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	345246	A. BUILDING _____ B. WING _____	C 02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 No deficiencies were cited as a result of the complaint investigation. Event ID #JPHY11.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to evaluate implemented nutritional interventions which resulted in a significant weight loss for 1 of 1 residents (Resident #31) sampled for weight loss. Findings included: Resident #31 was admitted to the facility on 07/10/12. Diagnoses included Alzheimer's disease, paralysis agitans, depression, anemia, and bipolar disorder. On 11/03/14, the resident was documented to weigh 117 pounds. The quarterly Minimum Data Set (MDS) dated 01/16/15 indicated Resident #31 was severely cognitively impaired and required supervision with set-up help of one staff member for eating. The MDS further indicated the resident had no signs or symptoms of a possible swallowing disorder. Also, the MDS specified the resident had not had a weight loss of 5% or greater in the previous month or a weight loss of 10% or greater in the previous six months. A review of the care plan, with an onset date of 07/10/12 and a goal date of 01/18/15, revealed	F 282	282 SERVICES PROVIDED BY QUALIFIED PERSONS/PER CARE PLAN Disclaimer Clause: Preparation and or execution of this plan of correction and credible allegation of compliance does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action for those resident(s) found to have been affected: Resident #31 weight was recalculated for accuracy by the Certified Dietary Manager (CDM) and was referred to the Registered Dietician for evaluation and recommendation on 2/22/15. A	4/8/15

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

Electronically Signed | 03/20/2015

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F 282	Continued From page 1 the facility established a plan of care for weight loss. The goals were established to assist the resident to tolerate the prescribed diet and have no significant weight loss. Interventions included monitoring of intake, weight, and lab results; a nutritional supplement at the lunch and dinner meals; fortified oatmeal at breakfast; and a nutritional drink at all meals. Further review of the medical record revealed fortified oatmeal was ordered 08/28/12, and nutritional drink and nutritional supplement were ordered 09/11/12. On 01/12/15, the resident was documented to weigh 102 pounds, identifying a significant weight loss of 12.8% since 11/03/14. A dietary noted dated 01/16/15 and signed by the Assistant Dietary Manager indicated Resident #31 ate an average 50-75% at most meals. The note further indicated the resident required set-up help with her meals, the ideal body weight range was 99 to 121 pounds, and there were no labs to review. No recommendations were made to add or change interventions. On 02/23/15, a weight of 94 pounds was documented, identifying a significant weight loss of 19.7% since 11/03/14. An interview was conducted with the Assistant Dietary Manager (ADM) on 02/25/15 at 11:21 AM. She stated weights were gathered and recorded every month for every resident, except when the weight management committee determined a need for weighing a resident more often. There was no documentation required for supplements that were supplied by the kitchen. Supplements were recorded as part of the total amount of solid food and liquids consumed. An interview was conducted with the Dietary Manager on 02/26/15 at 4:21 PM. She stated the weight management committee consisted of	F 282	gastrostomy tube was placed during the resident□s hospitalization 1/30 to 2/7/15. Tube feeding orders were implemented upon the resident□s return to the facility on 2/7/15 and the resident received 100% of nutrition via feeding tube until she expired on 3/14/14. Corrective Action for those resident(s) having potential to be affected: All residents weights were recalculated by the CDM on 3/14/15 for accuracy of the weight loss percentage and those that triggered for significant weight loss as defined by 5% in 30 days, 7.5% in 3 months and 10% in 6 months, were referred to the Registered Dietician for evaluation and recommendations. The Registered Dietician recommendations were implemented as ordered. The Administrator and CDM met with the Registered Dietician on 3/19/15 to review the elements of the plan of correction and establish parameters for contacting her off hours and to facilitate timely input on plan of care interventions. The Certified Dietary Manager (CDM), and Assistant Dietary Manager (ADM) were in-serviced by the Registered Dietician (RD) on 2/27/15 regarding monitoring dietary/fluid intake, laboratory/diagnostic evaluation, the parameters for significant weight loss as defined by 5% in 30 days, 7.5% in 3 months and 10% in 6 months and the	

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F 282	Continued From page 2 members from dietary and nursing, as well as the MDS Coordinator. The committee reviewed all of the weights weekly to identify changes and to recommend interventions. The Dietary Manager stated there was no documentation required for supplements provided by the kitchen and confirmed the weight management committee could not evaluate each supplement for effectiveness. Upon reviewing a list of residents who had been referred to the Registered Dietician from July 2014 to the date of the current survey, she verified Resident #31 had not been referred to the Registered Dietician. A follow-up interview was conducted with the Assistant Dietary Manager on 02/27/15 at 2:23 PM. She stated the facility uses an ideal body weight to monitor residents for weight. She stated she was aware of Resident #31 ' s weight loss at the time of the last assessment on 01/16/15, but it was still within the ideal body weight range so she felt further intervention was not necessary.	F 282	need for dietary interventions for residents exhibiting significant weight loss. Systemic Change: A meal/supplement consumption tracking tool was developed by the Quality Assurance Coordinator, to be used for nursing and nutrition staff in order to facilitate communication and revisions in the plan of care. The Nursing staff were in-serviced by the Staff Development Coordinator (SDC) regarding meal/supplement consumption, the importance of accurately recording meal consumption, and filling out the meal/supplement consumption tracking tool after each meal. The meal/supplement consumption tool will be turned in to the DON daily for review and concerns will be addressed in the weekly weight management team meeting. The CDM/ADM will calculate the percentage of weight loss using the formula: % of body weight loss = (usual weight - actual weight) / (usual weight) x 100, and will determine those residents identified with significant weight loss to be discussed at the weekly weight management team meeting. All newly admitted or readmitted residents, residents with skin integrity issues, triggered change in weight, or enteral feeding will be referred by the	

