STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 05/20/2015

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RALEIGH REHABILITATION CENTER	**616 WADE AVENUE RALEIGH, NC 27605**

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		6/10/15

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

Electronically Signed | 06/11/2015

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

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post names, addresses and telephone numbers of the state survey and certification agency Complaint Intake information and also failed to prominently display in the facility information about how to apply for and use Medicare and Medicaid benefits. The findings included: On 5/17/15 at 3:25PM, an initial tour of the facility was conducted. There was no posting of the state survey and certification agency Complaint intake information or Medicare/ Medicaid information. On 5/18/15 at 9:00AM and 4:00PM, a tour of the facility was conducted. There was no posting of the state survey and certification complaint intake unit information. There was also no posting of the Medicare and Medicaid information. ON 5/19/15 at 11:40AM, a tour of the facility was conducted with Administrative staff #1. He stated he thought the information was on the wall on the first floor beside the Resident rights. No information was noted on the first floor. Subsequent tours of the second, third and fourth floor was conducted with Administrative staff 1. There was no posting of the state survey and certification Complaint Intake information and no posting of Medicare/ Medicaid information. On 5/19/15 at 11:50AM, the regional clinical director stated she was aware that the Complaint	F 156	F-156 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. On 5/19, the Administrator made copies of the Resident Rights poster in Activities and placed them prominently throughout the building on each floor near the elevator. The Complaint Intake number was printed from DHSR and were framed and placed along with the new Resident Rights posters on each floor. We have ordered the ¿How to Apply for Medicaid..¿ The brochures are kept in the Admissions office and copies are made and given to the resident family in the admission package. ePASS brochures and will replace the copied ones we are currently using when they arrive. We made copies of the ePASS poster and displayed it prominently on 6/9. The Administrator will check each	

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F 156	Continued From page 3 Intake information and Medicare/ Medicaid information should be posted. Administrative staff #1 stated he was unaware that the information was not posted but the information would be posted in a prominent location.	F 156	location once per week for 10 weeks. Currently, there are 6 displays through the building and each are fastened to the wall in plain site. These results will be reviewed by QA/Safety Committee at the next Quarterly Meeting in July 2015. Any continuation will be discussed and may be continued or discontinued per Committee.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to honor the resident's choice to be a do not resuscitate (DNR) status for 1 of 1 sampled resident reviewed (Resident #36). Finding included: Resident #36 was admitted to the facility on 1/9/15 with multiple diagnoses including malignant neoplasm of the colon and secondary neoplasm of the liver. The hospice notes dated 3/4/15 were reviewed. The notes indicated " social worker conducted a routine visit to assess needs of patient and wife per request of son. Yesterday, wife was tearful due to patient's agitation and overall decline in	F 242	F-242 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	6/11/15

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F 242	Continued From page 4 condition. Social worker made contact with registered nurse and director of nursing to discuss needs especially in regards to code status. Son is adamant that patient is DNR. Social worker to relay to social worker in facility. Social worker provided support to patient and sensory stimulation, support to staff and son as well. Son requested increased presence for wife support. " Review of the March, 2015 physician's orders revealed that the resident was a " full code " from 2/3/15. A DNR consent form and a DNR order form (yellow form) dated 3/4/15 was found in the records of Resident #36. The nurse's notes dated 3/5/15 at 9:53 AM was reviewed. The notes indicated " upon entering the room this nurse noted the resident to be without respiration or pulse and unresponsive to stimuli. Cardio pulmonary resuscitation (CPR) initiated per full code order and emergency medical services (EMS) notified at 9:11 AM. This nurse called (name of hospice agency) to notify of event and also call placed to son to notify of event. Discussion had with son regarding continuation of CPR and son stated that his father would not want to be on a machine. Son stated to discontinue CPR and thanked for the phone call. This nurse then instructed staff and EMS of family wishes to discontinue at 9:22 AM. " On 5/20/15 at 11:46 AM, administrative staff #1 was interviewed. Administrative staff #1 stated that he was in the room and the resident had no vital signs. The chart was checked and indicated that the resident was a full code. CPR was	F 242	1) Interventions for affected resident: The medical record of resident #36 contained an order for ¿full code¿ from 2/3/15. The medical record did not contain any obvious notation indicating the resident wished to be a DNR status. Administrative staff #6 noted the resident had had a decline and had discussed code status with the resident's legal representative on 3/4/15. Social support was given to the resident and to the resident's legal Representative. An order for code status to be changed to DNR was requested from the physician and a goldenrod was placed in the physicians box to be signed. 2) Interventions for residents identified as having the potential to be affected: A 100% audit was completed for all current residents in the facility to identify residents who may not have current code status orders in the chart. Audit materials included, legal DNR form, physicians order for code status, and consent for code status signed by the resident or the resident's legal representative. All current resident's medical records reflect accurate end of life wishes. 3) Systematic Change: The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or Unit Manager will provide in-servicing to all licensed nursing staff and social services staff on the importance of honoring the resident's right to make choices in regards to interests, assessments, and plans of	

