STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 274 SS=D	MDS 3.0 Focus and Staffing Survey 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to ensure Minimum Data Set assessments (MDS) accurately reflected residents Significant Change in Status for one of ten residents (R3) reviewed for MDS assessments in a sample of ten.

Finding include:

The facility's Change in a Resident's Condition or Status policy, dated 9/2013, documents, "A 'significant change' of condition is a decline or improvement in the resident's status that: Impacts more than one area of the resident's health status...If the significant change in the resident's

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/06/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

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F 274	Continued From page 1 physical or mental condition occurs a comprehensive assessment of the resident's condition will be conducted as required by the current OBRA (Omnibus Budget Reconciliation Act) regulations governing resident assessments and as outlined in the MDS (Minimum Data Set) RAI (Resident Assessment Instrument) Instruction Manual." R3's MDS, dated 1/22/16, documents in Section E Behavior that R3 has no Physical or Verbal behavioral symptoms towards others, in Section G Functional status that R3 requires one person physical assist for bed mobility and dressing, and in Section H Bladder and Bowel that R3 is frequently incontinent of urine. R3's MDS, dated 4/15/16, documents in Section E Behaviors that R3 had physical and verbal behaviors directed towards others that occurred one to three days and compared to the prior assessment R3's behavior status had worsened, in Section G Functional status that R3 requires two persons physical assist for bed mobility and dressing, and in Section H Bladder and Bowel that R3 is always incontinent of urine. On 6/22/16 at 12:00 p.m., E3 (MDS Coordinator) stated, "If two or more areas decline then we implement a significant change. Three sections of (R3's) 4/15/16 MDS worsened. There wasn't a significant change MDS done for this, it was a quarterly assessment."	F 274		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

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F 278	Continued From page 2 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 interview and record review the facility failed to ensure Minimum Data Set assessments (MDS) accurately reflected residents' status for five of 10 residents (R1, R2, R5, R6, R7) reviewed for MDS in a sample of 10. Findings include: 1. R2's Accident log dated 4/5/16 documents R2 sustained a fall without injury on that date.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

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F 278	Continued From page 3	F 278		

R2's MDS dated 4/13/16 Section J1800 Any Falls Since Admission/ Entry or Reentry or Prior Assessment documents R2 had no falls during the assessment period. R2's MDS Section J1900 Number of Falls Since Admission/ Entry or Reentry or Prior Assessment was left blank.

On 6/22/16 at 10:00a.m. E3 (MDS Coordinator) stated E3 documents residents' falls on the MDS. E3 verified R2 sustained a fall without injury on 4/5/16. E3 stated R2's MDS dated 4/13/16 Sections J1800 and J1900 were incorrect. E3 verified R2's 4/13/16 MDS Sections J1800 and J1900 should have been documented to reflect R2 had one fall with no injury since admission/entry or reentry or prior assessment.

2. R5's MDS dated 5/23/16 and 5/30/16 Section M0300 Current Number of Unhealed Pressure Ulcers at Each Stage documents that R5 has two stage II pressure ulcers which were present upon admission/entry or reentry. R5's MDS dated 5/30/16 Section M0900 Healed Pressure Ulcers documents that R5 has two healed stage II pressure ulcers.

R5's Wound Care Log dated 4/21/16 to 6/12/16 documents that R5 was admitted to the facility 4/21/16 with two stage II pressure ulcers, one to the right and left buttock, which healed on 6/12/16.

On 6/22/16 at 11:05a.m. E4 (Wound Nurse) verified R5 was admitted to the facility on 4/21/16 with two stage II pressure ulcers, one to the right and left buttock. E4 also verified R5's pressure ulcers were healed on 6/12/16. E4 stated that R5 was discharged with return anticipated to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

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F 278	Continued From page 4 hospital on 5/10/16 and returned to the facility on 5/16/16 at which time R5's pressure ulcers were still stage II pressure ulcers. On 6/22/16 at 10:00a.m. E3 (MDS Coordinator) stated E3 documents residents' pressure ulcers on the MDS. E3 verified R5 had two stage II pressure ulcers when R5 was discharged to the hospital on 5/10/16. E3 also verified R5's pressure ulcers were unchanged when R5 returned to the facility 5/16/16. E3 verified R5's wounds did not heal until 6/12/16. E3 stated R5's MDS dated 5/23/16 and 5/30/16 section M0300 and R5's MDS dated 5/30/16 section M0900 were incorrect and should have been coded to reflect that R5's pressure ulcers were not present on admit and they were not healed during the look back period of the 5/30/16 MDS. 3. R1's MDS (Minimum Data Set), dated 2/26/16, documents in Section M Skin Conditions that R1 has one unstageable pressure ulcer that was present upon admission/entry or reentry. R1's Admission Assessment, dated 7/24/15, documents that R1 was admitted with an unstageable pressure ulcer to R1's right heel. R1's Electronic Census Activity documents that R1 was discharged on 8/6/15 and was readmitted on 8/25/15. R1's MDS (Minimum Data Set), dated 5/27/16, documents in Section M Skin Conditions that R1	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(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 278	Continued From page 5	F 278		

