STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 01/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		2/5/16

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

Electronically Signed | 01/28/2016

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

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record reviews, the facility failed to report an allegation of neglect to the state's Health Care Personnel Registry (HCPR) within 24 hours, have evidence of the investigation, and report the findings of the investigation to the HCPR within 5 working days for 1 of 1 sampled resident who reported neglect. (Resident #131). The findings included: Resident #131 was admitted to the facility originally on 11/01/15 and most recently readmitted from the hospital on 12/01/15. His diagnoses included sepsis, muscle weakness, diabetes, hypertension, chronic obstructive pulmonary disease, anxiety disorder and end stage renal disease. A significant change Minimum Data Set dated 12/08/15 coded him with moderately impaired cognition (scoring a 12 out of 15 on the Brief Interview for Mental Status), having no mood or behavior issues, requiring extensive assistance with most activities of daily living skills, having an ostomy, and being incontinent of bladder. The cognitive Care Area Assessment (CAA) dated 12/11/15 stated Resident #131 was alert and oriented during the original admission. He was re-hospitalized related to sepsis and C-diff colitis and was on contact isolation. With this readmit he has short term memory impairment. The CAA noted anticipation of improved self awareness to return to prior level of functioning. A Service Concern Report noted the speech	F 225	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. F225 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Upon discovery of oversight, the Director of Nursing immediately completed a 24hr/5day Report of Allegation to the Department of Health and Human Services Personnel Registry. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ The Administrator and Corporate Nurse Consultant performed an audit of November, December and January Service Concern Forms for other potential oversights that may need to be addressed. Audit revealed no additional potential abuse allegations. Measures to be put in place or systemic changes made to ensure practice will not	

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F 225	Continued From page 2 therapist received a concern on 12/29/15 at 8:00 AM. The concern made by Resident #131 noted he awoke in the night with his colostomy bag broken. The nurse aide on 3rd shift accused the resident of getting out of bed and tearing the bag. Resident #131 stated the nurse aide cleaned him up and fussed at the resident, demanding he tell her what happened. She left him with no clothes on, wearing only an incontinent brief, a single sheet to cover himself and the call light was well out of his reach. The resident stated he was freezing but couldn't call for help. When the nurse aide finally came back in, the resident asked for a shirt because he was cold but was told he could not have one because he wouldn't tell the nurse aide what happened. He was unable to recall the nurse aide's name. Under action taken was a note that the staff member was terminated 12/29/15 and the responsible party was aware of the follow up on 12/29/15. There was no other documentation of any investigation. Review of the abuse investigations completed by the facility revealed no 24 hour or 5 day investigation had been sent to the state's HCPR related to the concern by Resident #131 on 12/29/15. On 01/04/16 at 2:38 PM, Resident #131 stated during interview that he got a girl fired the other night. He explained he woke up and the colostomy had busted and the nurse aide asked him why he got up. He stated she kept asking him why he got up. Resident #131 stated she kept hollering at him and when she cleaned him up, she covered him with only 2 sheets. He stated he was freezing and kept mashing the button. When she finally came back in, Resident	F 225	re-occur □ All staff re-in-serviced, by the Administrator, SDC, and DON on the Abuse and Neglect Policy and completion of Service Concern Forms. The Concern forms will be completed at the time of the concern and notification of Administrator or DON by the writer of any concern that implies an abuse allegation, so that immediate direction can be given at that time. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Audit of Service Concern Forms during morning stand-up to ensure that no Service Concerns contained allegations of abuse that had not been previously identified. These audits will be completed daily Monday-Friday for a period of 12 weeks.	

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F 225	Continued From page 3	F 225		

#131 stated he asked for a shirt and she said he was not getting anything until it was time to get up and then she left. Resident #131 stated his family told him she was fired.

The nursing notes did not have any documentation regarding this incident.

On 01/06/16 at 10:51 AM, Nurse Aide (NA) #1 and #2 were interviewed together and stated Resident #131 had complained that he rings his call light and no one comes to help him. NA #1 and #2 stated they report to the nurse when he has complained. NA #1 further stated that he complained to her, she thought last week, that his colostomy leaked and the aide did not bring him a blanket. She stated she reported it to the nurse on duty.