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F 242	Continued From page 5 initiated. Administrative staff #1 indicated that the DNR consent form and DNR order form were not in the chart at that time. On 5/20/15 at 12:10 PM, administrative staff #6 was interviewed. She stated that Resident #36 had a decline in condition lately. She stated that the hospice social worker had called her and told her that the son of Resident #36 wanted the resident to be a DNR. She then completed a DNR consent form and dated it 3/4/15. She also completed a DNR order form and dated it for 3/4/15. She left the form in the box for the doctor to sign. She indicated that she did not know when the doctor had signed the form. She added that the doctor might have signed the DNR order form and was brought to the medical records for filing.	F 242	care, specifically relating to end of life choices. In-servicing to include utilizing the code consent form and the yellow DNR form (when applicable) for documentation, and placing those documents on the resident's medical record immediately after forms are comleted. Additionally, newly hired nurses and social workers will be educated during their orientation period on placement of the signed DNR form and the DNR Consent form within the resident's medical record. Specifically, when a Social Worker receives a signed DNR form from the attending physician, he/she will immediately place it in the front of the resident's chart. Further, he/she will present any changes in Daily Stand Up the following morning to ensure that all staff are aware of these changes as soon as they occur. The Staff Development Coordinator will perform and audit 5 charts twice weekly for twelve weeks to ensure that the resident's medical record accurately reflects their current end of life wishes by verifying the code consent form and DNR form (when applicable)are in the medical record. All new admissions will be reviewed by the admissions nurse to ensure that the resident's medical record accurately reflects their currrent end of life choices. 4) Monitoring of the change to sustain ongoing system compliance: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for code status to the Quality Assurance and Performance	

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F 242	Continued From page 6	F 242	improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and determine the need for further auditing beyond the three (3) months.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide maintenance and housekeeping services necessary to maintain a safe and clean interior on 2 of 3 resident floors (3rd floor and 4th floor). The findings included: An observation of the 4th floor resident rooms and resident bathrooms was conducted on 5/20/15 at 3:15 PM. Peeled wallpaper by the main door, chipped paint on the back of the main door, a dislodged threshold leading into the bathroom, and dirt and dust along the baseboards in the bathroom were observed in Room 402. Black marks on the wall in the resident room, peeled baseboards in the bathroom and dirt and dust along the baseboards in the bathroom were observed in Room 403. Dirt and dust along the baseboards in the bathroom was observed in Room 404. Chipped paint on the back of the main door, chipped tile in the bathroom and a lack of a	F 253	F-253 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. The following interventions for affected residents were made following survey for affected residents:	6/17/15