has one unstageable pressure ulcer that was present upon admission/entry or reentry and no measurements of the wound are documented.

R1's Wound Assessment, dated 6/21/16, documents that on 5/21/16 R1's right heel pressure ulcer was unstageable and measured 2.2 cm (centimeters) x 2.2 cm x 0.2 cm.

On 6/22/16 at 11:05 a.m., E4 (Wound Nurse) stated, "(R1's) right heel has always been unstageable. (R1) went out to the hospital, and it got bigger but was still unstageable."

On 6/22/16 at 12:00 p.m., E3 (MDS Coordinator) stated, "(R1's) 5/27/16 MDS I should have put measurements in for (R1's) unstageable pressure ulcer. (R1's) pressure ulcer has always been unstageable. So on (R1's) 2/26/16 and 5/27/16 MDS present on admission should not have been coded."

4. R6's MDS (Minimum Data Set), dated 4/28/16, documents in Section I Active Diagnoses that R6 did not have a UTI (Urinary Tract Infection) in the last thirty days.

R6's Nurse's notes, dated 4/11/16, documents that R6 had a temperature of 103.5 degrees Fahrenheit and no urine output so the Nurse Practitioner was called and ordered to have R6 sent to the hospital for possible sepsis.

R6's Urine Culture, dated 4/12/16, documents that R6's urine cultured positive for greater than 100,000 colonies/ml (milliliter) of Escherichia coli.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

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F 278	Continued From page 6	F 278		

R6's hospital discharge summary, dated 4/15/16, documents that R6 had severe sepsis with the urinary source.

R6's Physician's orders, dated 6/21/16, documents that on 4/15/16 R6 received an order to receive Ampicillin (antibiotic) 500 mg (milligrams) by mouth four times a day for 10 days.

R6's MDS (Minimum Data Set), dated 5/12/16, documents in Section I Active Diagnoses that R6 did not have a UTI (Urinary Tract Infection) in the last thirty days.

R6's Urine Culture, dated 5/6/16, documents that R6's urine cultured positive for greater than 100,000 colonies/ml of Escherichia coli.

R6's Nurse's notes, dated 5/4/16, documents that a follow up urinalysis was obtained.

R6's Nurse's notes, dated 5/6/16, documents that R6 was seen by the Nurse Practitioner and was started on Cephalexin (antibiotic) 500 mg (milligram) by mouth every six hours for ten days to treat the Escherichia coli in R6's urine.

On 6/22/16 at 12:00 p.m., E3 (MDS Coordinator) stated, "Both (R6's) 4/28/16 and 5/12/16 MDS should have been coded that (R6) had a UTI in the past thirty days."

5. R7's MDS (Minimum Data Set), dated 5/30/16, documents in Section I Active Diagnoses that R7 did not have a UTI in the past thirty days.

R7's Nurse's notes, dated 5/10/16, documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(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 278	Continued From page 7 that R7 had blood tinged urine in R7's urinary catheter drainage bag, and new order was received to obtain an urinalysis for hematuria. R7's Physician's Orders, dated 6/21/16, documents that on 5/10/16 R7 received an order to receive Cipro (antibiotic) 500 mg by mouth two times a day for ten days for the diagnosis of UTI. R7's Urine Culture, dated 5/13/16, documents that R7's urine cultured positive for greater than 100,000 colonies/ml of Proteus mirabilis and Escherichia coli. On 6/22/16 at 12:00 p.m., E3 (MDS Coordinator) stated, "(R7's) 5/30/16 MDS should have been coded that (R7) had a UTI in the past thirty days."	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(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 279	Continued From page 8	F 279		

§483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to develop a comprehensive plan of care with interventions for the use of an antipsychotic medication for five of 10 residents (R1, R2, R3, R4, R8,) reviewed for care plans in a sample of 10.