An interview was conducted with the Administrator and Director of Nursing (DON) on 01/07/16 at 11:38 AM. DON stated due to several expressed concerns, she has had staff keep documentation of when they go into Resident #131's room to give care. DON stated she spoke to the aide on duty caring for Resident #131 during the night 12/28/15-12/29/15, who denied the incident. DON stated she did not speak to the nurse who was on duty that night and terminated the accused NA due to attendance problems and previous complaints against her. DON stated the way the concern was written it sounded like neglect, however, she did not consider Resident #131's concern to be neglect because she kept the documentation of when staff provided care to him and she knew he was not neglected. Review of the documentation of care provided during the 12/28/15 to 12/29/15 3rd shift revealed there was no documentation of any care noted between

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F 225	Continued From page 4 11:15 PM on 12/28/15 and 7:30 AM on 12/29/15. The Administrator stated that if they felt there was neglect of Resident #131 administration would have addressed it and sent in a 24 hour and 5 day report. She further stated they terminated the employee for failure to meet the facility's expectations of meeting the needs of a resident. The Administrator stated that every allegation should be treated as such, but the facility had bent over backwards for this resident and the DON was going to work with the resident the next day.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record reviews, the facility failed to follow the facility's abuse policy by thoroughly investigating and reporting an allegation of neglect for 1 of 1 sampled resident who reported neglect. (Resident #131). The findings included: The facility's Abuse/Neglect/Misappropriation/Crime policy dated 02/27/15 stated in part: *any and all suspected or witnessed incidents of patient neglect will result in internal investigation,	F 226	F226 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Upon discovery of oversight, the Director of Nursing immediately completed a 24hr/5day Report of Allegation to the Department of Health and Human Services Personnel Registry. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ The Administrator and Corporate Nurse Consultant performed an	2/5/16

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F 226	Continued From page 5 appropriate and timely reporting to the State survey Agency and other legally designated agencies, as well as staff corrective action; *the facility must report all alleged or reasonable suspected instances of mistreatment when staff is suspected of neglect; *the Administrator and/or Director of Nursing will immediately begin a thorough internal investigation of the alleged occurrence and will report within 24 hours of knowledge of the allegation; *the investigation protocol will include but not be limited to collecting evidence, interviewing "alleged" victims and witnesses, and involving other appropriate individuals, agents or authorities to assist in the process and determinations; *The Administrator will notify the state Health Care Personnel Registry (HCPR) within 24 hours of the knowledge of the allegation; and *The Administrator must thoroughly investigated and file a complete written report of the investigation to the appropriate state agency within 5 working days of the incident. Resident #131 was admitted to the facility originally on 11/01/15 and most recently readmitted from the hospital on 12/01/15. His diagnoses included sepsis, muscle weakness, diabetes, hypertension, chronic obstructive pulmonary disease, anxiety disorder and end stage renal disease. A significant change Minimum Data Set dated 12/08/15 coded him with moderately impaired cognition (scoring a 12 out of 15 on the Brief Interview for Mental Status), having no mood or behavior issues, requiring extensive assistance with most activities of daily living skills, having an	F 226	audit of November, December and January Service Concern Forms for other potential oversights that may need to be addressed. Measures to be put in place or systemic changes made to ensure practice will not re-occur □ All staff re-in-serviced on the Abuse and Neglect Policy and completion of Service Concern Forms by the Administrator, SDC and DON. To ensure that the problem does not reoccur, Service Concern forms will be completed by a licensed nurse at the time of the concern. The licensed nurse who received the concern will immediately remove patient from any potential danger and notify immediate supervisor. A licensed nurse will assess and assure patient safety by removing the accused employee, visitor or other patient from area, then notify the Administrator and/or DON. Upon receiving report of any potential abuse allegations, DON will notify NCHCPR within 24hrs of report. DON will investigate allegation via patient, family and/or staff interview and include results in the 5-working day report to NCHCPR, to ensure a thorough investigation was completed. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Monitoring of Service Concern Forms will take place during morning stand-up to ensure that no Service Concerns contained any potential allegations of abuse. This will be completed daily Monday-Friday for a	

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F 226	Continued From page 6 ostomy, and being incontinent of bladder. The cognitive Care Area Assessment (CAA) dated 12/11/15 stated Resident #131 was alert and oriented during the original admission. He was re-hospitalized related to sepsis and C-diff colitis and was on contact isolation. With this readmit he has short term memory impairment. The CAA noted anticipation of improved self awareness to return to prior level of functioning. A Service Concern Report noted the speech therapist received a concern on 12/29/15 at 8:00 AM. The concern made by Resident #131 noted he awoke in the night with his colostomy bag broken. The nurse aide on 3rd shift accused the resident of getting out of bed and tearing the bag. Resident #131 stated the nurse aide cleaned him up and fussed at the resident, demanding he tell her what happened. She left him with no clothes on, wearing only an incontinent brief, a single sheet to cover himself and the call light was well out of his reach. The resident stated he was freezing but couldn't call for help. When the nurse aide finally came back in, the resident asked for a shirt because he was cold but was told he could not have one because he wouldn't tell the nurse aide what happened. He was unable to recall the nurse aide's name. Under action taken was a note that the staff member was terminated 12/29/15 and the responsible party was aware of the follow up on 12/29/15. There was no other documentation of any investigation. Review of the abuse investigations completed by the facility revealed no 24 hour or 5 day investigation had been sent to the state's HCPR related to Resident #131's concern of 12/29/15.	F 226	period of 12 weeks. Continued monitoring of all service concern forms will take place monthly during QA committee meetings.	