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F 253	Continued From page 7 sink drain stopper were observed in Room 405. Peeled wallpaper behind the two resident ' s beds was observed in Room 406. Soiled wall tiles located underneath the sink were observed in Room 407. Dirt and dust along the baseboards in the bathroom was observed in Room 408. Two holes approximately ½ of an inch in diameter located in the wall of the resident room, peeled baseboards in the bathroom and dirt and dust along the baseboards in the bathroom were observed in Room 409. Chipped paint on the back of the main door, peeled baseboards in the bathroom and dirt and dust along the baseboards in the bathroom were observed in Room 410. A lack of a sink drain stopper was observed in Room 412. Chipped paint on the bathroom wall, dirt and dust along the baseboards in the bathroom and a lack of a sink drain stopper were observed in Room 414. An observation of the 3rd floor resident rooms and resident bathrooms was conducted on 5/20/15 at 3:45 PM. Dirt and rust were observed around the base of the commode in the bathroom in Room 302. Dirt and rust were observed around the base of the commode in the bathroom in Room 303. Dirt and a yellow stain were observed around the base of the commode, a toilet chair over the commode was dirty and a urine odor in the bathroom was observed in Room 304. Peeled baseboards in the resident room were observed in Room 305. A noise was created when the main door to the resident was closed and a strong odor of urine was observed in Room 306. A reddish brown color was observed around the base of the commode in Room 307. Peeled wallpaper around the vent located next to resident wardrobe for bed B was observed in Room 310. Peeled wallpaper on the wall approximately 4 feet in length, loose	F 253	Room 402 - The peeled wallpaper was repaired and the door was touched up. The dislodged threshold was repaired immediately while survey was present. The dirt and dust have been cleaned. Room 403 - Black marks were remove and the bathroom was detail cleaned to remove all dirt and dust. Room 404 ¿ Dirt cleaned and bathroom dusted. Room 405 ¿ The drain stopper was replaced and the door was painted. Room 406 ¿ The damaged wallpaper was replaced by Codex to protect the walls from future damage. Room 407 - The bathroom floors were cleaned. Room 408 ¿ The bathroom floors were cleaned. Room 409 - The holes were patched and painted and the bathroom floors were cleaned. Room 410 - The door was painted and the bathrooms were cleaned. Room 412 - The sink drain stopper was replaced. Room 414 ¿ The bathroom was detailed to include cleaning the floors and dusting. The sink drain stopper was replaced. Rooms 420-436 These rooms were inspected and all findings were cleaned and repaired or placed on the replacement list. Room 302 - The bathroom	

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F 253	Continued From page 8 baseboards approximately 6 to 8 inches long were observed in Room 312. Loose baseboards in the resident room, yellow stains around the base of the commode and a smell of urine were observed in Room 314. Peeled baseboard near the bathroom was observed in Room 320. A yellow stain was observed around the base of the commode in Room 322. Peeled wallpaper near bed A and a yellow color around the base of the commode were observed in Room 326. A brownish yellow color was observed around the base of the commode in Room 328. A missing piece of the baseboard near the bathroom and dirt around the perimeter of the bathroom walls were observed in Room 329. Loose baseboards in the resident room near bed A and in the bathroom, a yellowish brown stain around the base of the commode and dirt on the floor along the perimeter of the bathroom walls were observed in Room 330. Loose baseboard was observed near the bathroom in Room 331. Loose baseboard was observed in the bathroom in Room 332. Dirt on the floor around the perimeter of the bathroom walls and a small amount of brownish yellow material around the base of the commode were observed in Room 333. A tour of the 4th floor resident rooms and resident bathrooms was conducted with Administrative Staff #3, Administrative Staff #4 and Administrative Staff #5 on 5/20/15 at 3:50 PM. Administrative Staff #5 stated the floors in the resident ' s rooms and bathrooms were cleaned on a daily basis. He stated the dirt and the stain around the perimeter of the bathroom walls and the base of the commodes was difficult to remove with mopping. Administrative Staff #4 stated some of the sink drain stoppers were removed to help prevent the overflow of water in the sink. He	F 253	floor was detailed to remove dirt and dust. Room 303 ¿ The bathroom floor was cleaned and the toilet was scrubbed. Room 304 ¿ The toilet chair was cleaned in addition to the commode and the room was sprayed to remove urine odor. Room 305 ¿ The baseboards were repaired until new ones arrive to change them. Room 306 - This room is detailed daily and the resident now uses a charcoal pad in her scooter. This is an ongoing issue and neutralizing spray is being released in the hallway throughout the day. Room 307 - The bathroom floor was scrubbed, particularly around the toilet. Room 310 - The wallpaper has been repaired. Room 312 ¿ The wallpaper has been replaced with Codex to avoid future damage and the baseboards have been re-fastened and glued. Room 314 ¿ The bathroom floors and commode have been detailed and scrubbed. Room 320 ¿ The baseboard has been repaired awaiting replacement. Room 322 - The toilet and bathroom floor have been scrubbed. Room 326 - The wallpaper was repaired and the bathroom floor was scrubbed. Room 328 - The bathroom floor was cleaned to include the toilet. Room 329 - The bathroom	

