Cook #1 confirmed there was a thick layer of grease on the fire detection line and on top of the oven. In addition, stated the kitchen hood should be cleaned weekly. During an interview on 6/2/14 at 7:30 am, the Dietary Manager confirmed the thick layer of grease on the fire detection line and on top of the	F 371	F-371 Corrective Action - All staff has been inserviced regarding the need to label and date any opened food that is stored in refrigerators and that any outdated food must not be used and thrown away. All staff has been inserviced to proper/sanitary handling of food and food items. The hood has been cleaned effective 6/07/14 and placed on preventive maintenance with an outside vendor. Quarterly a de-greasing will occur commercially in addition to the daily cleaning schedule. Others Potentially Affected: Addressed for all. Compliance Measures: checklists for daily cleaning and auditing were implemented for all items above. Will add to QA meetings for trends for one year. Monitoring: The Dietary Department Head will monitor and the Administrator will assure compliance. Corrective Action Date: 7/18/14	7/18/14

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F 371	Continued From page 35 oven and stated it was cleaned professionally every 6 months. Record review on 6/2/14 at 7:30 am, revealed the kitchen hood and the top of the oven had not been listed on the daily or weekly cleaning schedule. Birch Court During the initial tour on 6/2/14 from 6:15 am-7:30 am of Birch Court, revealed the following: 1 undated, opened gallon of Darigold homogenized milk; 1 undated and unlabeled Atkins meatloaf frozen dinner; and 1 undated and unlabeled container of frozen sticky rice. Cedar Court During the initial tour on 6/2/14 from 6:15 am - 7:30 am of Cedar Court revealed the following: 1 open, unlabeled, undated bottle of vitamin water; 1 open Med Plus 2.0 Vanilla, dated 4/1/14; 1 chocolate cake, dated 5/13; Multiple celery snack packs, discolored brown with brown fluid in the packages with a best if	F 371		

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F 371	Continued From page 36 used by date of 5/8; Multiple jelly packets stored in a cabinet adjacent to "super-sani" chemical cleaning cloths; and White powdered debris present on buffet beverage prep area. During an interview on 6/2/14 at 6:30 am, CNA #3 verified that Med Plus 2.0 and the celery should have been discarded. In addition, the CNA stated it was housekeeping's responsibility to check outdates and keep area clean. An observation on 6/2/14 at 7:45 am, revealed Dietary Aide #1 wiping their nose several times while touching multiple trays in the cart ready to be delivered to the residents. Willow Court During the initial tour on 6/2/14 from 6:15 am-7:30 am of Willow Court revealed the temperature on the refrigerator was 32 degrees and had multiple frozen items in the refrigerator. In addition, the following items were either unlabeled, undated, or both: 1 unlabeled and undated frozen salad; 2 large pitchers of frozen juice; and 1 unlabeled and undated cake.	F 371		

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F 371	Continued From page 37	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that an effective system was in place for checking medications for expiration dates and for removing expired medications from medication and treatment carts. As a result, residents were at risk to receive outdated, potentially subtherapeutic medications. Findings:	F 425	F-425 Corrective Action: RN supervisors will make routine checks of medication carts on each unit weekly for expired medications and will remove any found. Others potentially affected: addresses all residents. Compliance Measures: Being added to the QA meetings for review for a year. Monitoring: The DNS will assure compliance with routine monitoring. Corrective Action Date: 7/18/14	7/18/14

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F 425	Continued From page 38 Birch Court During the initial tour on 6/2/14 from 6:15 am-7:30 am of Birch Court revealed an unopened bottle of Sterile Water for injection, dated 6/1/14, in the supply closet. During the facility environmental round tour with the Administrator, Maintenance Director and Maintenance Assistant on 6/4/14, the Administrator confirmed the bottle of Sterile Water was expired and should not be in the supply closet. Poplar Court Observations on 6/2/14 at 11:10 am of the medication cart, revealed: 1 Ketoconazol cream with an expiration date of 3/12/14; 8 tablets of Famotidine 10 mg with an expiration date of 11/13; and 11 tablets of Ranitidine 150 mg with an expiration date of 4/14. During an interview on 6/2/14 at 11:10 am, LN #6 stated it was every licensed nurse responsibility to check the medication cart for out dates; no single person was responsible. The IDON confirmed there was no policy available for checking medication outdates.	F 425		

