STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E361	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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 Annual Certification	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to formulate advance directives and incorporate advance directives into the plan of care for one of 12 residents (R10) reviewed for advance directives in the sample of 12 . FINDINGS INCLUDE: The facility policy, "Advance Directive" dated	F 155		

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

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F 155	Continued From page 1 (revised 11/09/13) directs staff, "At the time of admission each resident, POA (Power of Attorney), guardian or responsible party shall be given written information regarding resident rights and advance directive. At this time, each resident/responsible party will be requested to furnish this facility with copies of all existing advance directives. The day of admission to this facility, the Social Service Designee, Administrator or designee at admission shall meet with the resident/responsible party to review advance directives. After confirming the accuracy of provided documents with the resident/responsible party, the document will be sent for appropriate signatures. Any decision made by the resident shall be indicated in the chart in the manner easily understood by all staff. Code status shall also be recorded on the resident's Physician Order Sheet." R10's facility form, "Profile Face Sheet" documents that R10 was admitted to the facility on 02/23/15. This same form is blank under the "Advance Directives" tab, "Resuscitate". R10's medical record does not include a required state "Uniform Do Not Resuscitate (DNR) Order Form" under the "Advance Directives" tab. R10's current Care Plan, dated 03/12/15, includes the following "Problems": Cognition Loss, Psychotropic Drugs, ADL (Activities of Daily Living) Rehab (Rehabilitation), Continence, Falls, Medical Conditions, Pressure Ulcers and Nutrition. R10's current Physician's Order Sheet, dated June 2015 does not include a physician's order for advance directives.	F 155		

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F 155	Continued From page 2 On 06/23/15 at 10:45 A.M., E3 (Social Services Director) stated, "I don't handle DNR (Do Not Resuscitate) (or) full codes on admission, nursing does." On 06/23/15 at 2:15 A.M., E2 (Director of Nurses) confirmed there was not an advance directive on R10's chart, on R10's current physician's orders nor in R10's current care plan. E2 stated, "Nurses, on admission, explain what DNR (Do Not Resuscitate)/ Full Code entails to residents. The resident or their responsible party makes a decision and obtain the physician's order."	F 155		
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.	F 280		

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to revise the careplan to reflect the current ADL (Activities of Daily Living) status for one of 12 residents (R6) reviewed for careplans in a sample of 12. Findings Include: On 6/22/2015 at 10:15A.M. R6 was up in the hallway walking with wheeled walker with no assistance of staff, was able to sit in a regular chair with no special cushion in the chair and transfer self without assistance of staff. R6's careplan dated 2/4/2015, states, " Use 1:1 assist and gait belt for all transfers. Uses 1:1 limited assist and gait belt for all ambulation. Pressure relieving device in wheelchair." R6 stated on 6/22/15 at 10:30 AM, "I can walk on my own, transfer by myself to and from bathroom and to bed. I don't use a wheelchair or a special cushion in my wheelchair." On 6/23/2015 at 10:00A.M., E9, RN/MDSC (Registered Nurse Minimum Data Set Coordinator), stated, "(R6's) careplan is not updated to reflect current ADL (Activities of Daily Living) status, (R6) is up ambulatory with walker by himself, does not need any assistance from staff, does not use a wheelchair or special cushion."	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 4 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a dressing over a pressure ulcer on two separate occasions for one of three residents (R11) reviewed for pressure ulcers in a sample of 12 . FINDINGS INCLUDE: The facility policy, "Decubitus Care/Pressure Areas" dated (revised 05/07) instructs staff, "Notify the Physician for treatment orders. The Physician's orders should include: Type of treatment, Frequency treatment is to be performed, How to cleanse, if needed, Site of application." On 06/23/15 at 3:25 P.M., E4 and E5, both Certified Nursing Assistants (CNA's), prepared to transfer R11 from the wheel chair to the bed. Upon completion of the transfer, E4 removed R11's pants and adult incontinence brief. A large amount of green, brown liquid stool covered R11's entire buttocks. No pressure ulcer dressing was in place. R11's buttocks were reddened. Numerous, scattered open areas were present across R11's buttocks. A 3 CM (centimeter),	F 314		

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F 314	Continued From page 5	F 314		

stage 2 open area was present on the left buttocks. The pressure area had a yellow center and white edges. E4 removed the stool and applied a thick paste of incontinence cream over R11's entire buttocks. R11 yelled "Ouch, Ouch" throughout the procedure. E4 and E5 then positioned R11 onto R11's left side. Both CNA's then left the room and proceeded into another resident room.