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F 282	Continued From page 3	F 282	CDM/ADM to the Registered Dietician, physician or physician extender and reviewed at the weekly Weight Management Team meeting and corresponding interventions will be placed on the Care Plan. Weights and meal/supplement consumption will reviewed weekly by the Weight Management Team consisting of the Administrator, Certified Dietary Manager, Director of Nursing, Quality Assurance Coordinator, Therapy Director, Activities Director, Treatment Nurse, Restorative Aide, and Medical Records Clerk, with a focus on those residents that have been identified with significant weight loss until the resident maintains a stable weight for four weeks. Monitoring: The DON and CDM, together, will randomly audit 20 charts per week for four weeks and 5 charts per week for two more months of residents identified as eating 50% of their meal or less to ensure alternates are being offered, there is no corresponding weight loss, dietary interventions are being implemented as necessary, the Registered Dietician/Physician/Physician Extender has been notified, and the Care Plan has been updated as necessary. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for three months for	

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F 282	Continued From page 4	F 282	review and recommendations.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews the facility failed to shower a resident who required assistance with activities of daily living for 1 of 1 residents sampled for activities of daily living (Resident #83). The findings included: Resident #83 was admitted to the facility on 06/03/14 with diagnoses which included difficulty in walking, muscle weakness, below the knee amputation, heart disease, and end stage kidney disease. The quarterly Minimum Data Set (MDS) dated 02/17/15 coded Resident #83 as cognitively intact and capable of making his needs known. The MDS indicated Resident #83 required extensive assistance with his activities of daily living (ADLs) including dressing, toileting, and personal hygiene, and was totally dependent on staff for bathing. Further review of the MDS indicated Resident #83's preferences for showers was very important with no documented behaviors or refusal of care.	F 312	F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Disclaimer Clause: Preparation and or execution of this plan of correction and credible allegation of compliance does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action for those resident(s) found to have been affected: Resident #83 received a shower as scheduled on 2/24/15. Resident #87 was interviewed by the Director of Nursing regarding preferences for bath/shower days. Resident #87 did not request any changes regarding bath/shower days.	4/8/15

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F 312	Continued From page 5 A review of a facility document titled "Resident Bath" revealed Resident #83 had a shower on 02/14/15, 02/17/15, 02/21/15, and 02/24/15. A review of 24 hour communication reports revealed there was no documentation that Resident #83 had refused baths or showers. A review of nurse's notes revealed there was no documentation that Resident #83 had refused baths or showers. A review of care plans for activities of daily living dated 02/18/15 indicated assistance with ADLs to level needed to assure adequate care. During an interview with Resident #83 on 02/24/15 at 11:37 AM, he had not received a shower from 02/15/15 until 02/22/15. He stated he had received a shower on Saturday, 02/14/15 and on Sunday, 02/22/15 but only after his family had complained to the nurse. Resident #83 further stated he was supposed to have a shower every Tuesday and Saturday but was unaware of why he had not received a shower for this particular week. He further indicated he had asked for a shower during the week but no one came to take him for his shower until Sunday, 02/22/15 after his family had complained. During a follow-up interview with Resident #83 on 02/27/15 at 8:15 AM, he stated Nurse Aide (NA) #4 had given him a shower on 02/24/15 but from 02/15/15 until 02/22/15 he had not received a shower. During an interview on 02/27/15 at 2:33 PM with NA #4, she stated she had been assigned to care	F 312	The nursing assistant that failed to give the shower was in-serviced by the Staff Development Coordinator regarding importance of completing activities of daily living. Corrective Action for those resident(s) having potential to be affected: Alert and oriented residents were interviewed by the Director of Nursing on 4/7/15 regarding bath/shower preferences and whether or not baths/showers are being completed as ordered. Alert and oriented residents was determined according to a Brief Interview for Mental Status (BIMS) score of 13 or greater. The Director of Nursing will follow up with nursing assistants as necessary if there is determined to be a pattern with failing to give baths/showers on assigned days. Systemic Change: The daily ADL tracking tool was revised by the Quality Assurance (QA) Director on 4/3/15 to indicate whether or not a bath was received, what type of bath or shower was given, and to track refusal of ADL care. The ADL tracking tool will utilized by the licensed nurse as a means for checking and tracking whether scheduled ADL care is being provided and to follow up regarding refusal of care. The Director of Nursing will follow up with Nursing Assistants failing to complete scheduled care as necessary.	

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F 312	Continued From page 6 for Resident #83 and confirmed the resident required total assistance with showers but during the week of 02/15/15 through 02/21/15 she had given him a bed bath because there were so many residents on that hall that had been sick. She further stated she was aware that Resident #83's bathing preferences was that of a shower. During an interview on 02/27/15 at 2:45 PM with Nurse #4, she stated it was her expectation that residents should be showered two times a week as scheduled and as the resident had requested. She stated if a shower was refused or was not given it was to be reported to the floor nurse and documented in the medical record. She confirmed she had documented that Resident #83 had a shower on Tuesday, 02/17/15 but had not confirmed the resident actually had a shower before she documented it. She stated she had assumed the resident had a shower because the NA had not advised her otherwise. She further stated she was not aware Resident #83 had not received a shower from 02/15/15 until 02/22/15. During an interview on 02/27/15 at 3:48 PM with the Director of Nursing (DON), she stated it was her expectation for residents to be given showers according to their preferences and it should be documented appropriately on the monitoring sheet in the computer system. She further stated she would have expected the nurse to visualize the resident to ensure he had received a shower and then document the information on the monitoring sheet accordingly.	F 312	All newly admitted or readmitted residents will be informed of their scheduled shower days and shift at the time of admission. They will be asked regarding preferences for baths or showers and shft by the admitting licensed nurse. Requests to change ADL/shower preferences will be documentated on the 24 hour report sheet by the nurse on shift, so the change can be made by the DON and/or MDS nurse and the care plan updated. The nursing staff were in-serviced by the Staff Development Coordinator on 3/18/15 and 3/25/15 regarding completion and documentation of showers, baths, and bed baths on the shower sheets, notifying the nurse and documenting refusals of baths or showers, not changing bath days without supervisor approval, and licensed nurses completing the daily ADL audit. The in-service also included reporting to the nurse on shift requests to change ADL/shower preferences for documentation on the 24 hour report so the change can be made DON and/or MDS nurse and the care plan updated. The Administrative Rounds Sheet to be completed by the Administrative nurses was revised by the QA Director on 4/3/15 to include checking whether or not scheduled showers are completed.	