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F 425	Continued From page 39	F 425		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	F-441 Corrective Actions: All Staff have been inserviced to Standard and Transmission Based Precautions, including Hand Hygiene and proper PPE use for transmission based precautions guidelines, to include contact precautions. Infection Control Committee meets monthly to review all Infections, and review of investigations, controls, and preventative measures taken for prevention of infections. The Infection Preventionist (Staff Development Nurse) had been inserviced to the appropriate accumulation and reporting of infections to include; investigation, controls and preventative measures to prevent future infections. All Licensed staff and Medical Directors have been inserviced to Prestige (Interact) Care Path: Symptoms of UTI's for care of residents with possible infections and provide proper Antibiotic Stewardship. Residents #2, #5, #6, have all been addressed with the above implementations. Others Potentially Affected: Addressed for all. A review of the ordering process of supplies was performed with the outcome being that supplies will be ordered more frequently in order to meet the needs of the residents, including personal protective equipment. Compliance Measures: DNS will monitor and review prior to monthly meetings. Will be added to QA meeting for one year. Daily rounds by RN supervisors are completed to assure unlabeled personal items or outdated items are not left in common areas During routine Pharmacy consultation visits, Consultant Pharmacist routinely reviews all Antibiotics ordered for residents for appropriate methodology and use. The Consultant Pharmacist communicates his findings to the DNS and Medical Director. Monitoring: DNS will ensure monitoring and compliance. Corrective Action Date: 7/18/14	7/18/14

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F 441	Continued From page 40 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: . Based on record review, observation, and interview the facility failed to ensure: 1) staff understanding and practice of contact isolation; 2) personal care items were labeled with the resident name and/or removed from a community tub room; and 3) the infection control committee had met the requirements of the committee for antibiotic stewardship and that action steps education and infection trending were documented. This failed practice had the potential for increased risk for transmission of infection, cross-contamination and less than optimal use of antibiotics in a vulnerable population. Findings: Contact Precautions Resident #2 Record review from 6/2-5/14 revealed Resident #2 was admitted to the facility with diagnoses that included leg cellulitis/abscess (an acute inflammation of the connective tissue of the skin) and urinary tract infection (an infection that affects any part of the urinary system - kidneys, ureters, bladder and urethra). Random observations from 6/2-5/14 revealed a "Contact Precaution" sign on the doorframe of the Resident's room.	F 441		

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F 441	Continued From page 41 An observation of wound care on 6/2/14 at 1:55 pm, revealed LN #5 did not wear a gown during wound care. During an observation on 6/3/14 at 10:30 am, when asked why the Resident was in contact isolation LN #6 was not sure why, and was not sure where the infection was. During an interview on 6/3/14 at 10:40 am, EVS #1 stated only gloves were needed when entering and cleaning a room that had a contact isolation resident. Random observations on 6/4/14 from 6:50 am to 2:33 pm revealed a chest of drawers, used to store personal protective equipment for contact isolation outside Resident #2's room did not have any gowns for personal protection. During an interview on 6/4/14 at 9:00 am, the IP stated the expectations for staff with Residents who were on contact isolation were to wear gloves and a gown when providing resident cares or housekeeping. Record review of the physician progress notes, dated 4/20/14 at 14:55 (2:55 pm), revealed "...resident has MRSA (methicillin resistant staph aureus) in wound..." and 4/20/14 at 21:22 (9:22 pm), "Dressings to wounds...Staff observed MRSA [contact] precautions..." Review of the MACC (Managing Acute Condition Changes) book, from 6/4-5/14, revealed "4/21/14...Infection...Please access vitals, any bx, c/o [complaints of] pain & s/sx [signs/symptoms] of infection".	F 441		