On 06/24/15 at 8:55 A.M., E6 and E7, both Certified Nursing Assistants prepared to transfer R11 from the wheel chair to the bed. Upon completion of the transfer, E7 removed R11's pants and adult incontinence brief. A moderate amount of green, brown liquid stool covered R11's buttocks. R11's buttocks and coccyx area were reddened. A stage 2, 3 CM (centimeter) pressure ulcer was present on the left buttocks, covered in stool. No pressure ulcer dressing was covering the wound. E7 performed incontinence care to R11. R11 yelled, "Ouch, Ouch" throughout the procedure.

R11's "Nursing Admission Assessment" dated 06/04/15 documents a 2.5 CM (centimeter) X 2 CM open area present to the top of R11's left buttocks and a 2 CM X 1.5 CM open area present to the bottom of R11's buttocks.

R11's current Physician Order Sheet, dated June 2015 includes the following physician order: "Cleanse wound to left buttocks with soap and (water), pat dry, apply (calcium compound woven pad) and cover with an island dressing, daily until healed."

R11's current care plan, dated 06/19/15 includes the following approaches: Dressings as ordered

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F 314	Continued From page 6 by the physician. On 06/24/15 at 11:00 A.M., E2 Director of Nurses confirmed a dressing should be in place at all times to R11's buttocks.	F 314		
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 perform a psychotropic assessment for	F 329		

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F 329	Continued From page 7	F 329		

one resident (R10), failed to obtain consent for the administration of a psychotropic medication for two residents (R2 and R10), and failed to perform a gradual dose reduction of a psychoactive medication for one resident (R2), two of eight residents reviewed for psychoactive medications in the sample of 12.

FINDINGS INCLUDE:

The facility policy, titled" Psychotropic Medication Policy" dated (revised 12/30/13) directs staff to, "Initiate a Pre-Psychotropic Medication Assessment (prior to the start of therapy), Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative and Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue the drugs."

1.) R10's facility "Profile Face Sheet" documents that R10 was admitted to the facility on 02/23/15.

R10's "Admission Medication Care Plan" dated 02/23/15 documents R10 's admission medications included: Alprazolam, Risperidone and Trazadone.

R10's "Pharmacy Consulation Report" dated 04/01/15 includes the following comments,"(R10) receives several psychotropic medications, but a signed/dated informed consent form was not found in the resident record."

R10's "Psychotropic Medication Consent" for Alprazaloam, Risperidone and Trazadone was

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F 329	Continued From page 8 dated 04/13/15 by R10's Representative. R10's medical record also contained no psychotropic medication assessment On 06/23/15 at 2:15 P.M., E2 (Director of Nurses) confirmed the only signed consent forms for R10's psychotropic medications were dated 04/13/15. E2 also stated, "Nurses are to obtain a consent form from a resident or a (resident's) responsible party when a Physician orders a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic medicine is ordered." 2. R2's Physician's Orders dated 6/1/2015 thru 6/30/2015 documents Amitriptyline HCL 50 mg (milligram) anti-depressant take one tablet by mouth at bedtime. On 6/22/2015 at 10:30A.M. the consent for the Psychotropic drug Amitriptyline was not found in the chart. On 6/23/2015 at 12:45A.M., E2 RN DON (Registered Nurse Director of Nurses) states, "I could not find the consent for R2's Psychotropic medication Amitriptyline." 3. R2's Consultation Report dated October 1, 2014 thru October 2, 2014 recommendations: taper Amitriptyline to 25 mg at bedtime for 7 days then discontinue. Again in December 1, 2014 the recommendation documents to consider tapering Amitriptyline to 25mg at bedtime for 7 days then discontinue, and add Melatonin at bedtime. In March 1, 2015 the consultant report for R2 recommends to taper Amitriptyline to 25 mg at	F 329		

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F 329	Continued From page 9 bedtime for 7 days then discontinue. On 6/25/2015 at 9:20A.M. E2, RN/DON (Registered Nurse /Director of Nurses), stated, "I expect the nurses to reduce the psychotropic medication as directed by Physician."	F 329		
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 that ensure that --	F 334		

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F 334	Continued From page 10 (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, observation and record review, the facility failed to document the status of the pneumococcal vaccine and/or influenza	F 334		

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vaccine for ten of 12 residents reviewed for immunization status (R2, R3, R4, R6, R7, R8, R9, R10, R13 and R14), in the sample of 12 residents.

Findings include:

The facility policy titled, "Immunization of Residents" indicates that the facility, "Will offer (to residents) immunizations and vaccinations that aid in the prevention of infectious diseases.," Offer the Pneumonia vaccine as a one time dose unless a second dose is recommended by the resident's physician," "Offer the influenza immunization annually from October 1st through March 31st (with physician order)" and "Review the resident's Immunization Record, Physician Order Sheet (POS) and Consent form to verify timing of previous vaccinations, allergies and contraindications."

On 06/23/15, during the tour of the medication storage room, it was noted that the locked medication refrigerator did not contain any vials of pneumococcal or influenza vaccines.

