STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0246 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 34483 Based on interviews and observation, it was determined that the facility staff failed to honor the choices of Resident #57. This was evident for 1 of 36 residents selected for review during Stage 2 of the survey process. The findings include: On 7/28/17, a review of Resident #57's medical record was initiated. The concern exists that the Resident verbalized on 7/25/17 at 12:30 PM that facility staff is not getting him/her out of bed since the chair being used has been taken away. According to the Resident, it has been several months since the chair was removed. This Resident requires a bariatric sized chair, which is used for patients who require larger chairs to sit comfortably. In an interview with the DON (Director of Nursing), the reason given for the chair's removal was frequent refusals to get out of bed and the specialty chair, which was being rented, was returned. A review of medical record documentation doesn't reveal that the Resident refused to get out of bed. The Director of Nursing stated since the chair's return to the supplier, a dialysis chair had been set aside for the resident's use. But in an interview with the nurse in the dialysis center on 7/28/17 at 10:30 AM, it was stated that the center prefers their chairs not be used in the nursing center because they come back in bad condition and there are no available extra chairs in the dialysis center. In an intervew with employee #32 on 7/28/17 at 10:17 AM, it was revealed the Resident #57 has asked to get out of bed frequently, as recently as 2 weeks ago. When the nurse was made aware of the last request, the staff person was told that there were no chairs available. In a second interview with the Resident on 7/28/17 at 10 AM, he/she wanted to be able to get out of bed to relieve the pressure on his/her back and legs. The concern exists that the facility has not been meeting the needs of the Resident. The Director of Nursing and the Administrator were made aware at the exit conference.

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.

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

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F 0253 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide housekeeping and maintenance services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30535 Based on observation and staff interview, while conducting facility tours, it was determined that the facility staff failed to maintain residents' physical environment in a clean, orderly and safe manner. The findings include: 1) On 7/27/17 at 12:00 PM, during a tour of the facility with the Administrator, it was determined that the carpeting throughout the facility was stained, worn and unsightly. 2) During the 7/27/17 tour of resident areas with the facility's Administrator, it was determined that the three food service carts, three drink carts and three used dishes carts had debris and stains. Each cart had a buildup of debris around the base and wheel areas and sides. The food service cart outside room [ROOM NUMBER] also had a torn front panel. The food service cart in the Homestead Unit lacked sides around the dish storage area. The Administrator confirmed the findings on 7/27/17 at 12:00 PM that the facility failed to maintain food service carts and carpeting in a sanitary manner. 37585 3) During an obsevation of the facility's external environment that took place on 7/27/2017 at 11:45 AM, it was found that the facility had a large hole in the brick exterior wall. The hole was located on the building's southern wall outside of the rehabilitation suite, according to the Director of Maintenance. The hole measured 11 inches in diameter at the widest measurement and was found to be filled with loose dirty rags. A tour of the exterior facility was completed with the Director of Maintenance on 7/28/2017 at 9:30 AM. The Director of Maintenance confirmed the hole, removed the towels and identified that water piping could be found inside the hole. The piping segment had been filled with fiberglass but a small gap in the fiberglass was large enough to allow access to rodents and other vermin. There were no obvious signs of pests. The findings were reviewed with the Director of Nursing and Administrator during exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0323 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provide adequate supervision to prevent avoidable accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on review of MD00109991, MD00108061, medical records and interviews it was determined that the facility failed to 1) ensure that a resident's environment remained as free from accident hazards as possible as evidenced by the presence of side rails for a resident who had been assessed as not requiring side rails which resulted in bruising to the resident's forehead and eye (Resident #58) ; 2) & 3) ensure staff provided adequate supervision and assistance when utilizing a mechanical lift to prevent accidents as evidenced by two residents falling from the lift while being