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	345350	A. BUILDING _____ B. WING _____	C 03/10/2016

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F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility failed to inform residents of the location of their survey results and have them readily accessible available for the residents. The findings included: An interview with the Resident Council President, Resident #69 on 03/09/2016 at 11:30 AM revealed that the resident council meets monthly. She thought the state survey results were up front in the lobby. An observation in the front lobby on 03/09/2016 at 12:00 PM revealed there was no sign in the front lobby indicating the location of the state survey results or directing the residents to the state survey results' location. An interview with the Administrator was conducted on 03/09/2016 at 4:13 PM. He stated the sign stating the location of the last state survey results was in the front lobby last year	F 167	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. No adverse effects were noted as result of this deficient practice. All resident s have the potential to be affected by this deficient practice. On 3/9/16, facility updated the public notice that survey results are available for review and can be located in front lobby. On 3/9/16, the survey results binder was placed in the front lobby next to the receptionist desk.	4/7/2016

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

Administrator 3-31-16

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 167	Continued From page 1 when he was in the facility. He stated the survey results needed to be available to residents and an alternate place during renovations needed to be identified. An observation on 03/09/2016 at 4:15 PM with the administrator revealed that there was no sign or state survey results in the lobby. He stated they were supposed to be there and maybe they were moved due to renovations being done there earlier in the week. He asked staff and they stated they were in an office. He stated the survey results needed to be accessible to residents even during renovations and an alternative location that was accessible to the residents should have been identified. A sign informing them of the location of the survey results during front lobby renovation should have been posted.	F 167	MONITORING: Administrator (or Designee) will visually check the lobby weekly for four (4) weeks, then monthly for 2 months and randomly thereafter to ensure that survey results are readily available and within reach for review. Ongoing audits will be determined based on results of prior audits. All findings will be reported to the facility's Quality Assurance Committee and Performance Improvement Committee for review and further recommendations.	
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	F 278	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	4/7/2016

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F 278	Continued From page 2 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 staff interviews and medical record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate the number of unhealed pressure ulcers for 1 of 4 sampled residents reviewed for pressure ulcers (Resident #49); failed to accurately code the MDS to reflect the use of an antidepressant medication for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #150), and failed to accurately code the MDS to reflect the fall history for 1 of 3 sampled residents reviewed for accidents (Resident #18). The findings included: 1) Resident #49 was re-admitted to the facility on 10/10/13. Diagnoses included cellulitis, lower extremity edema and protein calorie malnutrition, among others. Review of a weekly pressure ulcer/wound log revealed Resident #49 developed a stage 3 pressure ulcer to her left heel on 11/04/15 and a stage 2 pressure ulcer to her right lateral ankle on	F 278	AFFECTED RESIDENTS: Resident #49, Resident #150 and Resident #18 – A corrected MDS assessment was completed and transmitted on 3/10/2016 prior to exit. POTENTIALLY AFFECTED RESIDENTS: An audit of current resident's MDS assessments will be completed on or before 4/1/16 by MDS Coordinators. Identified residents will have an MDS completed that accurately reflect current resident status and accurately code pressure ulcers, antidepressant medication or falls on or before 4/1/16. SYSTEMS CHANGE: The MDS Coordinators were reeducated by Director of Nursing on accurate MDS assessment on 3/25/16. MONITORING: An audit tool was developed to monitor MDS assessments Available Interdisciplinary Team Members (consisting of Administrator, Director of Nursing, Clinical Nurse Manager, Social Services Coordinator, Activities Coordinator, Rehab Therapy Manager, Registered Dietitian and	

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F 278	Continued From page 3 12/03/15. Review of the January 2016 Treatment Administration Record (TAR) revealed Resident #49 continued treatment to both the stage 3 left heel and right lateral ankle pressure ulcers. A quarterly MDS assessment dated 02/04/16, with an assessment reference date of 01/22/16 to 01/29/16 documented that Resident #49 did not have any unhealed pressure ulcers. An interview on 03/10/16 at 5:10 PM with MDS Nurse #1 revealed that when she completed the quarterly MDS dated 02/04/16 for Resident #49 she reviewed the January 2016 TAR and nurses's notes, but that she was not able to determine whether or not the Resident's skin breakdown was from pressure. MDS Nurse #1 stated she did not review the weekly pressure ulcer report which documented that Resident #49 had a stage 2 and a stage 3 pressure ulcer. MDS Nurse #1 further stated "That was my fault that I did not look at this report." An interview on 03/10/16 at 5:15 PM with the Director of Nursing revealed she expected the MDS to accurately assess a resident with pressure ulcers if the resident had pressure ulcers during the assessment reference period for the MDS. 2) Resident #150 was admitted to the facility on 2/9/16 from a hospital. His cumulative diagnoses included depression. A review of Resident #150's admission medication orders dated 2/9/16 included 20	F 278	MDS Coordinators) will conduct audits of 10% randomly selected residents for accurate MDS assessments in relation to pressure ulcers, antidepressant medications and pressure ulcers for four (4) weeks, then 10% of randomly selected residents each month for three (3) months. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed by Administrator and/or Director of Nursing and during the monthly Quality Assurance meeting.	