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F 253	Continued From page 9 stated the facility was in the process of removing the wallpaper in the resident rooms and replacing the floor in the resident bathrooms. Administrative Staff #4 stated the dislodged threshold going into the bathroom in Room 402 would be replaced by the end of the day. Administrative Staff #3 stated the cleanser used to clean the floors in the resident rooms and bathrooms was not adequate for removing the dirt and stain around the perimeter of the bathroom walls and the base of the commodes. He stated the facility was in the process of removing the wallpaper and replacing the bathroom floors in the resident rooms. He stated there was no date set for the completion of the work.	F 253	baseboard is reattached but scheduled to be replaced. The bathroom was scrubbed to remove dirt. Room 330 ¿ The baseboards have been repaired awaiting replacement and the batrhroom was detailed to include scrubbing and dusting. Room 331 ¿ The baseboard was repaired and will be replaced. Room 332 ¿ The baseboard was repaired and will be replaced. Room 333 ¿ The bathroom was detailed to include the flooring around the commode. ALL OF THE ABOVE BATHROOMS WILL BE RECEIVING NEW FLOORING, TOILETS AND BASEBOARDS. THE PROJECT WILL BEGIN IN LATE JUNE AND WILL BE COMPLETED OVER A 4 WEEK PROJECT. ALL MATERIALS HAVE BEEN ORDERED AND THE CONTRACT HAS BEEN SIGNED. Systematic Change: 2. All Housekeepers were immediately in-serviced on the the deficiencies and how we will proceed moving forward. The Regional Director for Healthcare Services Group was contacted by the Administrator of these results. As a result, the Regional staff member came by to do an inspection on Saturday, May 23rd and again on Monday, May 25th to discuss his findings with the Housekeeping Manager. The Regional Director has agreed to continue inspections with the Housekeeping	

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F 253	Continued From page 10	F 253	Manager every other week in addition to our rounding with said staff. 3. Nursing staff were given the findings and reminded that work orders can be generated for either maintenance or housekeeping findings when they come across them. Monitoring of the change to sustain system compliance ongoing: 4. Our management team will continue to inspect weekly to ensure compliance for the next 11 weeks. The Administrator, Housekeeping Manager and Maintenance Manager will conduct walk-throughs each week through July 31st. These walk-throughs will assure continued compliance with these changes moving forward and during project re-modeling. 5. Results will be reviewed by QA/Safety Committee at the next Quarterly Meeting in July 2015. Any continuation will be discussed and may be continued or discontinued per Committee.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278		6/11/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for dialysis for one of one residents reviewed for dialysis (Resident #129) and failed to accurately code level 2 Preadmission Screening and Resident Review (PASRR) on the admission and annual MDS for one of one residents reviewed for PASRR (Resident #25). The findings included: 1. Resident #129 was admitted to the facility 3/6/15. Cumulative diagnoses included end stage renal disease and dialysis. An admission Minimum Data Set (MDS) dated 3/13/15 indicated Resident #129 had not received	F 278	F278 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 05/20/2015