transferred resulting in a fractured hip for one resident and a head laceration for the second resident (Residents #257 and #81); 4) ensure that residents were transferred in a sit-to-stand lift by two staff members as required by the facility's procedures and nursing standard of care. The findings include: 1) On [DATE] review of Resident #58's medical record revealed the resident had resided at the facility for several years and whose diagnosis included dementia. On [DATE], a Bed Rails Eval was completed. This evaluation revealed the resident did not need bed rails for positioning/support and/or rising from supine to sitting/standing position as a mobility enabler and that Bed Rails were not indicated as a mobility enabler at this time. Nor were the bed rails a patient or resident representative preference. Review of nursing notes revealed a skin assessment was completed on [DATE] with no skin injury/wounds were noted. Further review of the nursing notes revealed that on [DATE] at 10:42 AM, the nurse documented: new onset/change in skin integrity as evidenced by bruise. Location: Resident noted to have bruise on right forehead as well as right outer eye. On [DATE] at 1:14 PM, nurse documented: [name of resident] has hand tremors and involuntary head movement (baseline) Has used top ,d+[DATE] rail to aide in independent bed mobility. Staff feels that [name of resident] may have bumped [his/her] head on the rail. Side rails have been removed. Skin is intact. No swelling. No signs of any distress. On [DATE] at 8:20 AM, interview with the Dementia Unit program manager revealed that if side rails were assessed as not being indicated they would either secure the rails in the down position or remove them from the bed. The Director of Nursing (DON) then reported that if the someone had snipped the tie down [securing device] then they would remove the rails from the bed and that if the resident can't use the rails they try to get rid of them. Surveyor then reviewed the concern that the resident had been assessed in December as not needing side rails but investigation into the bruising on the face in January determined it was a result of the side rails. On [DATE], the DON confirmed that side rails were on the resident's bed at the time of the injury and she had them removed from the bed after the injury was noted. 2) On [DATE] review of Resident #257's medical record revealed diagnosis which included: stroke with right sided weakness; and heart disease. The [DATE] Minimum Data Set assessment revealed that the resident was totally dependant for transfers with the assist of at least two staff persons. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing notes revealed that on [DATE] Resident fell off hoyer lift while being transferred from the wheel chair to the shower chair with assist of 2 CNAs [certified nursing assistants]. One of the sling straps slid out the hook, and resident fell on the floor hitting [his/her] fore head, sustaining a hematoma [bruise]. Resident also complained of right knee pain Ice applied to hematoma. Patient sent to ED [emergency department] via 911. On [DATE], a Change in Condition Followup note revealed staff contacted the hospital and was informed that the resident had been admitted with a right hip fracture. On [DATE] at 3:10 PM, interview with GNA Staff #22 revealed that on [DATE] another GNA [Staff #23] had come to assist her with the transfer of the resident; she hooked her side and the other GNA hooked the other side; during the transfer the other GNA's side came loose. When asked if anything could of been done differently she replied: double check; if someone doesn't want to participate the right way get someone else to participate. Review of the employee file for the GNA Staff #23 revealed that on [DATE] an Individual Performance Improvement Plan was put in place regarding the incident on [DATE]. Review of this form revealed Resident [ID number] was being lifted via a mechanical lift when [s/he] slipped out of the sling causing [him/her] to fall to the floor. Patient received a fracture which necessitated transfer to the hospital. Upon investigation, it was determined that 1. the sling was not fastened correctly to the lift and 2. [Staff #23] failed to wait for the second GNA to assist with swinging patient over to the shower chair. On [DATE] at 5:00 PM, surveyor reviewed the concern with the DON and the Administrator regarding the resident's fall during the mechanical lift transfer which resulted in harm to the resident. 21859 3) The facility failed to maintain the safety of resident (#81) during transfer, resulting in a laceration to the forehead and cheek, bruising to the left shoulder and knee - requiring steri-strips and pain medication. Steri Strips are sterile pieces of medical tape used to close wounds. A Hoyer Lift is an assistive device that allows patient/patients to be transferred between a bed and a chair or other similar resting places. By way of history, according to the medical record, (resident #81) has End stage Dementia and is totally dependent on staff for care. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	An investigation was performed of facility reported incident # MD00113747, which included review of the medical record, review of the facility's investigation, and interviews with the DON (Director of Nursing) on [DATE] at 1 pm, GNA (Geriatric Nursing Assistant) #1 on [DATE] at 2 pm, and GNA #2 on [DATE] at 11 am. The investigation reavealed that, on [DATE] at approximately 9:40 am, GNA #1 and GNA #2 were transferring the resident from the bed to the chair using a Hoyer Lift. During the transfer, the sling strap came off the Hoyer Lift's hook and the resident fell to the floor. GNA #1 stated GNA #2 failed to properly secure the straps to the Hoyer Lift, causing the resident to fall out. GNA#2 stated s/he was unsure as to why the strap came off, but verified the allegation that the strap came off during transfer. The resident sustained a laceration to the forehead and cheek (requiring steri strips) and bruising to the left shoulder and knee (requiring pain management). The resident was given PRN (when needed) Tylenol 650 mg by mouth and steri strips were applied to the forehead at the time of the incident. Further review of the medical record revealed the resident was seen and assessed by the physician on [DATE] at 9:45 am, who rendered the following orders: Morphine Sulfate Concentrate (MSIR) 20mg/cc liquid. Give (0.25 cc) 5 mg (milligrams) po (by mouth) every hour PRN for mild pain or distress. Morphine Sulfate Concentrate (MSIR) 20mg/cc liquid. Give (0.5 cc) 10mg (milligrams) po (by mouth) every hour PRN for moderate pain or distress. Morphine Sulfate Concentrate (MSIR) is used to treat moderate to severe pain. On [DATE], the resident received the following doses of pain medication. 10:45 am 5 mg MSIR, 1:02 pm 10 mg MSIR, 2:45 pm 10 mg MSIR and 8:23 pm 10 mg MSIR. On [DATE], at 2:45 pm the resident was seen by the NP (Nurse Practitioner). New order to administer Morphine Sulfate Concentrate (MSIR) 20mg/cc liquid. Give (0.25 cc) 5 mg (milligrams) sublingual (under the tongue) every 12 hours at 6 am and 6 pm for pain. Continue PRN dosing. The resident received the scheduled MSIR (5 mg) at 6 pm on [DATE]. On [DATE], the resident received the following doses of pain medication. 6 am 5 mg MSIR (routine), 8:23 am 10mg MSIR (PRN), 12:30 pm 10 mg MSIR (PRN). On [DATE] at 12:30, a new order was given for Morphine Sulfate Concentrate (MSIR) 20 mg/cc. Give (0.25 cc) 5 mg sublingual every 8 hours for pain. Hold if respirations 14 or below per minute. The resident received MSIR at 6pm (routine) and the MSIR 5 mg (PRN) at 10:10 pm. On [DATE], the resident received the following doses of pain medication: 12 am, MSIR 5mg (routine) 8 am, MSIR 5mg (routine) (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	9:51 am MSIR 5mg (PRN) 12:31 pm MSIR 5mg (PRN) 4 pm MSIR 5 mg (held) - held respirations 10. 11:58 pm Tylenol Suppository 650 mg for elevated temp (temperature) of 102. On [DATE], the resident received the following pain medications: 12am MSIR 5 mg (routine) and MSIR 10 mg (PRN) 6 a m, MSIR 5mg (routine) 6:48 am Tylenol Suppository 650 mg for elevated temp of 101.8 8 am MSIR 5mg (routine) 12:28 pm MSIR 5mg (PRN) 4 pm MSIR 5 mg (routine) 10:35 pm Tylenol Suppository 650 mg for elevated temp of 100.2 10:37 pm MSIR 10 mg (PRN) On [DATE], the resident received the following pain medication: 12:00 AM: MSIR 5mg (routine) 5:19 AM: Tylenol Suppository 650 mg for elevated temp (temperature) of 102. 8:00 AM: MSIR 5mg (routine) 11:12 AM: MSIR 10mg (PRN) 4:00 PM: MSIR 5mg (routine) The resident expired on [DATE] at 8:40 PM. Review of the medical record revealed a (MOLST) Maryland medical Orders for Life-Sustaining Treatment. According to the document the resident was a do not transfer, but treat with options available outside of the hospital. At the time of the incident, the resident was on hospice care for end stage dementia and had been for greater than a year. During interview with the Director of Nursing on [DATE] at 1 pm, he/she stated that GNA #1 and GNA #2 had been in-serviced on the proper use of the Hoyer Lift, pad and straps. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	37585 4) During an interview with Resident #125 that took place on [DATE] at 1:26 PM, the resident stated that s/he had been transferred that morning with a sit-to-stand lift with the assistance of only one nursing assistant. The resident idenified Geriatric Nursing Assistant (GNA) #17 as the staff member who assisted him/her with the sit-to-stand lift this morning. A review of the facility's policy of resident transfers with Hoyer Lifts and Sit-to-Stand Lifts reveals that the facility requires two personnel to assist with all transfers. An interview with the Director of Nursing (DON) that took place at 2:00 PM on the same day confirmed this expectation. GNA #17 was interviewed at 2:30 PM and confirmed that s/he transferred Resident #125 that morning all by himself/herself. GNA #17 stated that s/he has had to do it alone other times before, and that the usual reason is not enough staff to help. The GNA stated that was also the reason this morning. These concerns were reviewed with the Administrator during survey exit.