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F 278	Continued From page 4 milligrams (mg) fluoxetine (an antidepressant medication) to be given as one capsule by mouth every day for depression. A review of Resident #150's Medication Administration Record (MAR) revealed the resident received an antidepressant medication on 7 of 7 days from 2/10/16 to 2/16/16. Resident #150's admission Minimum Data Set (MDS) assessment was dated 2/16/16. Section N of the MDS indicated the resident did not receive an antidepressant medication during the 7-day look back period (2/10/16 to 2/16/16). An interview was conducted on 3/10/16 at 1:20 PM with MDS Nurse #1. MDS Nurse #1 reported she was responsible for gathering the assessment information and entering it into the MDS system for Resident #150. After a review of Resident #150's MDS (Section N) and his MAR, the MDS Nurse #1 acknowledged Section N of the MDS had been miscoded. An interview was conducted on 3/10/16 at 6:20 PM with the facility's Director of Nursing (DON). During the interview, the DON indicated her expectation was for the MDS to be accurately coded. 3) Resident #18 was admitted to the facility on 1/21/16 from a hospital. His cumulative diagnoses included pneumonia, shortness of breath, and weakness. A review of the facility's Accident/Incident Log included an incident involving Resident #18 on 1/25/16 at 10:20 PM. The log indicated Resident #18 tried to transfer himself from the bed to his	F 278		

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F 278	Continued From page 5	F 278		

recliner and slid, resulting in a fall. A review of the Post Fall Review dated 1/25/16 reiterated the resident tried to get out of bed to sit in the recliner or wheelchair and slid to the floor from the bed. He had no apparent injuries.

A review of Resident #18's care plan dated 1/25/16 included a focus area related to his risk of falls due to being a new admission, non-ambulatory, and having a recent fall. A hand-written note on the care plan read: "1/25/16 fall no injury; attempting to get OOB (out of bed) into recliner--non-ambulatory; resident A & O x 4 (alert and oriented to person, plan, time, and situation)--staff educated to utilize call bell and wait for assist."

Resident #18's admission Minimum Data Set (MDS) was dated 1/28/16. The MDS indicated the resident had moderately impaired cognitive skills for daily decision making. The MDS also revealed Resident #18 required extensive assistance for all of his Activities of Daily Living (ADLs), with the exception of needing supervision only for eating. Section J of the MDS indicated the resident had not had any falls since his admission on 1/21/16.

An interview was conducted on 3/10/16 at 5:55 PM with MDS Nurse #2. MDS Nurse #2 reported she was responsible for gathering the assessment information and entering it into the MDS system for Resident #18. During the interview, MDS Nurse #2 reported the look back period for an admission MDS dated 1/28/16 was 1/22-1/28/16. When asked to review Section J of the MDS related to falls, the MDS nurse acknowledged the fall experienced by this resident on 1/25/16 was not coded accurately on

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F 278	Continued From page 6 the MDS. MDS Nurse #2 stated it was "human error" and indicated she missed coding the resident's recent fall on the MDS. An interview was conducted on 3/10/16 at 6:20 PM with the facility's Director of Nursing (DON). During the interview, the DON indicated her expectation was for the MDS to be accurately coded.	F 278		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on an observation, staff interviews and review of the medical record, the facility failed to apply a topical debridement to a right lateral ankle pressure ulcer with necrotic tissue as ordered by the physician and maintain a wound dressing intact on a chronic left heel wound for 1 of 4 sampled residents reviewed with pressure ulcers (Resident #49). The findings included: Resident #49 was admitted to the facility on 10/10/13. Diagnoses included cellulitis, joint pain,	F 314	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. AFFECTED RESIDENTS: This deficient practice affected Resident #49. Corrective action for this resident included application of Santyl to right lateral ankle pressure, cover with foam dressing; Prisma to the left heel pressure and cover with foam	4/7/2016

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F 314	Continued From page 7 osteoarthritis, and osteoporosis, among others. Resident #49's October 2015 care plan identified the Resident was at risk for altered skin integrity related to fragile skin due to aging, limited joint mobility, diuretic use and a current pressure ulcer to the left heel. Review of the facility's weekly pressure ulcer log revealed Resident #49 developed a left heel stage 3 pressure ulcer on 11/04/15 with treatment in place. Continued review of the facility's weekly pressure ulcer log revealed that on 12/03/15, Resident #49 developed a stage 2 pressure ulcer to her right lateral ankle with treatment in place. The February 2016 care plan documented to continue treatment to the left heel pressure ulcer and the right lateral ankle pressure ulcer and to treat the wounds as ordered. A quarterly Minimum Data Set assessment dated 02/04/16, documented that Resident #49 did not have any unhealed pressure ulcers. Review of a dietary progress noted dated 02/09/16 revealed Resident #49 received Magic cup (a frozen nutritional supplement) and one packet of Juven (nutritional supplement for tissue development) daily for nutritional support and wound healing of a stage 3 left heel pressure ulcer and a stage 2 right lateral ankle pressure ulcer. A nurse practitioner progress note dated 03/02/16 recorded that Resident #49 was deconditioned with trace edema to her bilateral lower	F 314	dressing on 3/7/2016 as ordered by the physician. Medical Director was also informed on 3/7/16 that hydrocolloid dressing was observed on resident's R lateral ankle and no dressing was observed to L heel. No further physician orders were determined as necessary during that time. Appropriate action and follow up was accomplished with the specific staff member involved. POTENTIALLY AFFECTED RESIDENTS: An audit of current residents with wound care orders was completed on 3/25/16 to validate current wound treatment is applied as ordered, and wound dressing is intact. SYSTEMS CHANGE: Staff Development Coordinator will conduct in-services to all staff on April 6 and 7, 2016 on Pressure Ulcer and Wound Care Management. The education will include verification of current wound care orders when completing wound care treatments, and notification of appropriate nursing staff, which includes Licensed Nurse assigned to resident and/or Wound Care Nurse, when wound care dressing	