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F 278	Continued From page 12 dialysis while a resident in the facility. A review of the medical record revealed a nursing note that indicated Resident #129 was moderately impaired in cognition. The MDS indicated " No ' for dialysis while not a resident and while a resident during the assessment period. A care plan dated 3/16/15 and last reviewed on 5/5/15 indicated Resident #129 required hemodialysis due to end stage renal failure. Interventions included: encourage Resident #129 to go for the scheduled dialysis appointments on each Monday, Wednesday and Friday. On 05/19/2015 at 10:47AM, an interview was conducted with Resident #129 who stated she had been receiving dialysis for three years or so and went every Monday, Wednesday and Friday. On 05/20/2015 at 1:12PM, MDS nurse #1 stated she would look for the information that a resident received dialysis on the hospital discharge summary sheet or the Medication Administration Record (MAR) so she could code the information on the MDS. She stated Resident #129 should have been coded as having received dialysis on the MDS and it was an oversight. 2. Resident #25 was admitted to the facility on 5/22/14. Cumulative diagnoses included: vascular dementia, anxiety and depression. An Admission Minimum Data Set (MDS) dated 5/29/14 indicated preadmission screening and resident review (PASRR) as " 0 " . An Annual MDS dated 4/28/15 indicated	F 278	1) Interventions for affected resident : Resident # 129 had an MDS modification completed to include the dialysis for the resident. Resident # 25 also had an MDS Modification completed to include correct Passar level. 2) Interventions for residents identified as having the potential to be affected: An audit was conducted to ensure current residents with dialysis and passar level 2 have been coded corrected. There were no other current residents without the correct coding of dialysis and or Passar level 2. 3) Systematic Change: The Lead MDS nurse will review each MDS to ensure residents with a diagnosis of renal failure and receiving dialysis is coded correctly before transmission to state. This will be documented on MDS Audit log for residents receiving dialysis and reviewed at PPS three times per week for four weeks , then twice per week for four weeks and finally weekly for four weeks. The Social Worker will audit residents Passar level upon admission. Residents with a level 2 Passar will be documented on a Passar Level Audit form. This form willl be utilized when completing MDS to ensure proper coding of residents with a level 2 Passar. Once MDS is completed for residents with level 2 Passar, the Social Worker and Lead MDS will review for accuracy using the Passar Audit tool. This will be completed at PPS meeting three times per week for four weeks, then two times per week for four weeks and finally weekly for four weeks. This will be documented on the MDS Completion	

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F 278	Continued From page 13 preadmission screening and resident review (PASRR) as "0". No mood or behaviors were noted during the assessment period. The medical record was reviewed and revealed the following PASRR level 2 and screening history. Resident #25 was admitted to the facility on 5/22/14 with a PASRR #_____F with an expiration date of 8/18/14. A change in condition review (PASRR only) was submitted on 10/08/14 and completed 10/13/14 with PASRR#_____B with no expiration date. There was no resubmission submitted by 8/18/14 for a PASRR level 2 renewal. On 5/20/15 at 12:51PM, Administrative staff #2 stated that section A that contained the PASRR information was completed by the MDS nurse. She stated she did not provide the MDS nurses with a list of current PASRR level 2 residents. On 05/20/2015 at 1:06PM, MDS nurse #1 stated the social worker was supposed to let them know when a person was PASRR level 2. Sometimes, the business office and/or social worker would scan the information under the miscellaneous section in the resident ' s computerized chart. She stated the MDS asks for PASRR level 2 under section A and should be coded appropriately. On 05/20/2015 at 1:40PM, MDS nurse #3 stated she had completed the MDS information for the Admission MDS dated 5/29/14. She stated she did not know that Resident #25 was PASRR level 2 and, if she had known, she would have coded it on the MDS. On 05/20/2015 at 1:44PM, MDS nurse #2 stated	F 278	Audit tool for Dislysis and Passar level 2. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the MDS Nurse and Social Worker will report the results of the audits for proper completion of the MDS and follow up on MDS with Dialysis and Passar Level 2. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing, beyond the three (3) months period.	

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F 278	Continued From page 14 if the PASRR information was not under the miscellaneous section in the computerized resident record, she relied on the social worker to inform them of the PASRR level 2 status. She said she did not know Resident #25 was PASRR level 2 and would have coded it on section A of the MDS if she had known	F 278		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 285		6/11/15

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F 285	Continued From page 15 and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to coordinate with the Preadmission Screening and Resident Review Program (PASRR) for reevaluation of PASRR for continued stay at the facility for one of one sampled residents with a level two screening (Resident #25). Resident #25 was admitted to the facility on 5/22/14. Cumulative diagnoses included: vascular dementia, anxiety and depression. An Admission Minimum Data Set (MDS) dated 5/29/14 indicated preadmission screening and resident review (PASRR) as " 0 " . An Annual MDS dated 4/28/15 indicated preadmission screening and resident review (PASRR) as "0". No mood or behaviors were noted during the assessment period. The medical record was reviewed and revealed	F 285	F-285 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: Resident #25's PASRR level 2 was completed on 10/13/14. 2) Interventions for residents identified as having the potential to be affected: An audit of all residents with a level 2 PASRR was completed to ensure all level	