1. R14's Admission Data Sheet indicates that R14 was admitted during the fluvac administration season on 03/19/15. R14's Immunization Record Sheet has no documentation of R14 receiving either the fluvac or the pneumovac.

R14's March and April 2015 Physician Order Sheet (POS) indicates that, as part of the facility's standing orders, R14 may receive the fluvac and pneumovac.

Review of R14's entire current, closed record

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indicates R14 had a short term stay of 29 days, but contains no data, history or documentation of ever receiving or being offered the fluvac or pneumovac in that time frame.

2. R13's June 2015 Physician Order Sheet (POS) indicates that, as part of the facility's standing orders, R13 may receive the fluvac and pneumovac.

The facility provided, on 06/23/15, an immunization tracking form for all current residents. R13 was not listed on this form as receiving or refusing a pneumovac.

R13's current medical record has no data, history or documentation of ever receiving or being offered the pneumovac.

3. Similar issues, as noted above, regarding the lack of documentation in current medical records and/or failure to maintain separate tracking sheets for pneumovac and/or fluvac status were noted with R2, R3, R4, R6, R7, R8, R9, and R10, also.

On 06/23/15 at 1:50 P.M., E2, Director of Nursing (DON), stated that E2 had been working in the facility for the past month. E2 stated that the previous DON, "Was supposed to have ordered the pneumococcal vaccination (pneumovac) serum when the previous DON had left, "But it has not arrived as of yet." On 06/24/15 at 1:30 P.M. E2 stated that E2 did not know why influenza vaccines (fluvac) had not been offered to (R6, R7, R8, R9, R10 and R14) during the dates as noted in the facility's policy, but assigned the failure on the part of the previous DON.

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F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have the minimum required Registered Nurse hours for two of 14 consecutive days. This failure has the potential to affect all 46 residents in the facility. Findings include: The facility Registered Nurse Staffing sheet from 6/8/15 through 6/21/15 indicated that on 6/13/15 and 6/14/15, the facility did not have a Registered Nurse scheduled in a 24 hour period. On 6/25/15 at 9:20 a.m. E2/ DON (Director of Nursing) verified that in a 24 hour period on 6/13/15 and 6/14/15, the facility did not have Registered Nurses working in the facility. According to the Resident Census and Conditions of Residents, Centers for Medicare and Medicaid Services-672 form, dated 6/22/15, the facility's current census is 46.	F 354		

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F 441 SS=E	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 transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Facility non-compliance resulted in two deficient practices: A. Based on observation, interview and record review, the facility failed to perform hand hygiene between medication administration for four residents (R15, R16, R17, and R18) and failed to wear protective personal equipment while handling medications for one resident (R2), five of seven residents reviewed for infection control in a sample of 12. B. Based on observation, interview and record review, the facility failed to perform incontinence care to prevent cross contamination for R7 and R11, two of seven residents reviewed for infection control in a sample of 12. A. The facility policy, titled "Medication Administration" dated (revised 10/27/10) directs staff, "Appropriate hand washing or use of an alcohol based gel must be performed throughout the medication pass. This should occur: Before and after medication pass, After touching an oral medication during administration. It is acceptable to use an antiseptic gel type solution between residents." On 06/22/15 at 11:40 A.M., E11 (LPN) Licensed Practical Nurse prepared to administer medications to R15. Without performing hand hygiene, E11 (LPN) punched two tablets of medication from a numbered medication card into a medication cup, filled a cup with water, administered the medication to R15, took the used medication cup and water cup and placed them in the trash, documented the administration	F 441		

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in the Medication Administration Record and then prepared to administer medication to R16. Without performing hand hygiene, E11 (LPN) continued to administer medications to R16, R17 and R18.

On 06/22/15 at 2:18 P.M., E11 (LPN) stated, "I use sanitizer after every third administration."

On 06/23/15 at 2:15 P.M., E2 Director of Nurses stated, "It is acceptable to use hand gel between residents."

On 6/22/2015 at 11:40A.M. E10 LPN (Licensed Practical Nurse) did not wash hands before administering Hydro/Acetamin 5-325 Tab (tablet) po (by mouth) to R2. E10 punched the medication out of the bubble pack with bare fingers, and placed the medication in a small medication cup. E10 then proceeded to administer the medication to R2.

On 6/22/2015 at 11:50 A.M. E10 administered Lamotrigine 25 mg (milligrams) to R19 without washing hands before or after the administration of the medication.