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F 314	Continued From page 8 extremities, and had a chronic left heel wound that required dressing changes as ordered which was managed by a wound care nurse. A weekly pressure ulcer record dated 03/03/16 for Resident #49's stage 2 right lateral ankle pressure ulcer assessed the wound bed as pink with slough and measured 0.4 centimeter (cm) by 0.4 cm by 0.2 cm with a small amount of serosanguinous drainage. A weekly pressure ulcer record dated 03/03/16 for Resident #49's stage 3 left heel pressure ulcer assessed the wound bed as pale pink with macerated wound edges and measured 0.5 cm by 0.5 cm by 0.5 cm with a small amount of serosanguinous drainage. A physician's order dated 03/03/16 recorded to discontinue the previous treatment to the left heel (Aquacel and Hydrocolloid dressing) and discontinue the treatment to the right lateral ankle (Aquacel and foam dressing); begin Santyl (debridement) to the right lateral ankle pressure ulcer, cover with foam dressing, daily; Prisma (wound dressing for non-healing, chronic wounds) to the left heel pressure ulcer and cover with foam dressing, daily. An interview with Nurse #3 (treatment nurse) on 03/07/16 at 4:11 PM revealed Resident #49 had an unstageable pressure ulcer to the right lateral ankle with slough/necrotic tissue and a chronic stage 3 pressure ulcer to her left heel that was previously healed and then re-opened in November 2015. Nurse #3 stated the pressure ulcers for Resident #49 were difficult to heal and that her wounds were followed weekly by a Wound Consultant (WC).	F 314	is not observed as intact on a resident. Any staff member on LOA or otherwise out will be educated prior to returning to assignment. MONITORING: An audit tool was developed to monitor current wound care treatments are applied as ordered and wound dressings remain intact on resident as ordered. Wound Care Nurse (or Designee) will conduct audits on five (5) residents with wound care orders two (2) times per week for four (4) weeks then five (5) residents with wound care orders one (1) time per week x 8 weeks. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Nursing and during the monthly Quality Assurance and Performance Improvement Committee meeting.	

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F 314	Continued From page 9 An observation of wound care for Resident #49 occurred on 03/07/16 at 4:20 PM. Nurse #3 (Wound Nurse) removed the right shoe and sock for Resident #49 and then removed a thick, opaque, gelatinous dressing from the wound bed of the right lateral ankle. Nurse #3 stated that she was not certain, but the dressing in place to the Resident's right lateral ankle looked to be a Hydrocolloid dressing which was not the current treatment. Nurse #3 reviewed the treatment administration record (TAR) and stated that the current treatment order for Resident #49's right lateral ankle pressure ulcer was to apply Santyl to the wound bed and cover with a foam dressing, daily. Nurse #3 described the right ankle wound bed as having 100% slough. Nurse #3 was observed to remove the shoe and sock to Resident #49's left foot and the stage 3 left heel pressure ulcer was observed without a dressing intact. There was no dressing observed in the Resident's sock or shoe. Nurse #3 reviewed the TAR and stated the current treatment for the Resident's left heel pressure ulcer was to apply Prisma to the wound bed and cover with a foam dressing daily. Nurse #3 described the left heel wound bed as pale pink with macerated edges. Nurse #3 stated that wound care for Resident #49 was completed on 03/06/16 by Nurse #6. An interview on 03/08/16 at 11:42 AM with Nurse #6 revealed Resident #49 was followed by a WC and received daily wound care for a stage 3 chronic left heel wound and a stage 2 right lateral ankle wound. Nurse #6 reviewed the TAR for Resident #49 stated he provided wound care to both wounds for Resident #49 on 03/06/16, but that he must have followed the wrong physician's order. Nurse #6 stated that he usually referred to	F 314		

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the TAR when providing wound care, but that he must have made a mistake. He further stated that he was sure he provided wound care to Resident #49's left heel wound on 03/06/16 and perhaps the dressing came off, which he stated had happened a few times before. Nurse #6 stated that in the past he provided wound care to Resident #49 and she did not have a dressing intact, but that he had not reported this to the Wound Nurse. Nurse #6 stated he expected nurse aides to inform the nurse if they noted Resident #49 without a dressing intact to her left heel or right ankle.

An interview on 03/09/16 at 11:44 AM with the WC revealed she rounded each Thursday and assessed/measured wounds with Nurse #3. The WC stated Resident #49's right lateral ankle wound was not showing progress, so on 03/03/16 she changed the treatment to Santyl with a foam dressing to stimulate healing and provide better protection to the wound with the foam dressing. The WCstated the Hydrocolloid dressing would provide the same treatment to the wound without the debriding agent, so no harm would occur to the wound if the Hydrocolloid treatment was used instead of the Santyl, "but it would not stimulate the progress we are aiming for by using the debriding agent from the Santyl." The WC further stated that she would have expected staff to inform the nurse if the dressing was not intact so that the wound could be redressed. The WC stated, "of course we would like for the wound to be dressed, but if the dressing is not there it should not cause harm since the left heel wound was covered with the sock." The WC stated that had she been informed that Resident #49's pressure ulcer was noted without a dressing intact more than once, she would have changed