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F 226	Continued From page 7	F 226		

On 01/04/16 at 2:38 PM, Resident #131 stated during interview that he got a girl fired the other night. He explained he woke up and the colostomy had busted and the nurse aide asked him why he got up. He stated she kept asking him why he got up. Resident #131 stated she kept hollering at him and when she cleaned him up, she covered him with only 2 sheets. He stated he was freezing and kept mashing the button. When she finally came back in, Resident #131 stated he asked for a shirt and she said he was not getting anything until it was time to get up and then she left. Resident #131 stated his family told him she was fired.

The nursing notes did not have any documentation regarding this incident.

On 01/06/16 at 10:51 AM, Nurse Aides (NA) #1 and #2 were interviewed together and stated he has complained that he rings his call light and no one comes to help him. they stated they report to the nurse when he has complained. NA #1 further stated that he complained to her, she thought last week, that his colostomy leaked and the aide did not bring him a blanket. She stated she reported it to the nurse on duty.

An interview was conducted with the Administrator and Director of Nursing (DON) on 01/07/16 at 11:38 AM. DON stated due to several expressed concerns, she has had staff keep documentation of when they go into Resident #131's room to give care. DON stated she spoke to the aide on duty caring for Resident #131 during the night 12/28-12/29/15, who denied the incident. DON stated she did not speak to the nurse who was on duty that night and terminated

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F 226	Continued From page 8 the accused NA due to attendance problems and previous complaints against her. DON stated the way the concern was written it sounded like neglect, however, she did not consider Resident #131's concern to be neglect because she kept the documentation of when staff provided care to him and she knew he was not neglected. Review of the documentation of care provided during the 12/28/15 to 12/29/15 3rd shift revealed there was no documentation of any care noted between 11:15 PM on 12/28/15 and 7:30 AM on 12/29/15. The Administrator stated that if they felt there was neglect of Resident #131 administration would have addressed it and sent in a 24 hour and 5 day report. She further stated they terminated the employee for failure to meet the facility's expectations of meeting the needs of a resident. The Administrator stated that every allegation should be treated as such, but the facility had bent over backwards for this resident and the DON was going to work with the resident the next day.	F 226		
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 reviews and family and staff interviews the facility failed to assess residents	F 242	F242 How corrective action will be accomplished for each resident found to	2/5/16

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F 242	Continued From page 9 regarding the number of showers preferred per week for 1 of 5 residents reviewed for choices (Resident #135). The findings included: Resident #135 was admitted to the facility on 09/16/15 with diagnoses of diabetes, Alzheimer's disease and muscle weakness. The quarterly Minimum Data Set (MDS) dated 12/11/15 revealed Resident #135 was severely cognitively impaired and required extensive assistance with bathing. An interview was conducted with Resident #135's family member on 01/05/16 at 11:01 AM. During the interview the family member stated Resident #135 received 2 showers a week and she would like for him to have 3 showers a week. The interview further revealed the family member had not been asked how many showers a week Resident #135 preferred. During an interview on 01/06/16 at 10:54 AM nurse aide (NA) #2 stated residents were scheduled 2 showers a week and she checked the daily assignment sheet at the beginning of the shift to see which of her residents were scheduled for showers that day. NA #2 further stated if a resident requested additional showers she tried to accommodate the request. An interview with Nurse #1 on 01/06/16 at 4:20 PM revealed residents were scheduled 2 showers a week and if they requested additional showers the NAs tried to accommodate the request but extra showers were not added to the shower schedule to be ongoing. During an interview conducted on 01/08/16 at 9:23 AM the Director of Nursing (DON) stated residents were given 2 showers a week but could	F 242	have been affected by the deficient practice □ For resident #135 his shower schedule was changed to reflect wife□s preferences for receiving 3 showers a week. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ Facility tool Resident Preferences was completed on all residents in the facility and placed in Resident Preference Notebooks located in the DON□s office. Upon completion of preference sheet the UM/DON/SDC ensured preferences were updated in PCC and Care plan. Unit managers will monitor adherence of resident□s preferences by reviewing daily shower sheets and supporting documentation in PCC. MDS was given the forms for signature to notify them of patient preferences for completion of MDS. Measures to be put in place or systemic changes made to ensure practice will not re-occur- Resident Preferences tool will be completed on all new admissions by the Discharge Planner/Designee during Jumpstart Meetings□ with resident and or RP. If patient is cognitively impaired RP will be notified regarding preferences. Completed forms will be given to UM/Designee to update preferences in PCC/Care Plan. Unit managers will audit 5 patients, in-house, weekly to ensure patient preferences are being honored, for a period of 12 weeks.	