B. The facility policy, titled "Perineal Cleansing" dated (revised 9/21/10) instructs staff to, "Position resident on back with knees bent and slightly apart. Wet wash cloth with cleansing agent chosen. Wash pubic area including upper inner aspect of both thighs and frontal portion of perineum (as well as the penis and scrotum). Use long strokes from the most anterior down to the base of the labia.(For males, Retract foreskin and wash carefully, then wash under the scrotum.) Follow same sequence for rinsing area. Dry thoroughly. Instruct or assist resident to turn on

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side with top leg slightly bent. Wash peri-anal area thoroughly with each stroke beginning at the base of the labia and extending up over the buttocks (for males, cleanse the anal area, ending with center of the anal area). Rinse entire area in the same sequence. Dry area thoroughly.

On 06/23/15 at 9:50 A.M., E12 and E13 both Certified Nursing Assistants (CNAs) prepared to perform catheter care for R7. E12 removed R7's pants and adult incontinence brief, then wet the end of a bath towel with water and soap from a wall dispenser. E12 CNA applied the end of the soapy towel to R7's scrotum and inner thighs, then retracted R7's foreskin and wiped around R7's penis in a circular motion. E12 CNA then handed the bath towel to E13 and stated, "Get this wet so I can clean (R7)'s bottom when (R7) stands up." E13 wet the end of the towel with water, and while handing the towel back to E12, the bath towel came unfolded and the used end of the towel came into direct contact with the entire front of E12's uniform top.

On 06/13/15 at 10:09 A.M., E12 stated, "I guess I need to be more careful."

On 06/24/15 at 8:55 A.M., E6 and E7, both Certified Nursing Assistants (CNA's) prepared to perform incontinence care for R11. Both CNAs applied gloves and transferred R11 from the wheel chair to the bed. E6 removed R11's pants and adult incontinence brief. R11 had a moderate amount of green/brown stool present in brief and on (R11)'s skin. E7 began cleaning R11 with a soapy wash cloth in the coccyx area. Once the stool was removed from R11's bottom, E6 rolled R11 onto R11's back. Without changing gloves and with obvious signs of stool present on gloves,

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F 441	Continued From page 18 E7 washed and dried R11's peri area and inner thighs. On 06/24/15 at 2:15 A.M., E2/Director of Nurses confirmed incontinence care should be performed beginning with the cleanest area to the dirtiest area.	F 441		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to perform a physician ordered laboratory monitoring for one resident (R6) of 12 reviewed for careplans in a sample of 12. Findings Include: The facility policy titled, "Laboratory Test" dated, 01/02 documents under procedure: 2. "Fasting Blood Glucose will be done monthly on all diabetics receiving insulin unless ordered by the physician." R6's Physician's Orders dated, 6/1/2015 thru 6/30/2015 documents a diagnosis of Diabetes Mellitus and Insulin injections at bedtime. R6's Physician's Orders dated, 6/1/2015 thru 6/30/2015 states," FBS (Fasting Blood Sugar) to be drawn monthly."	F 504		

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F 504	Continued From page 19 R6's medical record contained no laboratory results for FBS since February 2015. On 6/23/2015 at 12:35P.M., E2, RN/DON (Registered Nurse/Director of Nurses) stated that FBS labs have not been drawn for R6 since February 2015."	F 504		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to transcribe a medication to the current physician's order sheet for one resident (R19) of 12 in a sample of 12 reviewed for medical records accuracy. Findings Include: On 6/22/2015 at 11:50A.M. during medication pass, E10 LPN (Licensed Practical Nurse) administered Alprazolam 0.5mg (milligram) to	F 514		

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F 514	Continued From page 20 R19. R19's Physician's Orders dated 5/27/2015 documents, "Alprazolam 0.5 mg at 8A.M. and 12P.M." R19's Medication Record dated 5/26/2015 documents, "Alprazolam 0.5 mg: give one every AM and Noon." R19's current Physician Orders dated 6/1/2015 thru 6/30/2015 does not document the Alprazolam 0.5 mg order. On 6/23/2015 at 1:55P.M. E2, RN/DON (Registered Nurse/ Director of Nurses) states, "I didn't get the Alprazolam transcribed to the current June's orders."	F 514		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		

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F 520	Continued From page 21 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to hold two of the four quarterly Quality Assurance meetings over the past year. This failure has the potential to affect all 46 of the facility's residents. Findings include: The facility policy for Quality Assurance (QA) Committee was requested on 06/24/15 and again on 06/25/15. On 06/25/15 E1, Administrator, stated that the (corporate owner's main office) stated there was no policy specific to the Quality Assurance Committee for all their facilities. On 06/24/15, E1, Administrator, was asked to provide the sign-in sheets for the quarterly QA meetings. E1 stated that, for various reasons, both the July 2014 and October 2014 QA meetings had not been held and, therefore, there were no sign-in sheets for those dates. E1 verified that E1 was aware this was a requirement. According to the Resident Census and Conditions of Residents, Centers for Medicare and Medicaid Services-672 form, dated 6/22/15, the facility's current census is 46.	F 520		

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