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F 312	Continued From page 7	F 312	Monitoring: The DON will audit weekly for three months, the ADL tracking tool and the Weekly Administrative Rounds Sheet to monitor for trends with shower/bath, completion and refusal of care. She will follow up with nursing staff as necessary and assure the Care Plan has been updated as necessary. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility left a resident with no balance for sitting on the side of the bed unattended for 1 of 3 sampled residents reviewed for accidents (Resident #87). The findings included:	F 323	F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Disclaimer Clause: Preparation and or execution of this plan of correction and credible allegation of	4/8/15

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F 323	Continued From page 8 Resident #87 was admitted to the facility on 04/22/14 with diagnoses which included muscle weakness, high blood pressure, diabetes mellitus, left sided hemiplegia, and paralysis. Review of the quarterly Minimum Data Set (MDS) dated 01/30/15 indicated Resident #87 was cognitively intact and capable of making daily decisions. Resident #87 was coded to need extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene, and totally dependent of staff for bathing. Further review of the MDS coded Resident #87 with an un-steady balance and only able to stabilize with staff assistance, and was always incontinent of bowel and bladder. A care plan dated 02/19/15 specified Resident #87 was at risk for falls related to an unsteady gait and unsteady balance, history of falls, which included decreased mobility, left sided hemiparesis, and incontinence. The care plan goal was for the resident to have no major injury related to falls through the next review. Care plan interventions included call light within easy reach, assist with safety awareness, keep pathway clear of clutter, keep bed at lowest position, and document all falls. Review of Resident #87's medical record revealed an unwitnessed fall on 01/13/15 at 8:03 AM. The nurse's entry specified the resident was found lying on the floor beside her bed and she had sustained no injuries. Further review of the medical record revealed an intervention of restorative therapy was currently in place for the resident.	F 323	compliance does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action for those resident(s) found to have been affected: The Care Plan for Resident #87 was reviewed and updated by the Minimum Data Set (MDS) Nurse on 3/16/15 upon the resident□s return from the hospital. NA #1 was interviewed and counseled by the Director of Nursing on 2/24/15 regarding maintaining resident safety and the designated amount of assistance indicated on the care plan. Corrective Action for those resident(s) having potential to be affected: All facility residents were reassessed by the MDS Nurse on 3/25/15 for high risk of falls, defined by a fall risk score of 20 or greater and the care plans were revised to include interventions and additional interventions as indicated. Specific focus was on those resident identified as needing a two-person extensive assistance for transfers and bed mobility to ensure the increased need for assistance was identified on the Care Plan.	

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F 323	Continued From page 9 On 02/24/15 at 11:24 AM, an interview was conducted with Nurse #4 and Resident #87's falls were reviewed. She stated Resident #87 had poor safety awareness and was known to set on the edge of the bed which would result in a fall because if the resident soiled the bed she expected it to be changed immediately. She further stated she was unaware of injuries with her un-witnessed falls and that Resident #87 was capable of getting out of the bed on her own but was advised to use the call light for assistance related to her unsteadiness and difficulty with walking. On 02/24/15 at 5:38 PM, an interview was conducted with the Director of Nursing (DON). She stated the "fall team" would meet every morning Monday through Friday to discuss each resident's fall and the recommendations/interventions were written by the DON on the bottom of each incident/accident report. The DON indicated the falls that occurred on the weekends were discussed at the Monday morning meetings. She further stated after Resident #87's fall on 01/13/15 the team had met on the morning of 01/14/15 and agreed that no other intervention was to be implemented at the time. Further review of the medical record revealed a fall on 01/20/15 at 9:15 PM. The nurse's entry specified the fall was unwitnessed and the resident was in the floor beside her bed and she had sustained no injuries. An intervention was noted that the resident was re-educated to not sit on the side of the bed. On 02/24/15 at 5:38 PM, an interview was conducted with the DON. She stated the team	F 323	Systemic Change: All nursing staff were in-serviced by the Staff Development Coordinator on 3/18/15 and 3/25/15 regarding fall prevention, the parameters of two person assist and incident management (specifically fall investigation). The licensed nurses were in-serviced by the Staff Development Coordinator regarding detailed documentation of incidents, taking statements from involved parties and and conducting an environmental scan to determine how the incident occurred. A Fall Scene Investigation Report tool was implemented by the Director of Nursing on 3/18/15 to assist with guiding the licensed nurses in investigating the cause of a fall. Falls will be reviewed daily Monday through Friday in the morning interdisciplinary team meeting indefinitely to ensure investigations are complete and an intervention is put in place. The Care Plan will be updated by the MDS Nurse at that time. Falls will be reviewed by the Administrative nurse on call on Saturday and Sunday for completion an incident report and the Fall Scene Investigation Report and ensure an intervention was put in place. The incident report and Fall Scene Investigation Report will be forwarded to the Director of Nursing for review on Monday in the interdisciplinary team meeting. Interventions will be written on the 24 hour	

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F 323	Continued From page 10	F 323		

had met on 01/21/15 and agreed to re-educate the resident as to not sit on the side of her bed and no other intervention was discussed to be implemented.

Further review of the medical record revealed a fall on 01/24/15 at 5:15 PM. The nurse's entry specified an unwitnessed fall, she was found sitting on the floor in her room with the wheelchair behind her, and had sustained no injuries. The interventions indicated an alarm would be placed in the wheelchair, she was currently on restorative therapy's caseload, and that physical therapy would evaluate/screen the resident.