Findings include:

A Care Plans-Comprehensive policy dated 9/2010 states, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs is developed for each resident."

1. R2's physician's orders (POS) dated 6/14/16 document R2 was prescribed Risperidone (antipsychotic) 1mg (milligrams), one tablet every morning and Risperidone 0.5mg, three tablets every night.

R2's current care plan does not include a comprehensive plan of care with interventions for the use of the antipsychotic medication Risperidone.

On 6/22/16 at 9:15a.m. E3 (Minimum Data Set/MDS Coordinator) stated E3 develops residents' care plans. E3 verified R2's care plan did not include a comprehensive plan of care with interventions to address R2's care while taking an antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(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 279	Continued From page 9	F 279		

2. R4's physician's orders (POS) dated 6/10/16 document R4 was prescribed Quetiapine (antipsychotic) 25mg (milligrams), one tablet every morning and Quetiapine 50mg, one tablet every night.

R4's current care plan does not include a comprehensive plan of care with interventions for the use of the antipsychotic medication Quetiapine.

On 6/22/16 at 9:15a.m. E3 (Minimum Data Set/MDS Coordinator) stated E3 develops residents' care plans. E3 verified R4's care plan did not include a comprehensive plan of care with interventions to address R4's care while taking an antipsychotic medication.

3. R8's physician's orders (POS) dated 3/25/16 document R8 was prescribed Quetiapine (antipsychotic) 25mg (milligrams) two times daily.

R8's current care plan does not include a comprehensive plan of care with interventions for the use of the antipsychotic medication Quetiapine.

On 6/22/16 at 9:15a.m. E3 (Minimum Data Set/MDS Coordinator) stated E3 develops residents' care plans. E3 verified R8's care plan did not include a comprehensive plan of care with interventions to address R8's care while taking an antipsychotic medication.

4. R1's Physician's Orders, dated 6/20/16, document that R1 has an order to receive Abilify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(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 279	Continued From page 10 (antipsychotic) 5 mg (milligrams) by mouth daily. R1's Care plan, dated 6/20/16, has no comprehensive care plan addressing R1's use of an antipsychotic. On 6/22/16 at 12:00 p.m., E3 (Minimum Data Set Coordinator) stated, "There is no care plan addressing (R1's) antipsychotic. 5. R3's Physician's Orders, dated 6/20/16, document that R3 has an order to receive Seroquel (antipsychotic) 12.5 mg (milligrams) by mouth two times a day. R3's Care plan, dated 6/20/16, has no comprehensive care plan addressing R3's use of an antipsychotic. On 6/22/16 at 12:00 p.m., E3 (Minimum Data Set Coordinator) stated, "There is not a care plan for the use of (R3's) Seroquel."	F 279		
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	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(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 280	Continued From page 11	F 280		

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 observation, interview, and record review, the facility failed to revise a comprehensive care plan with the development of a pressure ulcer for one of three residents (R3) reviewed for pressure ulcers in the sample of ten.

Findings include:

The facility's Wound Care log, dated 6/2016, documents that on 5/30/16 R3 acquired an in house pressure ulcer to R3's left buttock.

On 6/21/16 at 12:50 p.m., E5 (Licensed Practical Nurse) and E4 (Wound Nurse) positioned R3 to R3's right side. A quarter sized round wound with dark brown/black tissue covering about 70% of the wound bed was on R3's left buttock.

R3's Risk for Skin Breakdown Care plan, dated 6/20/16, has no documentation addressing R3's pressure ulcer to R3's left buttock nor did it document any new interventions when R3's pressure ulcer was discovered.

On 6/22/16 at 12:00 p.m., E3 (Minimum Data Set Coordinator) stated, "(R3's) pressure ulcer was not addressed on (R3's) care plan. I didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(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 280	Continued From page 12 implement any new interventions for the pressure ulcer on (R3's) care plan."	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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, interview, and record review the facility failed to prevent a pressure ulcer from worsening, to ensure that a pressure ulcer treatment was in place, and to maintain a clean field during a pressure ulcer dressing change for one of three residents (R3) reviewed for pressure ulcers in the sample of ten. Findings include: The facility's Pressure Ulcer Treatment policy, dated 2/2014, documents, "Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed...The following equipment and supplies will be necessary when performing this procedure: Establish a clean field; Place the clean equipment on the clean field;...Apply the ordered dressing and secure	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

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F 314	Continued From page 13	F 314		

with tape or bordered dressing per order."