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F 441	Continued From page 42 Review on 6/5/14 of the facility policy "Transmission Based Precautions", dated 1/14, revealed "Contact precautions: Personnel having contact with the infected resident should wear gloves and a gown." Personal Care Items During the initial tour on 6/2/14 from 7:45 am-8:30 am of the Tub Room on Alder Court, revealed the following unlabeled personal items stored on the shower room shelf: 1 - McKesson flouride toothpaste; 1 - 3 oz. bottle of Afta aftershave skin conditioner; 1 - Dawn Mist shave cream; 1 - 3-N-1 Foam Body Wash; and 2 - Opened packs of Pro Care adult large disposable wash clothes. Further observation of the Tub Room revealed a wall mounted pump dispenser of a 1 gallon 7 fl oz. plastic pump bottle of Aloe Vista Skin Conditioner approximately ¼ full with an expiration date of 3/09. During an interview during the facility environmental tour with the Administrator, Maintenance Director and Maintenance Assistant	F 441		

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F 441	Continued From page 43 on 6/4/14, the Administrator confirmed the personal items stored on the shelf should not be there and removed them for disposal. The expired date on the Aloe Vista Skin Conditioner was also confirmed and the bottle was removed. Infection Control Committee Record review on 6/5/14 at 8:30 am of the "Infection Control Meeting" minutes from 6/2013 - 5/2014, revealed no documentation of discussion for the multiple infections treated with antibiotics that did not meet "infection criteria." The minutes revealed: May 2014: 1 respiratory illness; April 2014: 1 urinary tract infection, 1 skin (infection) and, 2 respiratory illnesses; March 2014: 5 urinary tract infections, 3 skin (infections), and 1 respiratory illness; February 2014: 3 urinary tract infections and 1 respiratory illness; January 2014: 3 urinary tract infections; December 2013: 1 urinary tract infection and 1 skin (infection); November 2013: 3 urinary tract infections and 1 skin (infection); October 2013: 4 urinary tract infections and 2 skin (infections); September 2013: 2 urinary tract infections; and	F 441		

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F 441	Continued From page 44 August 2013: 3 urinary tract infections and 1 respiratory infection. During an interview on 6/5/14 at 9:00 am, the IP stated the Pharmacist had not attended the Infection Control meetings and there was no documentation of antibiotic review by the Medical Director in the meeting meetings. During the interview, the IP was unable to describe how the trending data was used to improve or prevent infections. The IP talked about what actions were implemented but was unable to provide action plans. Record review on 5/8/14 at 8:15 am of the "Summary of Consultation Pharmacist Visit", from 8/2013-5/2014, revealed no documentation of antibiotic review by the pharmacist.	F 441		
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.	F 460		

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F 460	Continued From page 45 This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and record review, the facility failed to ensure the ability to provide full visual privacy for 4 residents (#s 7; 23; 26; and 27) with the potential to effect 18 residents who lived in multiple resident rooms when receiving personal care or when they requested privacy. This failed practice placed the residents at risk for embarrassment, and decreased psychosocial well-being. Findings: Random observations from 6/2-5/14, revealed the following remodeled double rooms lacked the ability to provide privacy for both Residents by either lacking two curtains or by having curtains on tracks that did not track around the bed: Cedar 105, 106, and 113 Alder 205, 206, and 213 Spruce 105, 106, and 113 Willow 105, 106, and 113 Poplar 205,206, and 213 Birch 205, 206, and 213 Resident #7 During an interview on 6/2/14 at 1:00 pm	F 460	F-460 Corrective Action: Bedrooms assure full visual privacy. Invoicing showing that the privacy curtains and tracks were provided to the surveyor. We will ensure that they arrive and are installed for privacy. Others Potentially Affected: addressed for all. Measures to ensure compliance: Central Supply will be responsible for monitoring order and installation. CS will also ensure continued compliance with inventory tracking and management. Monitoring: Central Supply will monitor inventory to ensure that privacy curtains are available at all times. Corrective Action Date: 7/18/14	7/18/14