On 02/24/15 at 5:38 PM, an interview was conducted with the DON. She stated the team had met on 01/26/15 and had agreed to have an alarm placed in Resident #87's wheelchair and to have the resident evaluated by physical therapy (PT).

The medical record indicated Resident #87 had an unwitnessed fall on 02/19/15 at 8:50 AM. The nurse's entry specified the resident was found on the floor beside of her bed with no injuries.

On 02/24/15 at 5:38 PM, an interview was conducted with the DON. She stated Resident #87 had poor safety awareness, was unsafe to transfer herself, and required 2 person assist with transfers and bed mobility. She indicated Resident #87's falls were mostly contributed to her not wanting to wait for her call light to be answered when her bed was soiled. She stated Resident #87 would twist and turn until she would get herself to an upright position and set on the side of the bed, and that was the reason she was more likely to slide off of the bed. She further

report sheet to notify staff of the change in plan of care.

Monitoring:

All falls will be audited by the DON/Administrator for six months for intervention and documentation follow-up for 5 calendar days after initial review of the incident.

The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for six months for review and recommendations

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CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

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stated Resident #87 was difficult to reason with, a challenge, and she was unsure of what other interventions they would have put into place as to prevent Resident #87's falls and/or to keep her safe.

On 02/23/15 at 12:19 PM, Resident #87 was observed with a large bruise to her left arm. She indicated she had fallen from her bed into the floor and hit her arm.

On 02/23/15 at 1:33 PM, Resident #87 was observed to be alert and oriented. She stated she was feeling very tired, wished to take a nap, and would like to participate in the resident to surveyor interview on Tuesday 02/24/15.

Resident #87's medical record indicated she had an unwitnessed fall on 02/24/15 at 9:30 PM. The nurse's entry indicated Resident #87 was found in the floor with a head injury, a deep laceration above her right eye, and a skin tear to her right elbow. Resident #87 was sent to a local hospital by emergency medical services (EMS) ambulance for evaluation and treatment.

A review of the EMS report dated 02/24/15 at 10:00 PM indicated Resident #87 had a traumatic injury with hemorrhage (bleeding) over the right eye and was transported to a local hospital.

A review of the hospital records dated 02/24/15 indicated Resident #87 was transferred from the local hospital to a trauma hospital for an intracranial hemorrhage (a buildup of blood within the skull) and a subdural hematoma (a collection of blood outside the brain) for evaluation and treatment by a neurosurgeon.

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On 02/25/15 at 5:16 PM, an interview was conducted with nurse aide (NA) #1. She stated she was working the 3:00 PM to 11:00 PM shift on 02/24/15 when Resident #87 sustained an unwitnessed fall. She stated the resident was sitting on the right side of her bed with her feet dangling and the tips of her toes touching the floor when she went into Resident #87's room to inform her that she would be right back to change her bed after she had obtained clean bed linens. She demonstrated Resident #87's bed was not in the lowest position but was at upper thigh to crotch level, and Resident #87 insisted that her bed remain at that level. She further stated she left the resident unattended sitting on the side of the bed to retrieve linens from the linen cart. She stated when she returned to Resident #87's room she found the resident on the left side of the bed in the floor face down, and blood was in the floor. She indicated she called for help, NA #2 and Nurse #1 came to the resident's room immediately, and Nurse #1 assessed the resident before they assisted the resident from the floor back into her bed. She further stated she was aware Resident #87 was at risk for falls and was not thinking when she left the resident unattended.

On 02/25/15 at 5:26 PM, an interview was conducted with NA #2. She stated she had informed NA #1 that there were no linens on linen cart and she would need to go off of the hall to obtain linens. She further stated NA #1 instructed her to go on her supper break, and NA #1 would get someone else to assist her to change the resident's bed linens. She indicated Resident #87 was lying in her bed when she went into the resident's room to answer the call light. She indicated she was gone off of the hall

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approximately 10 minutes and when she returned to the hall she heard NA #1 calling out for help at which time she observed blood in the floor and Resident #87 lying face down in the floor on the left side of her bed. She further stated Nurse #1 assessed the resident before they assisted Resident #87 from the floor back into her bed.

On 02/25/15 at 5:34 PM, an interview was conducted with Nurse #1. He stated Resident #87 was not very strong and had very poor safety awareness. He further stated he would have expected the NA to have assisted Resident #87 back into the bed before she left the resident's room to obtain bed linens.

On 02/26/15 at 12:44 PM, an interview was conducted with Physical Therapist (PT). She stated in the fall team's morning meetings the DON goes over all resident falls from the previous day and the interventions to be put into place were discussed and implemented accordingly. She further stated she had assessed Resident #87 on 02/20/15. The PT stated she had reminded the resident to use her call light, ask for assistance when getting out of bed on her own. The PT indicated the resident was under the services of restorative therapy and that was why Resident #87 was not placed back on the physical therapy workload. The PT stated she had observed restorative therapy to work with the resident and that the resident had appeared to be her normal self and had no need for any additional therapy. The PT further stated Resident #87 was unable to walk by herself and/or transfer without assistance and had poor safety awareness.