R3's Braden Assessment, dated 4/15/16, documents that R3 scored a 10 putting R3 at high risk for developing a pressure ulcer

The facility's Wound Care log, dated 6/2016, documents that R3 has a facility acquired pressure ulcer that was acquired on 5/30/16, and on 6/18/16 R3's left buttock pressure ulcer was a Stage 2 and measured 0.8 cm (centimeters) x 1 cm x 0.2 cm.

R3's Physician's Orders and Treatment Administration Record, dated 6/20/16, documents that R3 has an order to apply silver gel with calcium alginate to R3's left buttock and cover with gauze and paper tape daily and as needed.

R3's Risk for Skin Breakdown Care plan, dated 6/20/16, has no documentation addressing R3's pressure ulcer to R3's left buttock nor did it document any new interventions for pressure relief when R3's pressure ulcer was discovered on 5/30/16. On 6/22/16 at 12:00 p.m., E3 (Minimum Data Set Coordinator) confirmed that R3's care plan did not address R3's pressure ulcer.

On 6/21/16 at 12:50 p.m., E5 (Licensed Practical Nurse) and E4 (Wound Nurse) positioned R3 to R3's right side. A quarter sized round wound with dark brown/black tissue covering about 70% of the wound bed was on R3's left buttock with no dressing in place. E5 confirmed that R3 did not have a dressing on R3's buttock. E4 stated, "(R3's) pressure ulcer was a Stage two now it's unstageable because 70% of the wound bed is covered with eschar (brown/black tissue)." E5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

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F 314	Continued From page 14 placed two stacks of gauze, tape, and calcium alginate directly on R3's bedside table, with no clean field established. E5 grabbed one stack of gauze from the bedside table and cleansed R3's wound with normal saline and gauze. Then, E5 applied the silver gel to the second stack of gauze, placed the piece of calcium alginate in the gel, and applied the dressing to R3's left buttock." On 6/21/16 at 1:05 p.m., E6 (Certified Nursing Assistant) stated, "I got (R3) up for lunch and did (R3's) incontinent care. (R3) did not have a dressing on (R3's) bottom. I also laid (R3) down after lunch, and she was not incontinent. I didn't know (R3) was supposed to have a dressing on (R3's) bottom." On 6/21/16 at 1:42 p.m., E5 stated, "I should have had something down for a clean field when doing (R3's) treatment. No one alerted me that (R3's) treatment was not on." On 6/21/16 at 3:30 p.m., Z1 (R3's Nurse Practitioner) stated, "Having no treatment in place to the pressure ulcer could cause the wound to worsen...My expectations for (R3's) wound is for it to improve not worsen." On 6/22/16 at 11:05 a.m., E4 (Wound Nurse) stated, "(R3's) Braden risk assessment says that (R3) is a risk for pressure ulcers...(R3's) not able to voice the need to turn and reposition, (R3's) incontinent, and (R3) requires staff assistance for turning and positioning. I wouldn't have expected the wound to worsen to unstageable."	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

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F 329	Continued From page 15 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 observation, interview, and record review the facility failed to assess for underlying causes, appropriate clinical indications, and identify targeted behaviors prior to and during treatment with antipsychotic medications for two of five residents (R2, R8) reviewed for antipsychotic medications in a sample of 10. Findings include: An Antipsychotic Medication Use policy dated	F 329		

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F 329	Continued From page 16	F 329		

3/2015 states, "Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed....The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others...Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use...Diagnoses alone do not warrant the use of antipsychotic medication...For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are: Not due to a medical condition or problem...that can be expected to improve or resolve as the underlying condition is treated...Antipsychotic medications will not be used if the only symptoms are...wandering, Restless, Mild anxiety, nervousness; or uncooperativeness."

1. R2's nurses' notes dated 5/26/16 document that on that date, "(R2) was noted to have decreased ability to focus on commands during therapy and noted to have some increased confusion..." The nurses' notes also indicate R2's physician ordered for a Urinalysis with Culture and Sensitivity (UA C&S) to be obtained. Nurses' notes dated 5/28/16 document R2's UA C&S was not obtained until that date. Nurses' notes dated 5/30/16 to 6/2/16 document R2 was having increased confusion which progressed to R2 "yelling," having "increased agitation and delusions," and "scream and strike out..."

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F 329	Continued From page 17	F 329		

Nurses' notes dated 6/2/16 document R2 was sent to the hospital for evaluation and treatment following R2's increasing behaviors. Nurses' notes dated 6/13/16 document R2 returned from the hospital on that date with the diagnoses of Pneumonia and Urinary Tract Infection (UTI).