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F 0329 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident's 1) entire drug/medication regimen is free from unnecessary drugs; and 2) is managed and monitored to achieve highest level of well-being. 21859 The facility staff failed to provide adequate indication for administering of an antipsychotic medication for resident (#255). This occurred in 1 of 36 resident in the stage 2 sample. The findings include: Quetiapine Fumarate (Seroquel) is a medication used treat schizophrenia, bipolar disorder and depression. Review of resident (#255) medical record on 7/26/17 at 11 am revealed a physician order dated 7/6/17, to administer Quetiapine Fumarate (Seroquel) 150 mg (milligrams) by mouth at bedtime for depression. Further review of the medical record revealed the resident did not have a diagnosis of depression; however did have a diagnosis of schizophrenia. During interview with the Director of Nursing on 7/26/17 at 1 pm, it was revealed the resident is ordered the medication for schizophrenia and not depression. Not having the adequate indication for this medication could result in behaviors not being monitored to determine if the medication is needed.

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F 0371 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Store, cook, and serve food in a safe and clean way. 16218 Based on staff interviews, observation, and review of temperature logs and other pertinent documentation, it was determined that the facility 1) failed to take food temperature readings at critical control points during cooling of meats; 2) failed to ensure the reach in refrigerator in the kitchen was in good working order; and 3) failed to ensure the ceiling of the dry storage area was intact. Each of these unsafe practices placed all residents who consume food from the kitchen at increased risk for food borne illness. The findings include: 1) On 7/24/17 at approximately 10:30 AM, the Certified Dietary Manager (CDM Staff #25) reported that they do sometimes cook large pieces of meat that are then cooled down for later use. S/he went on to report that the cooks do monitor the cooling process but stated that they do not document the temperatures during the cooling process. Confirmed that there were no cooling logs. On 7/24/17 at 12:45 PM, the CDM presented the surveyor with a blank [name of corporation] Cooling Chart and reported that s/he was in the process of inservicing staff in the use of this form. Review of this form revealed the following instructions: Start recording temperature once the food reaches 135 F. Cool from 135 F to 70 F in 2 hours, then 70 F to 41 F or below for the remaining 4 hours. If product does not achieve cooling from 135 F to 70 F in 2 hours , it must be thrown out or reheated and then cooled again. The form also had columns to document the: Date; Food name of Roast Meat/Food item; Cook temperature and time, Time Begins (with 135 pre-printed in the temperature row); 1st hour, 2nd hour, 4th hour and 6th hour with rows for time and temperature for these reading. On 7/27/17 at approximately 1:00 PM, surveyor observed a Cooling Chart posted in the kitchen which had documentation of a temperature of 190 at 12:30 in the Cook column; 1:30 in the Times Begins column; 170 at the 1st hour, and 140 at 2nd hour. There was no documentation found on this posted chart as to the date, the name of the food item or any temperatures below 140. When the surveyor asked the cook (Staff #27), if a roast is at 135 degrees at 11:00 am and two hours later the temperature is at 80 degrees what would you do? The cook's response was to cut the meat down [into smaller pieces] to get it cooled down some more. After reviewing the Cooling Chart instructions with the cook, she stated she had answered the question wrong. The cook denied having received any recent inservices regarding the cooling process of meats. The concern regarding the failure of kitchen staff to document cooling temperatures and the cook's inability to verbalize the appropriate action if food had not cooled to the proper temperature was reviewed on 7/27/17 with the acting food service director (Staff #26). This concern was also reviewed with the Administrator on 7/27/17 at 5:00 PM. (continued on next page)

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F 0371 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 7/24/17 at approximately 10:15 AM during the kitchen tour the surveyor observed, in the presence of the CDM (Staff #25), the temperature of the reach in refrigerator (#2) to be 50 degrees. The CDM reported they had been using the refrigerator a lot that morning. At 12:45 PM, the CDM reported to the surveyor that the temperature of the reach in refrigerator was now down to 40 degrees. Review of the facility's HACCP [Hazardous Analysis Critical Control Point] Food Flow Chart for Cold Ready to Eat Foods revealed that items should be stored in a refrigerator at 40 F or less. On 7/27/17 at approximately 12:15 PM during a re-visit to the kitchen the surveyor observed, in the presence of the acting food service director (Staff #26), that the temperature of the reach in refrigerator was above 45 degrees. At 4:40 PM surveyor observed that all of the items had been removed from the reach in refrigerator and a sign had been posted to not use the refrigerator. Staff #26 reported that there was an issue with the refrigerator not getting to temperature, that he had thrown out all the items that had been stored in that refrigerator and had contacted a repair company. Surveyor then reviewed the July 2017 Refrigerator temperature log identified by staff as being for the reach in refrigerator. This log revealed that the temperature was documented every day at 6:00. On the following dates the temperature was documented above 40 degrees: 7/5: 46 degrees 7/6: 42 degrees 7/13: 46 degrees 7/14: 44 degrees 7/19: 42 degrees 7/21: 42 degrees No documentation was provided to indicate these elevated refrigerator temperatures had been addressed by staff prior to 7/27/17. The concern regarding the refrigerator temperatures was addressed with the Administrator on 7/27/17 at 5:00 PM. The Administrator reported they expected the repairmen that evening. 3) On 7/24/17 at 10:05 AM during tour of the dry storage area of the kitchen it was observed that approximately a 6 inch x 18 inch section of a ceiling tile was missing, pipes were noted going up into the ceiling and insulation was exposed. At 12:45 PM the Certified Dietary Manager (Staff #25) reported that maintenance was addressing the open area in the ceiling today. On 7/27/17 surveyor observed, in the presence of the acting food service director (Staff #26) that part of the open area had been repaired; however, there remained open areas of approximately 1 inch by 2 inches from the wall to one of the pipes; and an open area of approximately 1.5 x 1 inch around the second pipe. Surveyor discussed the concern with the food service director that these open areas can be a point of access for insects or mice. (continued on next page)

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F 0371 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The concern regarding the open areas in the ceiling of the dry storage area was addressed with the Administrator on 7/27/17 at 5:00 PM.