On 02/27/15 at 7:32 AM, an interview was

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F 323	Continued From page 14 conducted with Nurse #2. She stated Resident #87 was encouraged to not attempt to get out of bed on her own but she had poor safety awareness and frequently attempted to get out of bed, especially when the bed was wet. She indicated she would have expected the NA to have assisted Resident #87 back into the bed before the NA left the room for bed linens. On 02/27/15 at 2:01 PM, an interview was conducted with the Director of Nursing (DON). She stated Resident #87 had poor safety awareness and was not to be positioned on the side of the bed. She further stated she would have expected 2 staff members to transfer the resident into her wheelchair while they changed her soiled bed linens. She indicated the resident should not have been setting on the side of the bed and/or left unattended.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews,	F 325	F 325 MAINTAIN NUTRITION STATUS	4/8/15

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F 325	Continued From page 15 the facility failed to address unintended significant weight loss for 1 of 1 residents (Resident #31) sampled for weight loss. Findings included: Resident #31 was admitted to the facility on 07/10/12. Diagnoses included Alzheimer's disease, paralysis agitans, and anemia. Resident #31 was discharged on 1/30/2015. A medical record review revealed the following nutritional supplements had been ordered and were being given until the resident was discharged on 01/30/2015: Supercereal on 08/28/12, Great Shake on 09/11/12, and house supplement on 05/01/14. The following medications had been ordered to manage the resident's weight: megestrol acetate, a medication to increase appetite, on 07/18/14 and mirtazapine, another medication to increase appetite, was ordered on 08/05/14. Review of Resident #31's weights revealed the resident weighed 117 pounds on 11/03/14 and 104 pounds on 01/02/15, a significant weight loss of 11.1%. A progress noted dated 01/02/15 and signed by the Medical Director indicated a medication called mirtazapine (an antidepressant and appetite-stimulating medication) was being used to help stimulate Resident #31 ' s appetite and the medication was fairly successful. The physician also indicated the prognosis for Resident #31 was fair. Review of Resident #31's weights revealed the resident weighed 102 pounds on 01/12/15, identifying a significant weight loss of 12.8% since 11/03/14. A medical record review revealed a quarterly nutrition assessment completed on 01/16/15 indicating Resident #31 ate an average of 50-75% of meals offered.	F 325	UNLESS UNAVOIDABLE Disclaimer Clause: Preparation and or execution of this plan of correction and credible allegation of compliance does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action for those resident(s) found to have been affected: Resident #31 weight was recalculated for accuracy by the Certified Dietary Manager (CDM) and was referred to the Registered Dietician for evaluation and recommendation on 2/22/15. A gastrostomy tube was placed during the residents hospitalization 1/30 to 2/7/15. Tube feeding orders were implemented upon the resident□'s return to the facility on 2/7/15 and the resident received 100% of nutrition via feeding tube until she expired on 3/14/14. Corrective Action for those resident(s) having potential to be affected: All residents weights were recalculated by the CDM on 3/14/15 for accuracy of the weight loss percentage and those that triggered for significant weight loss as defined by 5% in 30 days, 7.5% in 3 months and 10% in 6 months, were	

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F 325	Continued From page 16 The quarterly Minimum Data Set (MDS) dated 01/16/15 indicated Resident #31 was severely cognitively impaired and required supervision with set-up help of one staff member for eating. The MDS further indicated the resident had no signs or symptoms of a possible swallowing disorder. A care plan was developed upon admission to the facility and revised 01/18/15. The goals were to tolerate the prescribed diet and have no significant weight loss in ninety days. The care plan included interventions to monitor Resident #31's food intake and weights in order to keep the resident within the ideal body weight of 99 to 121 pounds, as established by the facility. An interview was conducted with the Assistant Dietary Manager (ADM) on 02/25/15 at 11:21 AM. She stated weights were gathered and recorded every month for every resident, but Resident #31's weight was being obtained weekly. The ADM specified a weight change of 5% would trigger the weight management committee to begin starting interventions to manage weight. She indicated there were many supplements that could be recommended, and the weight management committee could refer to the physician for medical interventions. The ADM was unable to provide any new interventions implemented since Resident #31's weight loss was noted on 01/02/2015. An interview was conducted with the Registered Dietician on 02/25/15 at 3:00 PM. She stated she was familiar with Resident #31 but could not remember the last time she had seen or evaluated the resident. She was unaware of the 12.8% weight loss present at the time of the dietary evaluation on 01/16/15. The Registered Dietician was unable to provide anything in the last year that she had completed concerning Resident #31 ' s dietary status. The Dietary	F 325	referred to the Registered Dietician for evaluation and recommendations. The Registered Dietician recommendations were implemented as ordered. The Administrator and CDM met with the Registered Dietician on 3/19/15 to review the elements of the plan of correction and establish parameters for contacting her off hours and to facilitate timely input on plan of care interventions. The Certified Dietary Manager (CDM), and Assistant Dietary Manager (ADM) were in-serviced by the Registered Dietician (RD) on 2/27/15 regarding monitoring dietary/fluid intake, laboratory/diagnostic evaluation, the parameters for significant weight loss as defined by 5% in 30 days, 7.5% in 3 months and 10% in 6 months and the need for dietary interventions for residents exhibiting significant weight loss. Systemic Change: A meal/supplement consumption tracking tool was developed by the Quality Assurance Coordinator, to be used for nursing and nutrition staff in order to facilitate communication and revisions in the plan of care. The Nursing staff were in-serviced by the Staff Development Coordinator (SDC) regarding meal/supplement consumption, the importance of accurately recording meal consumption, and filling out the	

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F 325	Continued From page 17 Manager and the Assistant Dietary Manager were completing the quarterly nutritional assessments. An interview was conducted with the Nurse Practitioner (NP) on 02/25/15 at 4:28 PM. The NP explained that she had written an order for mirtazapine, the appetite stimulating medication, in August 2014. She did not recall discussing Resident #31's weight since writing that order. An interview was conducted with the Medical Director on 02/26/15 at 4:37 PM. He stated he went over weight loss in the monthly quality assurance committee. He felt notification of weight loss was a nursing judgment. He stated it was his expectation for Resident #31 to lose weight because Alzheimer's Disease affected the body's ability to absorb calories and also affected appetite. A follow-up interview was conducted with the Assistant Dietary Manager on 02/27/15 at 2:23 PM. She stated the facility used an ideal body weight to monitor residents for weight. She stated she was aware of Resident #31's weight loss at the time of the last assessment on 01/16/15, but it was still within the ideal body weight range so she felt further intervention was not necessary.	F 325	meal/supplement consumption tracking tool after each meal. The meal/supplement consumption tool will be turned in to the DON daily for review and concerns will be addressed in the weekly weight management team meeting. The CDM/ADM will calculate the percentage of weight loss using the formula: % of body weight loss = (usual weight - actual weight) / (usual weight) x 100, and will determine those residents identified with significant weight loss to be discussed at the weekly weight management team meeting. All newly admitted or readmitted residents, residents with skin integrity issues, triggered change in weight, or enteral feeding will be referred by the CDM/ADM to the Registered Dietician, physician or physician extender and reviewed at the weekly Weight Management Team meeting and corresponding interventions will be placed on the Care Plan. Weights and meal/supplement consumption will reviewed weekly by the Weight Management Team consisting of the Administrator, Certified Dietary Manager, Director of Nursing, Quality Assurance Coordinator, Therapy Director, Activities Director, Treatment Nurse, Restorative Aide, and Medical Records Clerk, with a focus on those residents that have been identified with significant	