A hospital physician's progress note dated 6/4/16 states, "(R2) is pleasantly confused and demented...Urinary Tract Infection...has likely exacerbated R2's underlying dementia...This appears to be acutely exacerbated from R2's Urinary Tract Infection..."

R2's physician's orders (POS) dated 6/14/16 document R2 was prescribed the antipsychitic medication Risperidone 1mg (milligram) once daily in the morning and Risperidone 0.5mg, three tablets every day at hour of sleep for the diagnosis of delusional disorders.

R2's medical record including nurses' notes dated 6/13/16 to 6/20/16 do not include documentation that R2 was,"...evaluated for the appropriateness and indications," for the use of the antipsychotic medication Risperidone at the time it was initiated.

R2's behavior tracking log dated 6/2016 documents that R2 is being monitored for the behavior of, "I become nervous/shaky during care task, therapies, ambulation/transfers, etc. (etcetera)."

On 6/21/16 at 9:40a.m. R2 was seated in a recliner in R2's room. R2 was calm and pleasant while talking with R2's family.

On 6/22/16 at 11:25a.m. E7 (Certified Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	06/22/2016

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F 329	Continued From page 18	F 329		

Aide/CNA) stated E7 knows R2 very well and has provided care to R2. E7 stated that R2 was, "...normally very cognitively intact and very sweet. (R2) can tell you what (R2) wants." E7 stated R2 had increased confusion and behavior problems right before going to the hospital 6/2/16. E7 stated since R2's return from the hospital, R2 is back to normal except for some occasional confusion. E7 stated R2 had not been having delusions or hallucinations, and was not a danger to self or others.

On 6/21/16 at 12:10p.m. E2 (Director of Nurses) verified R2 was not given a formal assessment prior to initiating the antipsychotic medication Risperidone. E2 verified R2 was not assessed to ensure R2 had the appropriate indications for the use of Risperidone, to ensure R2's behaviors were not the result of a medical condition such as UTI or Pneumonia, or to identify appropriate target behaviors. E2 also verified R2 is being monitored for the behaviors of "nervous/shaky" during personal cares and therapy.

2. R8's physician's orders (POS) dated 3/25/16 document R8 was prescribed Quetiapine (antipsychotic) 25mg (milligrams) two times daily for the diagnosis of Mood Disorder due to known physiological condition with depressive features.

R8's Informed Consent for Psychoactive Medications form dated 3/25/16 sections titled Purpose the Psychoachive Medication is Indicated and Purposed Course of the Medication were left blank.

R8's current medical record does not include documentation R8 was,"...evaluated for the appropriateness and indications," for the use of

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	145457	A. BUILDING _____ B. WING _____	06/22/2016

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F 329	Continued From page 19 the antipsychotic medication Quetiapine at the time the medication was initiated. R8's Behavior Tracking log dated 3/2016 to 5/2016 document R8 was being monitored for the behaviors of "wandering". On 6/22/16 at 8:30a.m. E2 (Director of Nurses) verified R8 was not give a formal assessment prior to initiating the antipsychotic medication Quetiapine. E2 also verified R8 was not assessed to ensure R8 had the appropriate indications for the use of Quetiapine or to identify appropriate target behaviors.`	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356	Continued From page 20	F 356		

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to have an updated and accurate nurse staff information posting to include actual nursing hours worked and correct number of residents in the facility, and failed to maintain 18 months of daily nurse staffing postings. This had the potential to affect all 72 residents residing in the facility.

Finding include:

On 6/20/16 at 10:00 a.m., the facility's Daily Staffing posting was posted outside of the dining room in a common area hallway. The facility's Daily Staffing posting, dated 6/20/16, has no documentation of the actual nursing hours worked. The daily staffing posting also documented that the facility's census was 69 on 6/20/16.

On 6/22/16 at 8:30 a.m., E2 (Director of Nursing) confirmed that the Daily Staffing posting that is posted for the public is not kept for each day.

On 6/22/16 at 1:05 p.m., E1 (Administrator) stated, "The daily staffing posting for 6/20/16 was incorrect on census. Our census on 6/20/16 was

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F 356	Continued From page 21 72. On 6/22/16 at 1:25 p.m., E2 (Director of Nursing) confirmed that the hours specified for the daily staffing posting are the scheduled hours only; not the actual hours worked. The facility data sheet dated 6/20/16, completed and signed by E1, documents that 72 residents reside in the facility.	F 356		