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F 460	Continued From page 46 Resident #7 stated they had requested a curtain from the facility. Resident #7 also stated the facility does not have one for their side of the room. The Resident also said there is a lack of privacy when their roommate's family comes to visit. In addition, the Resident stated everyone can look into their area of the room and see their wounds and then added, "I get to watch everyone who goes to the bathroom." During an interview on 6/2/14 at 1:45 pm, RCM #1 stated there was no way to provide privacy for the Resident if family was visiting the roommate. Resident #23 During an interview on 6/3/14 at 8:40 am, Resident #23 stated in regards to the room, "There is no privacy" and confirmed that the curtain in the room goes through the middle of her bed and that they were unable to pull a curtain around her bed for privacy. Resident #26 During an interview on 6/3/14 at 8:30 am, Resident #26 was in a double room with no current roommate and stated, "There isn't room here for a second person." The Resident further stated, "It's too small and there wouldn't be any privacy. This should be a single room." Resident #28 During an interview on 6/3/14 at 9:40 am, Resident #28 stated, "I don't like how visitors can	F 460		

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F 460	Continued From page 47 stand in my room...There's no separation." During an interview with the IDON on 6/3/14 at 10:30 am, the IDON stated the curtain tracks did not follow the bed direction for the rooms, did not provide for resident privacy, and needed to be replaced on Cedar Court for rooms 105, 106, and 113. Record review 6/5/14 of "Resident's Rights" handout given to the residents as a part of the admission packet revealed, "...11. To be treated with consideration, respect, and dignity and assured complete privacy during treatment and when receiving personal care."	F 460		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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.	F 514		

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F 514	Continued From page 48 This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure documentation in the medical record was consistent and accurate. Specifically: 1) pain medication in the medication administration record (MAR) was not documented accurately for 1 resident (#2) and 2) lab results were not readily available for licensed care providers to review for 1 resident (#3); and 3) physician's orders were not signed for 9 (#s 2; 3; 6; 10; 11; 12; 15; 16; and 18) out of 20 residents whose medical records were reviewed. As a result staff may have had insufficient information about resident status for making clinical decisions. Findings: Pain Medication Resident #2 Record review from 6/2-5/14 revealed Resident #2 was admitted to the facility with diagnoses that included leg cellulitis/abscess (an acute inflammation of the connective tissue of the skin) and urinary tract infection (an infection that affects any part of the urinary system - kidneys, ureters, bladder and urethra). Resident's drug regimen included morphine IR, an immediate release narcotic pain medication. Review of the Resident's MAR (Medication Administration Record) revealed the Resident received morphine IR multiple times. Review of the narcotic book (narcotic control book used to document when narcotics were given to residents) revealed the documentation of the	F 514	F-514 Corrective Action: All licensed staff have been educated to Prestige Policy and Procedures for Medication and Treatment order for transcription and administering medications, to alleviate any potential medication errors. Licensed staff has been inserviced that both the floor nurse and one other Medical Records has been inserviced to assure that Lab results are available to both the LN staff and Physicians as soon as received for accuracy and timeliness of care. Others Potentially Affected: Addressed for all Compliance Measures: RN will review all transcriptions onto the MARs and cosign for accuracy. This includes the need for physician signature. QA review for a one year. Monitoring: QA review for one year. Review during daily MACC meetings. Corrective Action Date: 7/18/14	7/18/14