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F 325	Continued From page 18	F 325	weight loss until the resident maintains a stable weight for four weeks. Monitoring: The DON and CDM, together, will randomly audit 20 charts per week for four weeks and 5 charts per week for two more months of residents identified as eating 50% of their meal or less to ensure alternates are being offered, there is no corresponding weight loss, dietary interventions are being implemented as necessary, the Registered Dietician/Physician/Physician Extender has been notified, and the Care Plan has been updated as necessary. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations.	
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	F 329		4/8/15

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F 329	Continued From page 19 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 record reviews and staff interviews, the facility failed to obtain a lab ordered by the physician for required medication monitoring for 1 of 5 residents (Resident #69) sampled for unnecessary medications. Findings included: Resident #69 was admitted to the facility on 12/23/14. Diagnoses included dementia with behavioral disturbances, depression, and anxiety. A medical record review revealed Resident #69 was admitted to the facility with a physician order for valproic acid, an anti-seizure medication also used to treat mood disorders. Resident #69 was prescribed valproic acid for mood disorders. According to a lab protocol developed by the facility, if a resident was prescribed valproic acid, a valproic acid level was to be checked every month by drawing blood and sending the blood to a laboratory to be tested. The Director of Nursing signed the lab protocol on 09/23/14, and the Medical Director signed the lab protocol on 09/25/14. A medical record review revealed a valproic acid	F 329	F329 UNNECESSARY DRUGS Disclaimer Clause: Preparation and or execution of this plan of correction and credible allegation of compliance does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action for those resident(s) found to have been affected: A valproic acid level was obtained on resident #69 on 2/26/15. The physician was notified of results and the order for monthly monitoring was changed to every three months on 2/26/15.	

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F 329	Continued From page 20 level was drawn and checked on 12/30/14. There were no valproic acid levels present in the medical record for the months of January 2015 or February 2015. The result of the valproic acid level performed on 12/30/14 indicated the level was low and outside of the established therapeutic range identified by the laboratory. An interview was conducted with the Medical Records Director on 02/26/15 at 12:03 PM. She stated lab due dates are tracked electronically and on a paper calendar hanging at the nurses' station. She reviewed the electronic tracking for Resident #69 and discovered the valproic acid level was scheduled to be performed every six months. She stated the Unit Secretary must have entered the information in the electronic system incorrectly. She then reviewed the physician orders to verify the lab order had not been changed since admission. The order to perform a valproic acid level every month was still active. A review of the lab calendar hanging at the nurses' station revealed Resident #69's valproic acid level was not scheduled to be drawn on any date in February 2015. An interview with the laboratory that performs the labs for the facility was conducted on 02/26/15 at 12:19 PM. According to a Customer Service Representative, the last valproic acid level in their laboratory was completed on 12/30/14. An interview was conducted with the Director of Nursing on 02/26/15 at 12:50 PM. She stated her expectation was all labs are to be drawn as specified by the physician's order. She stated in September 2015, the facility had reviewed the lab protocol and made some changes to reflect current practice. These changes were then approved by herself and the Medical Director. An interview was conducted with the Medical Director on 02/26/15 at 4:02 PM. He stated it	F 329	The standing orders for high risk medication laboratory monitoring was revised and signed by the Medical Director on 4/3/15 and placed in resident #69□s chart. Corrective Action for those resident(s) having potential to be affected: A lab audit on all current residents was completed by the Unit Secretary on 3/11/15 with any issues addressed and corrected and reviewed by the Director of Nursing. The standing orders for high risk medication laboratory monitoring was revised and signed by the Medical Director on 4/3/15 and placed in the charts of all residents in the facility. The licensed nurses were inserviced by the Staff Development Coordinator on 3/18/15 regarding what medications need to be monitored and the importance of correctly transcribing orders to the lab requisitions to assure the laboratory monitoring takes place. Systemic Change: New labs ordered will be reviewed daily and logged on the Daily Lab Sheet by the unit secretary to ensure the lab requisitions are made out for future labs and the labs ordered for the previous day are completed. She will report to the Director of Nursing as necessary any	

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F 329	Continued From page 21 was his expectation for labs to be performed as ordered and notify him of the results. He explained valproic acid levels were drawn in order to monitor for drug toxicity. In Resident #69's situation, he stated since the medication was prescribed to treat a mood disorder, he would not order a valproic acid level every month. He stated a valproic acid level should be drawn every three to six months when the medication was prescribed to treat a mood disorder to monitor for drug toxicity, but this decision was left up to the nurses to decide. The Medical Director further explained a low valproic acid level was acceptable when the medication was prescribed for mood disorders.	F 329	failures in the lab process. The Director of Nursing will follow-up with the licensed nurses as necessary. The Staff Development Coordinator will re-educate the licensed nurses and unit secretary of any changes related to high risk medication monitoring or lab protocol that occur according to the Medical Director and Pharmacist. Monitoring: The scheduled labs will be audited daily by the unit secretary and treatment nurse for 5 days and then weekly for 3 months to ensure lab completion, results are received, and the physician has been notified of results. Results of those audits will be forwarded to the Director of Nursing for follow-up as necessary. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for six months for review and recommendations.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		4/7/15