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F 242	Continued From page 10 have more if they asked. The DON stated residents were not asked how many showers a week they preferred on admission or throughout their stay at the facility.	F 242	How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Audits of Admissions to ensure completion of Resident Preference tool is completed, task updated to indicate preference as well as the care plan, Monday through Friday for a period of 12 weeks. Weekly audits for patient preference compliance by Unit Managers/DON, will be submitted at monthly QA for review/revision for three consecutive months.	
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 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	F 278		2/5/16

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F 278	Continued From page 11 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 observations, record reviews, resident interview and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately to reflect dental status for 2 of 2 sampled residents reviewed for dental status and dental services (Residents #101 and #227). The findings included: Resident #101 was admitted on 05/16/14 with diagnoses including diabetes mellitus and rheumatoid arthritis. Review of the medical record revealed Resident #101 was examined by the Dentist on 03/19/15. The Dentist noted Resident #101 required hospital extraction of "root tip #13." The dental form was signed by the Physician's Assistant on 03/23/15. Review of the significant change Minimum Data Set (MDS) dated 09/17/15 revealed Resident #101 was cognitively intact. Under the section for Oral and Dental Status Resident #101 was coded as having no dental problems. The option for "Obvious or likely cavity or broken natural teeth" was not checked on the significant change MDS. During an interview on 01/04/16 at 12:42 PM Resident #101 stated she had a broken tooth on	F 278	F278 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #101 significant change MDS was modified on 1/25/16 to code section L appropriately and care planned. On 1/6/16, referral for dental consult was made to assess residents broke tooth, and to schedule resident□s dental extraction. Resident #101 is scheduled on 1/28/16 for dental extraction. Resident #227 On 1/6/16 and 1/7/16 staff interviews reported that resident did not have any natural teeth and her upper denture did not fit well. Resident #227 significant change MDS was modified on 1/7/16 to code section L appropriately, and care planned. Dentures have been ordered and anticipated to arrive 2/1/16. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice A visual audit by MDSCA of the dental condition of all current residents was completed by 1/29/16. Any issues identified were documented in the progress notes and	

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F 278	Continued From page 12 the upper left side of her mouth which was sharp. Resident #101 denied pain or difficulty chewing or swallowing. Resident #101 stated she was supposed to have the tooth pulled but did not know if this had been scheduled. An interview with the MDS Director on 01/08/16 at 10:21 AM revealed she completed the MDS assessments by using information gathered from observations, record reviews, and resident interviews. The MDS Director stated she typically looked in the resident's mouth when completing the Oral and Dental Status section of the MDS. The MDS Director confirmed she had completed Resident #101's significant change MDS dated 09/17/15 and stated Resident #101 did not mention the broken tooth to her at the time of the assessment. The MDS Director further stated she did not notice Resident #101's broken tooth when she completed the oral assessment nor did she recall reviewing the dental form dated 03/19/15. The MDS Director maintained her assessment of Resident #101's oral dental status for the MDS dated 09/17/15 was accurate. During a follow up interview on 01/08/16 at 10:48 AM Resident #101 stated she did not mention her broken tooth to the MDS Director at the time of the assessment but figured her medical record would be reviewed for any documentation by the Dentist. Observations were made of Resident #101's teeth during this interview and revealed there was a tooth on the upper left side of her mouth with a portion of the tooth missing down to the gum line. An interview was conducted with the Director of Nursing (DON) on 01/08/16 at 11:27 AM. The DON stated she would expect the MDS nurse to	F 278	referred to the dentist, or a consultation was made to an out of facility dentist. The completed Dental Condition Audit will be given to MDS so that they may check Section L of the MDS to ensure accuracy. Measures to be put in place or systemic changes made to ensure practice will not re-occur- On 1/13/16, the MDSC Regional consultant provided in-service education to the MDSC□s on assessing the residents oral status for obvious or likely cavity or broken teeth, broken or loosely fitting full or partial dentures, and no natural teeth or tooth fragments (edentulous), and coding of section L. MDSC conducted in-service education on 1/21/16 to educate staff on proper assessment of resident dental status. The dental status of residents will be assessed during each MDS in review during the ARD of the MDS look back period by the MDSC or unit manager. If the resident refuses a dental exam, facility physician will be notified. Any dental issues identified will be documented in the progress notes and directed to the dentist or will be referred to out of facility dentist. How facility will monitor corrective action(s) to ensure deficient practice will not reoccur- The MDSC, MDSC Assistant and/or designee will audit 5 MDS□s a week for 12 weeks, 5 MDS□s a month for a period of 9 months to ensure residents dental status is correctly coded	