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F 314	Continued From page 11 the treatment to a cover that would stay in place, but that she was not made aware. An interview on 03/09/16 at 12:14 PM with the Director of Nursing (DON) revealed she expected wound care to be provided per physician's order and wounds to be dressed per physician's order. The DON further stated that she was not aware that Resident #49's left heel wound was noted without a dressing in place by staff as a reoccurring issue; this should have been brought to the attention of the Wound Nurse and WC. An interview on 03/09/16 at 2:55 PM with Nurse Aide (NA) #4 revealed she worked with Resident #49 for the prior 3 - 4 days, but had not observed dressings to the Resident's feet/ankles and was not aware that Resident #49 received wound care. An interview on 03/09/16 at 6:25 PM with NA #5 revealed she worked with Resident #49 on 03/06/16 but could not recall seeing a dressing to her feet/ankles. NA #5 stated she was not aware of what treatments Resident #49 received, but that she used to see dressings to the Resident's feet "a while ago, but not recently." An interview on 03/09/2016 at 6:30 PM with NA #6 revealed she worked with Resident #6 on 03/06/16 and the Resident was wearing socks so NA #6 did not notice if dressings were in place to her feet/ankles. NA #6 stated she was not aware that Resident #49 currently received wound care, but that she did recall seeing dressings to the Resident's feet "a long time ago."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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	345350	A. BUILDING _____ B. WING _____	C 03/10/2016

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F 323	Continued From page 12 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to use a dependent lift required to safely transfer one of three sample residents reviewed for accidents, resulting in an assisted fall without injury (Resident #18). The findings included: Resident #18 was admitted to the facility on 1/21/16 from a hospital with a cumulative diagnoses which included pneumonia, shortness of breath, and weakness. The resident's admission Minimum Data Set (MDS) dated 1/28/16 indicated the resident had moderately impaired cognitive skills for daily decision making. The MDS also revealed Resident #18 required extensive assistance for all of his Activities of Daily Living (ADLs), with the exception of needing supervision only for eating. A review of the resident's medical record included a Lift Assessment for Residents completed on 1/21/16. The Lift Assessment indicated a dependent lift (also known as a Hoyer lift) was required for this resident. The Assessment indicated dependent lifts were used for totally dependent, non-weight bearing residents. A	F 323	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. AFFECTED RESIDENTS: This deficient practice affected Resident #18. Corrective action for this resident included verification of lift assessment accurately reflects current transfer status of resident and accurately documented on Resident Status Sheet. Appropriate action and follow up was accomplished with the specific staff members involved. POTENTIALLY AFFECTED RESIDENTS: Other residents potentially affected by the deficient practice have been assessed as follows:	4/7/2016

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F 323	Continued From page 13 dependent lift is a mechanical assistive device that utilizes slings and allows a resident to be transferred between a bed and a chair or other similar resting places. A review of the Resident Status and Care Plan form (undated) revealed Resident #18 required the assist of two staff members using a dependent lift. The Resident Status and Care Plan form was kept in the Nursing Assistants' care binder as a guide to the residents' care needs. Resident #18's care plan dated 1/25/16 included a focus area related to his risk of falls due to being a new admission, non-ambulatory, and having a recent fall. A hand-written note on the care plan read: "1/25/16 fall no injury; attempting to get OOB (out of bed) into recliner--non-ambulatory; resident A & O x4 (alert and oriented to person, plan, time, and situation)--staff educated to utilize call bell and wait for assist." Further review of the resident's care plan revealed an additional focus area related to his risk of falls was added on 2/2/16. The planned interventions included, "Give needed assist with transfers." A review of the resident's medical record included a Nurses' Note dated 2/10/16 at 3:00 - 11:00 PM (2nd shift). The note read, in part: "...Resident had fall in shower this shift. Staff attempting to get Resident in shower chair. Resident became light-headed. Staff slid Resident to floor and called for help. No injuries noted at that time ..."	F 323	- Lift assessment accurately reflects current transfer need of resident. - Resident Status Sheet accurately reflects appropriate lift required to safely transfer resident. Audits completed on 3/31/16 confirmed 100% compliance of accurate lift assessment, and resident care status sheet reflect resident current transfer need. SYSTEMS CHANGE: Staff Development Coordinator will conduct in-services to all staff on April 6 and 7, 2016 on utilization of lift when required to safely transfer a resident. Any staff member on LOA or otherwise out will be educated prior to returning to assignment. MONITORING: An audit tool was developed to monitor utilization of lift when required to safely transfer a resident. Licensed Nurse (or designee) will conduct audits of 10% randomly selected residents two (2) times per week for four (4) weeks, then 10% of randomly selected residents one (1) per week for 8 weeks.	

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F 323	Continued From page 14 A review of the Accident/Incident Log revealed an entry dated 2/10/16 at 3:25 PM reported Resident #18 had an observed fall while being transferred in the shower room. The log indicated the resident did not sustain an injury. A Post Fall Review dated 2/10/16 at 3:25 PM included a brief description of the event. The review indicated staff was with the resident in the shower room and attempting to place him in the shower chair. The staff reported he got light-headed and had to be lowered to floor. Handwritten statements from the two Nursing Assistants (NAs) present at the time of the incident both revealed a sit-to-stand lift was used to transfer the resident in the shower room. The resident was reported to have passed out and had to be lowered to the floor. A sit-to-stand lift is an assistive device designed to help patients with some mobility but who lack the strength or muscle control to rise to a standing position from a bed, wheelchair, chair, or commode. A sit-to-stand lift uses straps, vests, or belts (as opposed to slings used for a dependent lift) to make the transition possible. An interview was conducted on 3/9/16 at 5:49 PM with Nurse #1. Nurse #1 was the hall nurse assigned to care for Resident #18 on the 2nd shift of 2/10/16 when the assisted fall occurred in the shower room. Upon inquiry, Nurse #1 recalled the incident and reported she was called to assess the resident after the fall. The nurse indicated she checked his vital signs and reported they were good, although his blood pressure may have been a little low. She stated the resident did not sustain an injury. Nurse #1 reviewed the facility's post-fall procedures were followed and indicated she completed a Post Fall Review (paper form) along with the required computer reporting.	F 323	Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed by Administrator and/or Director of Nursing and during the monthly Quality Assurance and Performance Improvement Committee meeting.	