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F 371	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard an open container of cocoa with mold spores on the container top and on the outside of the container; keep kitchen equipment clean and free of food splatters and grease accumulation; keep food preparation and service equipment clean and dry; failed to keep cups stored with ice in the freezer covered and dated when placed in the freezer; failed to keep dinner plate bottoms, pans, bowls and cups ready for use free from moisture. The findings included: 1. On 02/23/15 at 11:10 AM a 5 lb container of cocoa was observed with mold spores on the top and outside of the container. Observed the cocoa inside the container and there was no evidence of microbial growth in the actual food product. An additional observation of the freezer on 02/25/15 at 9:05 AM revealed the 5 lb cocoa container remained in the freezer. An interview on 02/25/15 at 9:05 AM with the Assistant Dietary Manager (ADM) revealed the kitchen aide and cook stock the foods at night in the kitchen refrigerator and freezer and the expectation was the food containers should be checked for debris; and, food items dated later than 3 days should be discarded. The ADM was observed to remove the contaminated cocoa container from the freezer. 2. On 02/23/15 at 10:44 AM the kitchen ' s range was observed to have a ½ inch thick black crusted material around the front burners. The	F 371	F 371 FOOD PROCURE, STORE/PREPARE/SERVICE □ SANITARY Disclaimer Clause: Preparation and or execution of this plan of correction and credible allegation of compliance does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action for those resident(s) found to have been affected: The open container of cocoa with mold spores was discarded at the time of survey. The food spatters was cleaned from the kitchen equipment at the time of survey. The cups with ice was discarded at the time of survey. The dinner plate bottoms, pans, bowls, and cups were rewashed, dried and stored appropriately at the time of survey. No resident was found to have untoward affect from the items identified in the 2567. Corrective Action for those resident(s) having potential to be affecte:	

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F 371	Continued From page 23 sides of the range had a build-up of sticky greasy residue. Additional observation revealed 2 fryers adjacent to the kitchen range had greasy residue and spills on the controls and metal splash guard with build-up of grease and food debris on the inside of the fryers. On 02/25/15 at 9:07 AM revealed the kitchen range and 2 fryers had the same heavy greasy build-up as noted on 02/23/15. The sides of the range continued to have sticky greasy residue. An interview on 02/25/15 at 9:05 AM with the ADM revealed the kitchen range burners, oven and metal sides of the range should be checked and cleaned daily, if needed, by first shift kitchen staff before they leave the shift. The ADM revealed the kitchen aide would clean the range burners and metal sides of the range and the fryers. 3. On 02/23/15 at 10:40 AM the air filter vents over the ice machine were observed with ¼ inch dust debris. Also, on 02/23/15 at 10:40 AM observed cups in the freezer with ice in them ready for use uncovered and no date when placed in the freezer. An interview on 02/25/15 at 9:05 AM with the ADM revealed the air filter vents over the ice machine should be cleaned every Thursday. The ADM said the cups stored in the freezer with ice in them should have been covered and dated when placed in the freezer. The ADM stated the cups would be pulled out of the freezer and re-washed. 4. On 02/23/15 at 11:00 AM revealed 82 plate bottoms ready for use stacked on top of one another wet with moisture. Also, 31 bowls ready for use were observed stored wet with moisture; and, one medium metal pan ready for use was observed stacked over another medium pan wet with moisture.	F 371	All dietary staff were in-serviced by the Dietary Manager regarding food storage and sanitation guidelines and their individual responsibilities for daily sanitation on 3/18/15. Food storage and sanitation rounds to assure food items are properly stored and kitchen sanitation is completed was conducted on 3/26/15 by the Administrator. Issues of non-compliance were immediately corrected and the Dietary Staff will be followed up with by the CDM or ADM as necessary. Systemic Change: A daily signed check list for kitchen sanitation to be completed by assigned dietary staff was implemented by the CDM on 4/7/15. The checklist will be reviewed by the CDM/ADM for completion and accuracy. Food storage and sanitation rounds to assure food items are properly stored and kitchen sanitation is completed will be conducted weekly, ongoing, by the CDM and or ADM. Issues of non-compliance will be corrected immediately and the Dietary Staff will be followed up with by the CDM or ADM as necessary. Monitoring The food storage and sanitation rounds will be completed by the Dietary Manager and/or Assistant Dietary Manager twice weekly for four weeks and weekly for two	

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F 371	Continued From page 24 An interview on 02/25/15 at 9:05 AM with the ADM revealed food preparation equipment such as plates, pans, bowls and cups should be thoroughly dried when ready for use. 5. On 02/23/15 at 11:01 AM the metal knife holder was observed to have debris particles on the top of the metal holder. An interview on 02/25/15 at 9:05 AM with the ADM revealed the metal holder for the knives should be cleaned daily.	F 371	more months utilizing a QAPI audit tool to monitor effectiveness food storage and kitchen sanitation. Issues of non-compliance will be corrected immediately ath the time of audit. A summary of trends and/or issues of non-compliance will be discussed by the CDM, ADM, and Administrator weekly for four weeks and monthly thereafter, ongoing. Further re-training or disciplinary action will be implemented as necessary. The Certified Dietary Manager will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for six months for review and recommendations.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		4/8/15

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F 431	Continued From page 25 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to securely store Lasix, an anti-diuretic (water pill) in 1 of 4 medication carts during medication pass. The findings included: The facility's policy titled "Medication Storage," undated, read in part "all medications and prescription biologicals shall be stored in locked carts or medication rooms." Observation on 02/25/15 at 9:21 AM on the 100 Hall revealed Medication Aide (MA) #6 to come out of a resident's room from where she had administered medications. Observation revealed 4 plastic medication containers on top of the medication cart. The medication containers were not in view of MA #6 while she was in the resident's room with the door closed.	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS Disclaimer Clause: Preparation and or execution of this plan of correction and credible allegation of compliance does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action for those resident(s) found to have been affected: Medication pass audit and Education Remediation will be completed monthly for three months for Medication Aid #6 by	