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F 278	Continued From page 13 attempt an oral exam when completing the Oral and Dental Status section of the MDS assessment and observe for any abnormalities and if the resident was able to be interviewed ask if they were having any issues with their teeth, gums, or dentures. The DON further stated Resident #101's significant change MDS completed on 09/17/15 should have been coded to reflect a broken tooth. 2. Resident #227 was admitted to the facility on 11/20/15. Her diagnoses included sepsis, pneumonia, muscle weakness, end stage renal disease and anemia. The admission Minimum Data Set (MDS) dated 11/27/15 coded Resident #227 with having moderately impaired cognition (scoring 12 out of 15 on the Brief Interview for Mental Status), being able to feed herself with set up and receiving a mechanically altered diet. Under the section for Oral and Dental Status, Resident #227 was coded as having no dental problems. Neither "Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)" nor "No natural teeth or tooth fragment(s) (edentulous)" were checked as existing for Resident #227. On 01/04/16 at 1:13 PM, Resident #227 was observed with an extremely large upper denture that was too large for her mouth and moved as she spoke and having no lower teeth or denture. During interview on 01/04/16 at 1:20 PM, Resident #227 confirmed her top denture was too big and loose and she had no bottom denture. She further stated she thought she had new dentures ordered but was not sure of the details.	F 278	on the MDS. This will be accomplished by MDSC, MDSC Assistant and/or designee by direct visualization of dental condition and compared to Section L of the MDS. Any issues identified with the audits will be corrected immediately. These audits will be reviewed weekly during Weekly Risk for 12 weeks and discussed in monthly Quality Assurance Meeting monthly for 12 months.	

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F 278	Continued From page 14 On 01/06/16 at 8:50 AM, again her upper denture was observed to be too large for her mouth and when she spoke, Resident #227 was unable to close her lips around her upper plate which moved regularly as she spoke. On 01/06/16 at 11:03 AM, Nurse Aides #1 and #2 were interviewed together and both stated Resident#227 did not have any natural teeth and her upper denture did not fit well. On 01/07/16 at 12:39 the MDS Director was interviewed. MDS Director stated she completed the MDS by using information gathered from the record, observations, and resident interviews. She confirmed she completed the admission MDS on Resident #227. MDS Director stated that she completed the dental section of the MDS with information gathered when observing and having interactions with Resident #227. She further stated that she had never noticed her top denture was loose just that it was very large. She also stated she had not been coding that a resident was edentulous if they had dentures and exhibited no problems with them. On 01/07/16 at 3:11 PM during interview with the Dietary Manager and Director of Nursing, both stated they had noticed Resident #227's top teeth were loose.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		2/5/16

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F 279	Continued From page 15 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for bipolar disorder for 1 of 1 resident reviewed for preadmission screening and resident review (Resident #143). The findings included: Resident #143 was admitted to the facility on 03/17/15 with diagnoses of diabetes, hypertension and bipolar disorder. The quarterly Minimum Data Set (MDS) dated 10/14/15 revealed Resident #143 was cognitively intact and received antidepressant medication 7 times during the 7 day look back period of the MDS assessment. Review of the physician order's dated 01/2016 for Resident #143 revealed he received: · Lithium Carb ER, a mood stabilizer, 300 milligrams (mg) every day for bipolar disorder. · Remeron, an antidepressant, 15mg every day for depression/insomnia/appetite.	F 279	F279 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ At the time the discrepancy was noted on Resident #143 the care plan was updated to reflect patients Medical Condition for the need to have antipsychotics. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ All medical records for current residents with a psychiatric diagnosis will be audited, by MDSC coordinator, by January 29, 2016 to ensure the psychiatric diagnosis is care planned. The MDSCs will care plan any resident identified as having a psychiatric diagnosis and not care planned by	

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F 279	Continued From page 16 Review of the care plan dated 10/20/15 revealed there was no care plan for bipolar disorder for Resident #143. An interview conducted on 01/08/16 at 9:01 AM with the MDS Director revealed she created the care plan dated 10/20/15 for Resident #143. The MDS Director stated Resident #143 should have been care planned for bipolar disorder and stated she had not care planned him for bipolar disorder and did not know how she missed it. An interview conducted on 01/08/16 at 9:23 AM with the Director of Nursing (DON) revealed it was her expectation for all residents with bipolar disorder to be care planned for the illness.	F 279	January 29, 2016. Measures to be put in place or systemic changes made to ensure practice will not re-occur- On January 13, 2016 the MDSC Regional Consultant provided education to the MDSC that any resident with a psych diagnosis must be in the residents care plan. If a resident is diagnosed with a psych diagnosis between the residents MDS, then the IDT will add diagnosis and update plan of care. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur The MDSC, MDSC Assistant and/or designee will audit 5 MDS□s a week for 12 weeks, 5 MDS□s a month for a period of 9 months to ensure care plans are in place for bi-polar diagnosed patients. Any issues identified with the audits will be corrected immediately. These audits will be reviewed weekly during Weekly Risk for 12 weeks and discussed in monthly Quality Assurance Meeting monthly for 12 months.	
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,	F 325		2/5/16