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F 323	Continued From page 15 An interview was conducted on 3/10/16 at 9:33 AM with the facility's Director of Nursing (DON). During the interview, the DON reviewed the facility's procedures required after an accident/incident occurred. She indicated any change in interventions implemented after a fall would be communicated to the staff and put into place for the resident by the Nurse Supervisor. She also reported any education needed would be provided by the facility's Staff Development Coordinator (SDC). An interview was conducted on 3/10/16 at 2:46 PM with the facility's Nurse Supervisor. The Nurse Supervisor reviewed Resident #18's Lift Assessment and reported the assessment was done upon admission to the facility. The Nurse Supervisor stated that she herself had written on the Resident Status and Care Plan form for Resident #18 which noted use of a dependent lift was required for transferring the resident. However, she was uncertain as to the date this was done. Upon inquiry, the Nurse Supervisor stated she addressed the use of a sit-to-stand lift versus a dependent lift with the NAs involved in the incident on 2/10/16 with Resident #18. When asked, the Nurse Supervisor indicated she would have expected a dependent lift to have been used for Resident #18. An interview was conducted on 3/10/16 at 2:51 PM with NA #1. NA #1 reported she was typically assigned to care for Resident #18 on the 2nd shift. Upon request, NA #1 recalled the incident involving Resident #18 on 2/10/16. The NA recalled the 1st shift NAs had reported to the on-coming 2nd shift NAs that a sit-to-stand was used the last time this resident had a shower and	F 323		

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F 323	Continued From page 16 it, "worked perfectly." Therefore, NA #1 and NA #2 decided to use the sit-to-stand lift for Resident #18. As they began to get him up with lift, he passed out. She reported they lowered the sit-to-stand as low as it would go, and then unhooked the lift, lowered him to the ground, and got the nurses. Once the nurses came, they used a dependent lift to put him back into his wheelchair. They returned the resident to his room and put him into his bed. When asked, NA #1 reported that prior to the incident of 2/10/16, she had been using a dependent lift to transfer Resident #18. Upon further inquiry, the NA reported that the paperwork for this resident at the time of the incident instructed the NAs to use a dependent lift. After the fall, the NA reported she was told they had to use the dependent lift, "no matter what." An interview was conducted on 3/10/16 at 2:58 PM with NA #2. NA #2 worked the 2nd shift on 2/10/16. The NA recalled other nursing assistants had shared that they used a sit-to-stand lift to transfer Resident #18 for a previous shower and it worked. So, on 2/10/16, NA #2 reported she helped NA #1 transfer Resident #18 from his wheelchair to the shower chair in the shower room using a sit-to-stand lift. NA #2 reported at the time of this transfer, the shower chair was set up right beside the resident. However, the resident said he needed to sit down and, "he went down" (with assist) before the NAs could get him to the chair. When the nurses came to help, the NAs and nurses used the dependent lift to transfer the resident from the floor to his wheelchair, and then laid him down in his bed. Upon inquiry, NA #2 reported before this incident occurred on 2/10/16, she was using the dependent lift for all of Resident #18's transfers.	F 323		

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F 323	Continued From page 17 The NA also indicated she has used the dependent lift for this resident ever since the assisted fall. An interview was conducted on 3/10/16 at 3:06 PM with the facility's SDC. Upon inquiry, the SDC reported she was aware of Resident #18's assisted fall in the shower room. Upon review of Resident #18's Lift Assessment dated 1/21/16, the SDC stated she was not aware the resident had been assessed as requiring a dependent lift prior to the fall on 2/10/16. The SDC reported she had conducted an in-service training discussing " What to do once a resident has fallen." However, the SDC stated the in-service provided post-fall information and did not address the topic of being certain the correct lift was used to ensure residents were safely transferred. An interview was conducted on 3/10/16 at 3:19 PM with the facility's DON and Administrator. During the interview, the DON reported she was aware of Resident #18's assisted fall in the shower room and the use of the sit-to-stand lift instead of the dependent lift. Upon review of the resident's 1/21/16 Lift Assessment (which indicated a dependent lift was required for safe transfers), the DON stated, "I would expect them to use what was on the assessment."	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced	F 327		