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F 285	Continued From page 16 the following PASRR level 2 and screening history. Resident #25 was admitted to the facility on 5/22/14 with a PASRR level 2 #_____F with an expiration date of 8/18/14. A change in condition review (PASRR only) was submitted on 10/08/14 and completed 10/13/14 with PASRR level 2 #_____B with no expiration date. There was no resubmission submitted by 8/18/14 for a PASRR level 2 renewal. On 05/20/2015 at 12:51PM, Administrative staff #2 stated she had been at the facility for five years. She stated the admission department informed her when a resident was first admitted and let her know if they have a PASRR number that was expiring so she could resubmit the information seven days prior to the expiration. Administrative staff #2 stated she was reviewing Resident #25's chart in October and discovered that the PASRR had expired in August 2014. That was when she reapplied for his level 2 PASRR. She stated when a resident was admitted with a limited PASRR (30, 60, 90 days), she usually put it on her calendar to remind her to renew it prior to expiration. Administrative staff #2 stated the PASRR for Resident #25 should have been renewed prior to the expiration date of 8/18/14	F 285	2 PASRRs are up to date and in the resident record. The Staff Development Coordinator performed re-education with Social Workers and Admission Staff regarding procedures for obtaining the PASSR level 2 within the required time frame and documenting the PASRR level 2 in the patient's record. All newly hired Social Workers or Admission staff will be educated during their orientation period on procedures for obtaining the PASRR level 2 within the required time frame and documenting the PASRR level 2 in the patient's record. 3) Systematic Change: The Social Worker will audit all residents with a level 2 PASRR to ensure the PASRR has not expired and the PASRR is located on the resident's chart. The Audit will be completed 2 times a week for 12 weeks. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Social Worker will report the results of the audit to ensure PASSR level 2's have not expired and are located on the resident chart. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		6/11/15

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F 315	Continued From page 17 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to secure the indwelling urinary catheter tubing to prevent excessive tension or accidental displacement for 1 of 2 sampled residents with an indwelling urinary catheter (Resident #28). The finding included: Resident #28 was admitted to the facility on 9/27/06 with multiple diagnoses including urinary retention. The annual Minimum Data Set (MDS) assessment dated 3/3/15 indicated that Resident #28 had severe impairment in decision making and had an indwelling urinary catheter. The care plan was reviewed. A care plan was created on 5/18/15 for the use of the indwelling urinary catheter. The care area assessment (CAA) for urinary incontinence and indwelling catheter indicated that Resident #28 had an indwelling catheter. " The use of the catheter puts the resident at increased risk for urinary tract infection and catheter associated trauma. " The CAA also indicated that the " staff to provide catheter care per policy and procedure and monitor for associated complications. "	F 315	F-315 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: A leg strap was placed on resident #28 on 5/19/15 and the indwelling urinary catheter was secured to the resident's leg. 2) Interventions for residents identified as having the potential to be affected: An audit of all residents with an indwelling urinary catheter was completed to ensure that each catheter was properly secured. The Director of Nursing, Assistant Director of Nursing, Staff Development	