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F 325	Continued From page 17 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 observations, record review, resident and staff interviews, the facility failed to change nutritional interventions when 1 of 3 sampled residents experienced continued significant weight loss. (Resident #227). The findings included: Resident #227 was admitted to the facility on 11/20/15. Her diagnoses included sepsis, pneumonia, muscle weakness, end stage renal disease with dialysis, difficulty walking, an immune deficiency disease, anemia, and gastroesophageal reflux disease. A care plan was created on 11/23/15 for the focus that the resident had a nutritional problem or potential for a nutritional problem related to a recent hospitalization for fever, confusion, sepsis and pneumonia. She was also noted to receive dialysis 3 days a week and was on a fluid restriction. The goals were for Resident #227 to maintain adequate nutritional status and that she may be at risk of significant weight change due to end stage renal disease and on hemodialysis. Interventions included: *provide and serve diet as ordered. Monitor intake and record every meal; *Registered Dietician to evaluate and make diet	F 325	F325 How corrective action will be accomplished for each resident found to have been affected by the deficient practice An order for resident #227 to receive double portions at all meals was entered into Meal Tracker on 1/07/16 along with previously ordered Nepro 237ml/1 can daily and Prostat AWC 30ml BID. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice All residents with significant weight changes were reviewed to determine if nutritional interventions were added as appropriate and acceptance and intake reviewed. If resident was found to be non-compliant with nutritional intervention further changes were made as appropriate. Registered Dietician (RD) and Certified Dietary Manager (CDM) were in-serviced by Regional Corporate RD, on the proper procedures regarding nutritional supplement intake and documentation on 1/07/16.	

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F 325	Continued From page 18 change recommendations as needed; and *weights as ordered. Per the weight record in the medical record, Resident #227 was documented as weighing 133.4 on 11/24/15. The admission Minimum Data Set (MDS) dated 11/27/15 coded Resident #227 with having moderately impaired cognition (scoring 12 out of 15 on the Brief Interview for Mental Status) and in the previous two weeks being tired 2 to 6 days and having appetite issues 2 to 6 days. Resident #227 was coded as rejecting care 1 to 3 days over the assessment period and was able to feed herself with set up. She was coded as weighing 133 pounds, receiving a mechanically altered diet , having pressure sores, receiving dialysis and therapy. She was inaccurately coded with no dental problems. The MDS noted there was no history of weight loss. The Nutrition/Dietary Note dated 11/27/15 noted she was on a mechanical soft diet with 1500 milliliters fluid restriction and had a good intake of greater than 50 percent at most meals with set up help at times. The nutritional Care Area Assessment (CAA) dated 11/30/15 noted she was on a mechanical soft diet for chewing difficulties. On 12/01/15 1 can of Nepro (a dietary supplement with 425 calories) per day was ordered as recommended by the dialysis center. The Dehydration/Fluid Maintenance CAA dated 12/03/15 noted Resident #227 was receiving an antibiotic for pneumonia during the assessment period, was alert and oriented yet needed cueing for recall after 5 minutes, had lethargy at times,	F 325	Measures to be put in place or systemic changes made to ensure practice will not re-occur- All residents with significant weight changes will be reviewed weekly at the RISK meeting. Members which include nursing, administration, and dining services will be present. All residents with significant weight changes will be assessed weekly by the RD/CDM and or Designee for appropriate nutrition interventions and/or changes. Facility RD/CDM and or Designee will communicate weekly with dialysis RD/CDM and or Designee regarding all residents receiving out of facility dialysis. Facility RD/CDM and or Designee will discuss current nutritional interventions in place, resident□s current intake and appetite, resident weight changes and any further needed nutrition interventions that will be put in place. RD/CDM and or Designee to document in the medical record any conversations with dialysis RD. Nutritional supplement intake audits cross referenced with weight trends will be completed by Regional RD weekly X 4 weeks and monthly thereafter to ensure all patients with significant weight changes are prescribed appropriate nutritional supplements and interventions are put in place if resident is non-compliance with nutrition interventions. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur - Results of audits will be presented to monthly Quality Assurance meeting every week for 4 weeks and monthly thereafter for a period of 2	