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F 327	Continued From page 18 by: Based on staff interviews, nurse practitioner interview and review of the medical record, the facility failed to implement a physician's order and monitor a resident for fluid restrictions for 1 of 1 sampled residents reviewed with fluid restrictions (Resident #129). The findings included: The facility's Fluid Restrictions Policy, dated November 2015, recorded in part, that intake and output (I/O) data was collected by the RN (registered nurse), LPN (licensed practical nurse) and CNA (nurse aide); nursing and/or dining services would negotiate the percentage that each department would provide to the resident daily; staff should be accurate when recording fluid intake; nursing was responsible for ensuring the total I/O for the day which was recorded on the I/O sheet in the activities of daily living (ADL) book. Resident #129 was re-admitted to the facility on 12/31/15 and discharged to the hospital on 01/15/16 for evaluation of low blood pressure, nausea/vomiting and a low heart rate. Resident #129 did not return to the facility. Diagnoses on re-admission included adult failure to thrive (FTT), congestive heart failure (CHF), dehydration, hypoxia, acute peritonitis, protein calorie malnutrition, diverticulitis with perforation, colostomy status, atrial fibrillation, hypertension (HTN), chronic kidney disease, acute cystitis, malaise/fatigue, hypokalemia, seizures, dementia with memory impairment, chronic obstructive lung disease, edema, and chronic bronchitis, among others.	F 327	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. AFFECTED RESIDENTS: Resident #129 was discharged from facility to home on 1/11/2016. Resident #129 had Complete Blood Count (CBC) and Basic Metabolic Profile (BMP) drawn on 1/8/16. NP reviewed laboratory results on 1/8/16 and noted that the BUN was elevated, but not of concern at that point, because of her overall clinical picture. POTENTIALLY AFFECTED RESIDENTS: Director of Nursing (or Designee) completed 100% of all residents with physician's order for fluid restriction. Intake and Output	4/7/2016

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F 327	Continued From page 19 Medical record review revealed an admission nursing progress note dated 12/31/15 which documented that Resident #129 was alert and oriented to self and a colostomy intact to her left side. A December 2015 and January 2016 cumulative Physician's Order sheet (POS) and Medication Administration Record (MAR) for Resident #129 recorded a physician's order dated 01/02/13 to encourage limited fluid intake and educate the resident about the risk of consuming too much fluid. The December 2015 POS was reviewed and signed by the physician on 12/31/15. The January 2016 MAR recorded that Resident #129 followed a 2 liter fluid restriction. Further medical record review revealed Resident #129 received the following medications and monitoring per physician's order for management of CHF, HTN and fluid balance: · HTN o Norvasc 5 mg twice daily o Lopressor 50 mg twice daily; decreased on 01/05/16 to 25 mg twice daily and held for heart rate less than 60 (held 01/03/16, 01/05/16, 01/06/16 and 01/07/16) o Cozaar 100 mg daily · CHF o HCTZ 12.5 mg daily o Aldactone 25 mg daily o Potassium Chloride 20 MEQ daily (refused on 01/02/16) · Daily weights o Ranged 120.5 - 126 pounds · Daily vital signs · Bowel movements o 12/31/15 o 01/01/16 - 01/02/16, 01/05/16 - 01/07/16,	F 327	Record form was placed in the MAR binder for documentation of intake and output of residents with physician order for fluid restriction. SYSTEMS CHANGE: Nursing staff were re-educated on management and consistent accurate monitoring of any resident with physician order for fluid restriction on 3/22/16 and 3/25/16. Courtland Terrace Standing Orders was revised to include Fluid Restriction Reference Sheet. Courtland Terrace Intake and Output Policy was updated to include new process for management and monitoring of residents with fluid restriction orders. All staff will be educated on April 6 and 7, 2016 on the revised Intake and Output Policy and Courtland Terrace Standing Orders. MONITORING: An audit tool was developed to monitor management and monitoring of residents with physician orders for fluid restriction.	

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F 327	Continued From page 20 01/10/16 - 01/14/16 · Labs o 01/01/16, Basal Metabolic Panel (BMP) (Sodium 134, Potassium 4.2, and Blood Urea Nitrogen (BUN) 16); all within normal limits o 01/08/16, Complete Blood Count and BMP (Sodium 137, Potassium 5.2 and BUN 36); Sodium/Potassium within normal limits; BUN elevated · Nurse Aide ADL Tracking Form recorded the following total fluid intake for breakfast, lunch and dinner: o 12/31/15 there was no fluid intake recorded o 360 ML (01/01/16 - 01/05/16, 01/07/16, 01/09/16 - 01/11/16) o 480 ML (01/06/16, 01/08/16, 01/12/16 - 01/14/16) · Total Intake and Output Record completed by nurses recorded the following total fluid intake: o There were no totals recorded for 12/31/15 o There were no totals recorded for 01/01/16 - 01/06/16 o 01/07/16, 7A - 3P, 460 ml; there were no totals recorded for the 3P- 11P or 11P - 7A shifts o 01/08/16, 7A - 3P, 480 ml; there were no totals recorded for the 3P- 11P or 11P - 7A shifts o There were no other totals recorded for 01/09/16 - 01/15/16 A nurse's note dated 01/11/16 written by Nurse #7 recorded that she spoke to the family of Resident #129 regarding the diagnoses of CHF and the facility's implementation of their fluid restriction protocol and monitoring of fluid intake A Nurse Practitioner's (NP) progress note dated 01/12/16 recorded that Resident #129 was noted with trace edema to her bilateral ankles, medications were reviewed with new orders	F 327	Licensed Nurse (or designee) will conduct audits of residents with physician orders for fluid restriction two (2) times per week x 4 weeks, then one (1) time per week for 8 weeks. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Nursing and during the monthly Quality Assurance and Performance Improvement Committee meeting.	