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F 315	Continued From page 18 On 5/19/15 at 10:55 AM, Resident #28 was observed in bed with an indwelling urinary catheter in place. The indwelling urinary catheter tubing was observed with nursing assistant (NA) #1. The tubing was not secured at this time. NA #1 stated that she was not assigned to Resident #28. On 5/19/15 at 2:30 PM, Resident #28 was observed in bed with the indwelling urinary catheter in place. The catheter tubing was observed with NA #2 (assigned to Resident #28). The tubing was not secured at this time. NA #2 stated that residents with an indwelling urinary catheter should have a leg strap at all times. NA #2 further stated that he would get a new leg strap and would put it on the resident. On 5/19/15 at 2:35 PM, Nurse #1 was interviewed. She stated that the facility's policy was for each resident with an indwelling urinary catheter should have a leg strap on at all times to secure the tubing. She also stated that the NAs were responsible for checking the leg strap. On 5/20/15 at 3:40 PM, an interview with the administrative staff #1 was conducted. Administrative staff #1 stated that her expectation was for residents with an indwelling urinary catheter to have a leg strap on.	F 315	Coordinator, or Unit Manager performed re-education with Licensed Nurses on properly securing a urinary catheter to the resident to prevent tension or displacement and the use of the leg strap to secure a catheter. Newly hired Licensed Nurses will be educated during their orientation period on properly securing a urinary catheter to the resident to prevent tension or displacement and the use of the leg strap to secure the catheter 3) Systematic Change: The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all residents with an indwelling catheter to ensure the catheter is properly secured and a leg strap is in place weekly for 12 weeks. 4) Monitoring of the change to sustain system ongoing compliance: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for proper placement of a catheter leg strap to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and determine the need for further auditing beyond the three (3) months.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318		6/11/15

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F 318	Continued From page 19 resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to apply the left hand palm protector as recommended by the occupational therapist for 1 of 1 sampled resident with a contracture (Resident #28). The finding included: Resident #28 was admitted to the facility on 9/27/06 with multiple diagnoses including cerebro vascular accident (CVA). The annual Minimum Data Set (MDS) assessment dated 3/3/15 indicated that Resident #28 had severe impairment in decision making and had limitation in range of motion on both upper and lower extremities. The assessment also indicated that Resident #28 was not on a restorative nursing program for range of motion or splint/braces assistance. The care plan dated 3/3/15 was reviewed. One of the care plan problems was resident had limited physical mobility related to Huntington's disease, hemiplegia and left lower extremities contracture. The goal was resident will maintain current level of mobility through review date and the approaches included to provide gentle range of motion as tolerated with daily care. The care guide for Resident #28 was reviewed.	F 318	F-318 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: A palm protector was placed on the left hand of resident #28 on 5/19/15. 2) Interventions for residents identified as having the potential to be affected: An audit of all current residents with a physician's order for a palm protector to be placed was completed by the Director of Nursing to ensure each device was applied as ordered. All licensed and unlicensed nursing staff were reeducated on the proper placement and positioning of palm protectors, in addition to their use to prevent skin breakdown and decrease	

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F 318	Continued From page 20 Under the care guide, the functional maintenance program for the left hand was posted. The functional maintenance program read " palm protector should be in resident's left hand at all times, remove for hygiene only and check areas for redness. " The occupational therapy (OT) screening form dated 4/1/15 was reviewed. The form indicated " resident is required to have palm protector in left hand at all times except for hygiene purposes. Resident was found to not have palm protector in left hand. Therapist positioned palm protector in left hand and communicated to nursing the wearing schedule. Nursing requested another palm protector and therapist provided nursing with another palm protector. Therapist concerned about resident skin integrity/risk of skin breakdown and increased contracture in left digits if palm protector is not positioned in resident's left hand at all times. " The doctor's progress notes dated 4/17/15 was reviewed. The notes indicated that the left upper extremity had stiffness to shoulder/elbow and contractures to fingers. On 5/19/15 at 10:30 AM, 1:20 PM and 2:30 PM, Resident #28 was observed in bed. Her left hand was on a fist position and there was no palm protector observed. On 5/19/15 at 2:30 PM, NA #2 was interviewed. NA #2 stated that the restorative aides were responsible in providing the palm protector to Resident #28. On 5/19/15 at 2:33 PM, NA #3 (restorative aide) was interviewed. She stated that Resident #28	F 318	the risk for contractures in the digits of the hand that they are applied. Current and Newly hired licensed and unlicensed nursing staff will be in-serviced within their initial orientation period on the proper placement and positioning of palm protectors, in addition to their use to prevent skin breakdown and decrease the risk for contractures in the digits of the hand that they are applied. 3) Systematic Change: The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all residents with palm protectors twice weekly to ensure that they are applied correctly for a period of twelve weeks. Staff who are found to have not applied palm protectors correctly will be identified and immediately in-serviced on the correct procedure for application of a palm protector. 4) Monitoring of the change to sustain ongoing system compliance: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for proper positioning and application of palm protectors to the Quality Assurance and Performance improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 318	Continued From page 21 was not on their case load at this time. She stated that nursing was responsible in making sure that the palm protector was on at all times. On 5/19/15 at 2:35 PM, Nurse # 1 was interviewed. Nurse #1 stated that nursing (nurse and nursing assistant) was responsible for ensuring the palm protector was on at all times. She added that the palm protector must be in the laundry for washing and that was the reason why she was not wearing it. Nurse #1 was observed to open the resident bedside drawer and found a brand new palm protector. She was observed to apply the palm protector to the resident's left hand at this time.	F 318		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334		6/11/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 22 the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 05/20/2015