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F 325	Continued From page 19 had pressure ulcers she often refused to let the nurses treat, and she reported her appetite was improving some since admission. This CAA also noted she needed cueing for compliance with fluid restriction which was ordered. Notes from the Weight Committee Meeting dated 12/04/15 entered by the Registered Dietician (RD) noted Resident #227 had significant weight loss of 5.2% since 11/20/15. Her current diet was regular mechanical soft. Her intake had been greater than 75%. She was receiving Nepro and prostat (a protein supplement). The rationale for weight changes was that Resident #227 had end stage renal disease and was on hemodialysis and weight fluctuation was expected. She had adequate intake and nutritional support was being offered. The committee's recommendation was to continue the current plan of care and diet as tolerated, encourage adequate intake, provide adequate feeding assistance, continue to offer nutrition support, continue to monitor intake, weights, labs, skin and output. The note indicated the physician and responsible party were notified. Documented weights on the Weight record located in the medical record revealed the following weights for Resident #227: *11/20/15 133.6 pounds; *11/21/15 134.6 pounds; *11/24/15 133.4 pounds; *12/04/15 126.7 pounds; *12/08/15 124 pounds; *12/15/15 123.5 pounds; and *12/31/15 115.2 pounds. Notes from the Weight Committee Meeting dated 01/04/16 entered by the RD noted Resident #227	F 325	months, to ensure compliance and revision as needed.	

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had significant weight loss of 13.8% since 11/20/15. The notes indicated her diet was regular mechanical soft, her intake was greater than 50%, and she received prostat and Nepro interventions. The Rationale for weight changes was that she was on hemodialysis and weight fluctuations were expected. The note continued stating that her intake was adequate and nutrition support was being offered. The recommendation was to continue the current plan of care. The physician and responsible party were notified.

Review of the physician notes on 12/02/15, 12/30/15, 01/05/16, and 01/07/16 revealed no comments related to weight loss for Resident #227.

Review of the Medication Administration Records revealed Resident #227 did not take the Nepro 20 times in December 2015. In January 2016 she did not consume any Nepro the first 5 days.

Review of Resident #227's recorded meal intake revealed she ate 50 to 100 percent of each meal.

Resident #227 was observed on 01/04/16 at 1:13 PM with upper dentures which were too big for her mouth and loose and no bottom teeth. On 01/05/16 at 8:50 AM, she was observed with upper dentures which were too large and loose and no lower teeth. She stated she got plenty to eat. On 01/06/16 at 4:36 PM, Resident #227 was observed eating independently without problems.

On 01/07/15 at 3:11 PM the RD, Dietary Manager and the Director of Nursing, (members of the weight committee) were interviewed. The interview revealed a resident was discussed during weight committee meetings if they were

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F 325	Continued From page 21 new admissions or had new unplanned weight loss. Resident #227 was identified with significant weight loss on 12/04/15. The Nepro was added via dialysis recommendation for extra protein. RD stated that he maintained regular contact with the dialysis center related to the residents in the facility, however, RD was unable to recall if he had discussed Resident #227's weight change or her refusal of Nepro with the resident or the dialysis RD. A telephone interview was conducted with the dialysis RD on 01/07/16 at 4:02 PM. She stated that she was unaware that Resident #227 was refusing her Nepro supplements until this date. She further stated she noticed weight loss around 12/17/15. The dialysis RD stated Resident #227 told her this date she was not taking supplement and should be. The dialysis RD described Resident #227 as being compliant with dialysis and would most likely take the Nepro supplement with encouragement from dialysis and the facility.	F 325		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a	F 411		2/5/16

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F 411	Continued From page 22 dentist. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews the facility failed to provide an extraction recommended as a result of a comprehensive dental exam for 1 of 2 sampled resident reviewed for dental status and services (Resident #101). The findings included: Resident #101 was admitted on 05/16/14 with diagnoses including diabetes mellitus and rheumatoid arthritis. Review of the medical record revealed Resident #101 was examined by the Dentist on 03/19/15. The Dentist noted Resident #101 required hospital extraction of root tip #13. The dental form was signed by the Physician's Assistant (PA) on 03/23/15. Review of the significant change Minimum Data Set (MDS) dated 09/17/15 revealed Resident #101 was cognitively intact. The significant change MDS noted there were no broken natural teeth. During an interview on 01/04/16 at 12:42 PM Resident #101 stated she had broken tooth on the upper left side of her mouth which was sharp. Resident #101 denied pain or difficulty chewing or swallowing. Resident #101 stated she was supposed to have the tooth pulled but did not know if this had been scheduled.	F 411	F411 How corrective action will be accomplished for each resident found to have been affected by the deficient practice On 1/6/16, referral for dental consult was made to assess resident s broken tooth, and to schedule resident s dental extraction. Resident #101 is scheduled on 1/28/16 for dental extraction. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice Audit dental services progress notes, by Administrative Assistant, provided for current patient to ensure recommended procedures were followed. Measures to be put in place or systemic changes made to ensure practice will not re-occur- If the resident refuses a dental exam, facility physician will be notified. Any dental issues identified will be documented in the progress notes and directed to the dentist or will be referred to out of facility dentist. Scheduler was disciplined for failure to obtain appointment for surgical removal of tooth. Dental progress notes will be reviewed by Unit Secretary/Unit Manager and or Designee by the Administrator or DON and recommendations followed through with prior to progress notes being	