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F 514	Continued From page 49 MAR compared to the documentation of the narcotic book, for the same medication of morphine IR, did not match multiple times. Review of the medication error investigation, dated 5/27/14, revealed "...Transferred hospital 'Yes' "...Review of the progress notes revealed the Resident was not transferred to the hospital. During an interview on 6/4/14 at 8:45 am, the IDON was asked who was responsible for auditing MARs and the narcotic book. She said the DON. Lab Results Resident #3 Record review from 6/2-5/14 revealed Resident #3 was admitted to the facility with diagnoses that included diabetes and dementia (a decline in intellectual functioning, including problems with memory, reasoning, and thinking). Review of the Resident's medical record revealed a Physician's order, dated 5/26/14, was written for blood and urine lab tests. During an interview on 6/5/14 at 8:35 am, LN #1 was asked to review the lab results ordered by the Physician with this surveyor and LN #1 was unable to locate the test results. During an interview on 6/5/14 at 9:50 am, the IDON confirmed the lab test results should be available in the electronic record when resulted. Unsigned Physician's Orders	F 514	The RN Supervisors will review daily all ordered Lab work to assure these have been done and to expected date of report. If lab reports have not returned in a timely manner, the RN supervisor will check with Medical Records for results. If results have not returned, the RN Supervisor will contact the lab for results. Medical Records and LN staff have been inserviced for the need to assure that Physician's orders are signed in a timely manner per Prestige policy. (See inservice of6/18) All Licensed Staff have been inserviced to the proper procedures for the Narcotic Count and documentation in the Narcotic Books. A review of resident's charts has been conducted, looking for lack of MD orders. Any orders found have been given to the appropriate physician for signature. Residents #2, #3, , #6, #10, #11, #12, #15, #16, #18, have all been addressed with the above implementations. DNS, RN Supervisors, Medical Records will be responsible for this process. The DNS will assure compliance with routine monitoring.	

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F 514	Continued From page 50 Resident #2 Record review of the physician's orders for Resident #2 revealed multiple orders with no physician's signature. Resident #3 Record review of Resident #3's physician's orders revealed multiple orders with no physician's signature. Resident #6 Record review from 6/2-5/14 revealed Resident #6 was admitted with diagnoses that included dementia (a decline in intellectual functioning, including problems with memory, reasoning, and thinking), anxiety, and chronic pain. Record review of the physician's orders for Resident #6 revealed multiple orders with no physician's signature. Resident #10 Record review from 6/2-5/14 revealed Resident #10 was admitted to the facility with diagnoses that included cerebrovascular disease (damage to the blood vessels in the brain), pain, and anxiety. Record review of the physician's orders for Resident #10 revealed multiple orders with no physician's signature. Resident #11 Record review from 6/2-5/14 revealed Resident	F 514		

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F 514	Continued From page 51 #11 was admitted to the facility with diagnoses that included hip fracture, urinary tract infection, and C-Diff (Clostridium difficile, a spore forming toxin that can develop in the intestines after antibiotic use and causes watery diarrhea). Record review of the physician's orders for Resident #11 revealed multiple orders with no physician's signature. Resident #12 Record review from 6/2-5/14 revealed Resident #12 was admitted to the facility with diagnoses that included transient cerebral ischemia (a blockage of blood supply to the brain) and muscle weakness. The Resident was admitted for rehabilitation and medication management. Record review of the physician's orders for Resident #12 revealed multiple orders with no physician's signature. Resident #15 Record review from 6/2-5/14 revealed Resident #15 was admitted to the facility with diagnoses that included a fractured lumbar vertebra (broken back) and fractured right clavicle (collarbone). The Resident was admitted for strengthening and rehabilitation. Record review of the physician's orders for Resident #15 revealed multiple orders with no physician's signature. Resident #16	F 514		

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F 514	Continued From page 52 Record review from 6/2-5/14 revealed Resident #16 was admitted to the facility with diagnoses that included multiple fractured bones; diabetes; atrial fibrillation (irregular heartbeat); and dysphagia (swallowing disorder). The Resident was admitted for ongoing therapy, rehabilitation. Record review of the physician's orders for Resident #16 revealed multiple orders with no physician's signature. Resident #18 Record review from 6/5/14 revealed Resident #18 was admitted to the facility with diagnosis that included congestive heart failure (a chronic condition that results when the heart muscle is unable to pump blood efficiently). Record review of the physician's orders for Resident #18 revealed multiple orders with no physician's signature. During an interview on 6/5/14 at 8:30 am, the IDON stated the physician's orders should have been signed by the physician. Request for a policy on signing physician's orders had not been provided by the time of exit.	F 514		