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F 0498 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs. 16218 Based on review of MD00108061, medical records and employee files and interviews with staff it was determined that the facility failed to have a system in place to ensure all geriatric nursing assistants (GNA) received training and demonstrated competency in mechanical lift transfers after an incident in which a resident fell during a transfer; and failed to have an effective system in place to document that newly hired GNAs have demonstrated skills competency. These failures put all residents in the facility at risk of injury. The findings include: Cross reference to F 323. 1) On 7/26/17, review of the facility reported incident MD00108061 revealed that on 10/31/16 a resident had fallen during a mechanical lift transfer and that the facility was providing staff education on Safe Resident Handling which would include verbal and visual competencies and include a post test. On 7/26/17, the credible evidence that the GNAs had been observed using proper technique and were competent to perform transfers safely was reviewed. This review failed to reveal documentation that all of the GNAs that had been employed in November 2016 had been observed and deemed competent to perform transfers safely. On 7/26/17, the Nurse Practice Educator reported that she was not positive that every GNA that worked in the building as of 10/31/16 had received the training. She went on to report that she had not done all the trainings herself. On 7/27/16 after further review of the documentation with the surveyor, the Nurse Practice Educator confirmed that several GNAs missed the training/competency observation in November 2016. Surveyor then discussed the concern with the Nurse Practice Educator (NPE) that, when a training need is identified, there was no system in place to ensure all GNAs would receive the training. 2) On 7/27/17 at approximately 9:00 AM, the Director of Nursing reported that newly hired Geriatric Nursing Assistants (GNA) are assigned to work with a mentor and that there is a skills check off that should be completed and put in their employee files. On 7/27/17 review 5 GNAs hired since February 2017, who according to staffing sheets worked in July 2017, revealed that 4 (Staff #28, #29, #30 and #31) out of the 5 GNAs failed to have any documentation of skills competency prior to being allowed to work independently. This information was reviewed with the NPE who confirmed there was no new hire skills documentation for these employees. The NPE reported that she had identified this as a problem and had instituted a form that the new hires had to sign indicating they had to return the skills sheet prior to coming off orientation but was unable to state when she began using the form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0498 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/27/17 at 5:00 PM, surveyor reviewed the concern regarding the failure to complete the mechanical lift training with all of the GNAs after the October 2016 incident; and the failure to have a system in place to ensure newly hired GNAs have demonstrated skills competencies prior to working independently with the DON and the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0514 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep accurate, complete and organized clinical records on each resident that meet professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37585 Based on review of medical record and interview with facility staff, it was determined that the facility failed to have a resident's death certificate on file in the closed record at the time of the survey. This was true for 1 of 6 residents (Resident #81) reviewed that had had expired in the facility. The findings include: During a review of Resident #81's closed record that took place on [DATE] at 9:40 AM, it was found that, although the resident had expired in the facility, no death certificate could be found in the closed record. When this concern was brought up with Medical Records personnel #18 at 11:00 AM on the same day, the survey team was told that the death certificate had been misfiled. It was produced for the survey team at 10:00 AM on [DATE] and was placed into the resident's closed medical record. These findings were reviewed with the facility's Administrator and Director of Nursing during the exit conference.