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F 431	Continued From page 26 Observation on 02/25/15 at 9:30 AM revealed MA #6 prepared 9 medications at the medication cart for Resident #65. The MA entered the resident's room and administered the medications. The 4 plastic containers remained unattended on top of the medication cart during the medication administration. Observation on 02/25/15 at 9:37 AM revealed MA #6 left the medication cart to assist a nursing aide with a resident. The 4 plastic containers remained unattended on top of the medication cart and were not in view of MA #6 while she was in the resident's room with the door closed. Observation on 02/25/15 at 9:42 AM revealed 4 tablets of Lasix 40 milligrams (mg) in 1 plastic container on top of the medication cart and the other 3 plastic containers were empty. In an interview on 02/25/15 at 9:45 AM, MA #6 stated the facility policy was to keep all medications locked in the medication cart. MA #6 acknowledged she left the plastic container with 4 tablets of Lasix on top of the cart unattended. She stated "I had a question for the nurse about the medication but I should have locked them in the cart." In an interview on 02/25/15 at 2:44 PM, Nurse #5, assigned to oversee MA #6 for the 100 hall, stated she would have expected the MA to have kept the plastic container of 4 tablets of Lasix locked in the medication cart and that the Lasix should not have been left unattended on top of the medication cart. In an interview on 02/25/15 at 2:01 PM, the Director of Nursing (DON) stated the facility policy	F 431	the SDC or Administrative Registered Nurse. Corrective Action for those resident(s) having potential to be affecte: Medication pass audit and Education Remediation will be completed on all other medication aids will be completed by the SDC or Administrative Registered Nurse by 4/8/15. Medication Pass competency will be implemented immediately for all new hire medication aids and annually thereafter will be completed by the SDC or Administrative Registered Nurse An in-service was conducted on 3/18/15 and 3/26/15 for all licensed nurses and medication aids regarding medication storage, not leaving medications unattended on top of the med carts and locking med carts when unattended . Systemic Change: A random audit will be completed weekly, ongoing, by an Administrative nurse checking for unattended medications on to of the med cart and whether or not the cart is locked. Results of those audits will be forwarded to the Director of Nursing for follow-up and training as necessary. Monitoring:	

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F 431	Continued From page 27 was to keep all medications locked in the cart unless they were in view of the nurse passing medications. She stated her expectation was for the staff to store medications properly by locking them up any time they left the medication cart unattended.	F 431	A random audit will be completed weekly, three times weekly for four weeks and monthly, ongoing, by an Administrative nurse checking for unattended medications on to of the med cart and whether or not the cart is locked. Results of those audits will be forwarded to the Director of Nursing for follow-up and training as necessary. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for six months for review and recommendations.	
F 520 SS=D	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 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		4/8/15

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F 520	Continued From page 28 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 observations, record reviews, and staff and resident interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the Committee put into place in September 2014. This is for one deficiency that was originally cited in August 2014 on a recertification survey and also cited on the most recent recertification survey in February 2015. The recited deficiency is in the area of activities of daily living. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross-referred to: 1) F 312 : Activities of Daily Living : Based on record reviews, resident, and staff interviews the facility failed to shower a resident who required assistance with activities of daily living for 1 of 1 residents sampled for activities of daily living (Resident #83). F 312 was originally cited during the August 01, 2014 recertification survey for failing to change soiled clothing, failing to provide personal hygiene, and failing to keep a resident's fingernails clean and free of debris. On the current recertification survey, the facility was again cited for failing to provide showers. An interview with the Quality Assessment and Assurance (QAA) Coordinator was conducted on	F 520	F 520 QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS Disclaimer Clause: Preparation and or execution of this plan of correction and credible allegation of compliance does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action for those resident(s) found to have been affected: A tracker was developed by the Quality Assurance Coordinator to be implemented on 3/27/15 to facilitate monitoring of the plan of correction. A plan and root cause analysis will be developed specifically related to F312: Activities of Daily Living being re-cited on two federal surveys. Corrective Action for those resident(s) having potential to be affecte: Alert and oriented residents will interviewed on admission and quarterly	

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F 520	Continued From page 29 02/27/15 at 4:12 PM. Her responsibility was to coordinate the quality assessment and assurance process. She stated the QAA Committee had been reviewing activities of daily living as it related to the citation of F 312 on the previous survey. The facility had not received any complaints specifically about showers so showers were not being monitored on the monthly rounding checklist that had been developed by the QAA Committee.	F 520	regarding bath/shower preferences and whether or not Activities of Daily Living (ADI□s) are being completed as ordered. Alert and oriented residents was determined according to a Brief Interview for Mental Status (BIMS) score of 13 or greater. The Director of Nursing will follow up with nursing assistants as necessary if there is determined to be a pattern with failing to give baths/showers on assigned days. Corrective action for the Plan of Correction were identified by the QAPI committee for tracking and evaluation. Systemic Change: A tracker was developed by the Quality Assurance Coordinator to be implemented on 3/27/15 to facilitate monitoring of the plan of correction and other QA activities to be utilized by the Administrator and Quality Assurance Coordinator, ongoing. The Administrator will be present and an active participant in the monthly QAPI meetings. The Administrator, DON, and Quality Assurance Coordinator will meet monthly prior to each QAPI meeting to review the completion of audits due. Monitoring: The facility will monitor and evaluate effectiveness of the identified QAPI programs by achieving and maintaining	

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F 520	Continued From page 30	F 520	above identified thresholds. If identified QAPI programs drop below identified threshold (ie: 90%), the QAPI program will be revised and reevaluated as necessary. All QAPI monitoring programs will remain in effect for monitoring and review until it remains above the identified threshold for a period of a minimum of three months.	