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F 327	Continued From page 21 written. An interview on 03/09/16 at 8:25 AM with Registered Dietitian (RD) Consultant #1 revealed that the dietary department routinely provided residents with a minimum of 240 ml of fluids per meal and residents could request more. RD Consultant #1 stated that if a resident's fluids were restricted, nursing calculated the amount of fluids provided by each department, monitor and document the resident's fluid intake per meal and any fluids received between meals. RD Consultant #1 stated that if a resident with fluid restrictions in place also received liquid supplements, she communicated that to nursing to make sure the supplements were taken into consideration. An interview on 03/09/16 at 4:04 PM with Nurse #7 revealed that when a resident required fluid restrictions, nursing staff monitored the fluid intake by recording the total fluids received per shift on the I/O record. Nurses asked the NA and therapy staff how much fluid the resident received with each meal and the amount of fluids received between meals; this total was added to the total fluids received with medications. The total fluid intake for the resident was recorded by the nurse per shift on the I/O record for monitoring and reporting to the oncoming shift and the physician. Nurse #7 also stated that residents on fluid restrictions did not have water pitchers in their rooms for better monitoring of the residents fluid intake. Nurse #7 stated she recorded the 2 Liter fluid restriction on the January MAR for Resident #129 "sometime" after admission because of the physician's order and the diagnosis of CHF. Nurse #7 further stated that she missed recording the 2 liter fluid restriction on the December 2015	F 327		

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MAR when the Resident was re-admitted on 12/31/15, but she did not work with dietary to determine how many fluids the Resident would receive per shift/meal. Nurse #7 stated documentation of fluid monitoring should have been recorded by nurses each shift on the I/O records, but since she missed recording the fluid restriction on the December 2015 MAR and did not update the January 2016 MAR until "sometime" in January 2016, this would explain why nurses did not know to monitor fluids for Resident #129. Nurse #7 reviewed the medical record for Resident #129 and stated that there was only 1 I/O sheet available for nurses to document Resident #129's fluid intake and this record was incomplete. Nurse #7 stated "We should document each shift her fluid intake to make sure we are meeting her fluid needs." Nurse #7 stated that monitoring fluid intake was a routine practice for residents with CHF, but this was missed initially for Resident #129; once staff realized this was missed, the restriction was added to the MAR and staff initiated the I/O record for nurse monitoring.

An interview on 03/10/16 at 10:08 AM with Nurse #8 revealed she worked the 11PM - 7AM shift, but that she did not recall if Resident #129's fluids were restricted. Nurse #8 stated that fluids for residents on fluid restrictions were documented on the I/O sheet kept with the MAR. Nurse #8 stated she gave anywhere from 60 ml to 120 ml of fluids with med pass for a resident with fluid restrictions in place or gave medications in applesauce in order to meet the resident's fluid restrictions.

An interview with Nurse #9 on 03/10/16 at 10:28 AM revealed she worked with Resident #129 on

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the 3P - 11P shift. Nurse #9 stated she was not certain if fluids were monitored for Resident #129, but if a resident required fluid restrictions, the nurses kept track of the resident's fluids on the I/O record and if that record was not complete it would be difficult to monitor a resident's fluid intake. Nurse #9 stated she typically gave 120 ml of fluids with medication for a resident on fluid restrictions and if she "had to guess" how much fluid she could provide a resident with restrictions in place, she would assume the other nurses gave about the same amount of fluid with medications.

An interview on 03/10/16 at 10:44 AM with Nurse #10 revealed she worked with Resident #129 on the 7AM - 3PM shift. Nurse #10 stated she did not recall monitoring fluid restrictions for Resident #129 because she did not recall the Resident having fluid restrictions in place. Nurse #10 stated that if Resident #129 had fluid restrictions in place, nurses would have documented her fluid intake on the I/O record in her medical record.

An interview with NA #7 on 03/10/16 at 11:05 AM revealed she remembered that Resident #129 had fluid restrictions. NA #7 stated that Resident #129 also had a water pitcher in her room and drank sodas. NA #7 stated she reported the fluid intake for Resident #129 to the nurses and recorded her fluids at meals on the ADL Tracking form.

An interview with the Director of Nursing (DON) on 03/10/16 at 11:30 AM revealed that when a resident was placed on fluid restrictions, she expected the nurses to monitor and document the total fluids for the resident on the I/O Record each shift. The DON stated that if the nurses did not

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F 327	Continued From page 24 monitor the fluids received, they would not know if the resident's fluid restrictions were being followed. The DON further stated that she could not locate any additional documentation of fluid monitoring for Resident #129. An interview with the NP on 03/10/16 at 12:16 PM revealed Resident #129 was chronically ill, with history of FTT and in/out of the hospital with acute on chronic comorbidities. The NP stated that due the Resident's diagnosis of CHF and poor appetite, her labs and intake were monitored. The NP stated that she reviewed the lab results from 01/08/16 and noted that the BUN for Resident 129 was elevated, but not of concern at that point, because of her overall clinical picture. The NP stated Resident #129 was very sick and required a 2 liter fluid restriction. The NP stated she would have expected the nurses to monitor/document the Resident's fluid intake. The NP stated nursing communication, shift to shift would not be the best way to manage fluid restrictions, fluid intake should be monitored and documented.	F 327		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	4/7/2016