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F 334	Continued From page 23 refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer the influenza vaccine to 1 of 5 sampled residents (resident #31). The findings included: Resident #31 was admitted to the facility on 4/25/14 and readmitted on 11/4/15 with multiple diagnoses including vascular dementia, cellulitis and osteoarthritis. A consent for resident #31 to receive the influenza vaccine was signed in October 2014. A hand written notation at the bottom of the consent stated the resident had received the influenza vaccination during her hospital admission dated 10/30/14 to 11/4/15. A review of the Medication Administration Record dated October 2014 revealed the resident was not eligible to receive the influenza vaccine on 10/8/14 due to an increased temperature. An interview was conducted with Administrative Staff #1 on 5/20/15 at 5:12 PM. He stated the facility did not administer the influenza vaccination to resident #31 for the 2014 to 2015 influenza season. Administrative Staff #1 stated there was no documentation that the resident received the influenza vaccination during her hospitalization from 10/30/14 to 11/4/15. He stated he expected the nursing staff to verify that the resident received the influenza vaccination	F 334	F-334 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: Resident #31 POA was contacted via telephone. Information regarding risks and benefits of influenza vaccination were discussed according to facility policy and CDC guidelines. Influenza vaccination was offered and the resident¿s legal representative requested the vaccination be given. A physician¿s order was obtained for the immunization and the immunization was obtained from the facility pharmacy. The immunization was administered as ordered. 2) Interventions for residents identified as having the potential to be affected: A 100% audit was completed for all	

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F 334	Continued From page 24 during her hospitalization and to administer the vaccination upon readmission to the facility if not previously administered.	F 334	current residents in the facility to identify any current residents who may not have received the influenza vaccine in the time period of October 1st 2014 through March 31st, 2015. All current residents or their legal representative were provided education on the potential risks and benefits of immunization and were given the opportunity to consent or decline immunization. All current residents in which consent was given were vaccinated. 3) Systematic Change: Beginning October 1st, 2015 all current residents will be offered the influenza vaccine per facility policy and CDC guidelines. 1. Before offering the influenza immunization, the Director of Nursing, Assistant Director of Nursing, Unit Manager or designee will contact each resident, or the resident's legal representative to provide education regarding the benefits and potential side effects of the immunization. 2. Each resident will be offered an influenza vaccination unless the immunization is medically contraindicated or the resident has already been immunized during the time period. 3. The resident or the resident's legal representative will be given the opportunity to refuse immunization, and decision will be recorded in the medical record. 4. Appropriate assessment information will be collected and immunization will be administered as ordered by the attending	

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F 334	Continued From page 25	F 334	physician unless contraindicated. 5. Five current residents will be audited weekly for twelve weeks beginning October 1st to ensure compliance with immunization. 6. Admissions nurse will verify immunization status for all new admissions. If unvaccinated, consent will be discussed with the resident or resident's legal representative and immunization will be offered if applicable. 7. Current nursing staff and newly hired licensed and unlicensed nursing staff will be in-serviced within their initial orientation period in regards to the administration of flu and pneumonia vaccines and the audit process. 4) Monitoring of the change to sustain ongoing system compliance: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for proper immunization to the Quality Assurance and Performance improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and determine the need for further auditing beyond the three (3) months.	