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	345526	A. BUILDING _____ B. WING _____	C 01/08/2016

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F 411	Continued From page 23 An interview with Administrative Assistant #1 on 01/06/16 at 1:11 PM revealed she scheduled the Dentist's visits for the facility and after the Dentist's visits she placed the dental forms in the Physician's book their review. Administrative Assistant #1 further explained when she received a consultation order from the Physician she scheduled the referral for extraction with a local Dentist. The interview further revealed Administrative Assistant #1 did not get a Physician's order for Resident #101's extraction and she could not explain how this had been missed. On 01/06/16 at 2:07 PM Nurse #2 stated nurses were responsible for reviewing the dental forms before and after they were placed in the Physician's book for any orders. Nurse #2 further stated when the Physician wrote an order for a dental consult the nurse put the order in the computer and advised Administrative Assistant #1 so the appointment could be scheduled. During a follow up interview on 01/08/16 at 10:48 AM observations were made of Resident #101's teeth and revealed there was a tooth on the upper left side of her mouth with a portion of the tooth missing down to the gum line. An interview was conducted with the Director of Nursing (DON) on 01/08/16 at 11:21 AM. The DON stated when the Physician or PA signed a dental form they were agreeing with the Dentist's recommendation. The nurses were responsible for reviewing the dental forms and putting any orders in the computer. When a consultation with a Dentist was ordered by the Physician or PA the nurse was expected to notify Administrative Assistant #1 so the appointment could be	F 411	scanned into medical record for out of facility visits to dentist or scheduled facility visits by dentist. At the April and October scheduled dental visit the progress notes will be obtained by Unit Secretary and given to Unit Manager or designee to ensure recommended recommendations are scheduled. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur □ Once routine dental services are provided, copies dental recommendations will be provided by the Unit Managers to the Quality Assurance team for review during Monthly QA to determine compliance or modification of POC.	

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F 411	Continued From page 24 scheduled. The DON could not explain how the order for Resident #101's tooth extraction had been missed.	F 411		
F 520 SS=E	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. 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, staff and resident interviews, the facility's Quality Assessment and Assurance Committee failed to implement, monitor and revise as ended the	F 520	F520 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Cross Reference to F278 and	2/5/16

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F 520	Continued From page 25 action plan developed for the recertification survey dated 03/30/15 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiences for Accuracy of the Minimum Data Set (F278) on the surveys dated 02/12/15, 03/30/15 and 01/08/16 and for Development of Care Plans (F279) on the surveys dated 03/30/15 and 01/08/16. The continued failure of the facility during 3 federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F278: Accuracy of Assessments: Based on observations, record reviews, and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately to reflect dental status for 2 of 2 sampled residents reviewed for dental status and dental services (Residents #101 and #227). On the complaint survey of 02/12/15 the facility was cited for F278 for inaccurately coding the MDS for corrective lenses, diagnoses and history of falls and on the recertification/follow up survey of 03/30/15 the facility was cited for F278 for failure to accurately code the MDS for behaviros. On the current recertification survey, the facility was cited for inaccurately coding dental condition on the MDS. b. F279: Comprehensive Care Plans: Based on record review and staff interviews the facility failed to develop a care plan for bipolar disorder for 1 of 1 resident reviewed for preadmission screening and resident review (Resident #143).	F 520	F279. How the corrective action will be accomplished for the resident(s) affected. - Cross reference to F278 and F279. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. □ Cross reference to F278 and F279. Measures in place to ensure practices will not re-occur. - Corporate Education provided to Facility Administration on QA process and it□s relation to Plan of Correction by Corporate Quality Assurance Nurse. All audits cross referenced to F278 and F279 will be reviewed and changes recommended during the next 12 months during the now scheduled Monthly Quality Assurance Meeting.	

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F 520	Continued From page 26 On the recertification/follow up survey of 03/30/15, the facility failed to develop a care plan for exhibited behaviors. On the current recertification survey, the facility was cited for not developing a care plan for a mental illness. During an interview on 01/08/16 at 2:27 PM with the Administrator, the Administrator stated the facility continued to monitor the plan of correction through the Quality Assurance (QA)process until compliance was achieved. The Administrator stated the previous quality assurance monitoring was implemented for the specific areas the MDS and care plans were cited originally. The previous areas that were monitored via the QA process were different than the areas cited this survey for accuracy of dental status on the MDS and the development of a mental illness care plan cited this survey.	F 520		