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F 356	Continued From page 25 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post accurate nurse staffing information at the beginning of the shift for 3 of the past 4 days of the recertification survey; and failed to retain staff postings for 4 of the past 60 days (1/9/16, 1/22/16, 2/5/16 and 2/19/16) and 3 months of the past 18 months (9/14, 10/14, and 11/14). The findings included: An observation made on 3/7/16 at 10:10 AM revealed daily nurse staffing information posted in a glass display case across from the nursing station was dated 3/6/16. The posting included staffing through 3/7/16 at 7:00 AM. It was noted the nursing staff posting included all residents in	F 356	No adverse effects were noted as result of this deficient practice. All resident s have the potential to be affected by this deficient practice. Daily staffing information was posted at the beginning of 1st shift on 3/10/16 in glass display case across from the nursing station. SYSTEMS CHANGE: The Daily Staffing Form was revised to specify daily staffing information and census on Skilled Nursing Beds and Assisted Living Beds. Clinical Nurse Managers, Assistant Clinical Nurse Managers and Unit Clerk Coordinator were educated on the new process of staff posting. Unit Clerk Coordinator will keep current month staff posting in a binder at the nurses' station. At the end of each month, completed staff postings will be kept at Director of Nursing Office for maintenance of records. MONITORING: An Audit tool was developed to monitor the staff posting for timeliness of posting, accuracy of staff posting and maintenance of staff posting records.	

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F 356	Continued From page 26 the facility, including the Assisted Living residents. An observation made on 3/8/16 at 9:15 AM revealed daily nurse staffing information posted in a glass display case across from the nursing station was dated 3/7/16. The staff posting included staffing through 3/8/16 at 7:00 AM. An observation made on 3/8/16 at 9:41 AM revealed the nursing staff posted had been updated to include all three shifts for 3/8/16. The census number on the posting continued to combine Assisted Living residents with the skilled nursing residents. An observation made on 3/9/16 at 8:20 AM revealed daily nurse staffing information posted in a glass display case across from the nursing station was dated 3/8/16. The staff posting included staffing through 3/9/16 at 7:00 AM. An observation made on 3/9/16 at 10:002 AM revealed the nursing staff posted had been updated to include all three shifts for 3/9/16. The census number on the posting continued to combine Assisted Living residents with the skilled nursing residents. An interview was conducted on 3/9/16 at 1:55 PM with the facility ' s Unit Coordinator. During this interview, the Unit Coordinator reported that she herself was responsible to post the staffing information for all 3 shifts when she came into work at 9:00 AM each weekday, Monday through Friday. She reported the 2nd shift supervisor was responsible to be sure the postings were completed on the weekend. Upon inquiry, the Unit Coordinator reported the census information for the postings was obtained from the facility ' s midnight census. She confirmed the census number reported on the nursing staff postings	F 356	Director of Nursing (or Designee) will complete audit of staff posting weekly x four (4) weeks, then monthly for 3 months and randomly thereafter. Ongoing audits will be determined based on results of prior audits. All findings will be reported to the facility's Quality Assurance and Performance Improvement Committee for review and further recommendations.	

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F 356	Continued From page 27 included all residents in the facility, including both the skilled nursing residents and the Assisted Living residents. The Unit Coordinator also reported the nursing staff hours and numbers used for the staff posting included all of the nursing staff for the entire building, including those used for the Assisted Living residents. A review of previous nurse staff postings was conducted on 3/9/16 at 1:00 PM with the Unit Coordinator. The review revealed staff postings for 4 of the past 60 days were missing (1/9/16, 1/22/16, 2/5/16 and 2/19/16). Records retained by the Unit Coordinator dated back to 10/15/15. Upon inquiry, the Unit Coordinator reported additional postings had been kept by the facility ' s former Director. She indicated she would attempt to retrieve these as well. An interview was conducted on 3/9/16 at 2:53 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON indicated the daily nursing staff information was posted for all 3 shifts after 9:00 AM by the Unit Coordinator each weekday, Monday through Friday. She also reported the census number on the posting used the midnight census and was not updated each shift. The DON acknowledged the census on the postings included both the skilled nursing residents and Assisted Living residents; and, that the nursing staff hours/numbers used for the staff posting included all of the nursing staff for the entire building. She reported that to her knowledge, the facility had not separated out the census and nurse staffing information for the skilled nursing residents in the past for the nursing staff postings. A follow-up interview was conducted on 3/10/16	F 356		

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F 356	Continued From page 28 at 9:00 AM with the DON. While additional daily nursing staff posts dating back to 12/1/14 were provided by the facility, it was revealed that 3 months of the required 18 months of records were not accessible at the time of the investigation (September 2014, October 2014, and November 2014).	F 356	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	4/7/2016
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of menus, the facility failed to provide a 4 ounce portion of scrambled eggs to 38 residents according to the approved menu for 2 of 5 dining areas observed (Residents #2, #7, #12, #15, #18, #21, #30, #38, #39, #40, #45, #49, #51, #57, #68, #75, #76, #79, #89, #120, #127, #131, #134, #137, #144, #146, #147, #150, #161, #164, #182, #197, #225, #230, #234, #235, #236, and #237). The findings included: An observation of the breakfast meal tray line occurred on 03/08/16 from 07:48 AM to 08: 11 AM. Dietary Staff (DS) #I was observed plating breakfast for residents who ate in the main dining room (MDR) and the secured unit. The breakfast menu included scrambled eggs. DS #I was	F 363	AFFECTED RESIDENTS: This deficient practice affected Residents #2, #7, #12, #15, #18, #21, #30, # 38, #39, #40, #45, #49, #51, #57, #68, #75, #76, #79, #89, #120, #127, #131, #134, #137, #144, #146, #147, #150, #161, #164, #182, #187, #225, #230, #234, #235, #236, and # 237. No harm was identified on above residents; current menu provided >100% of estimated calorie and protein needs.	

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F 363	Continued From page 29 observed to provide residents who ate in the MDR and the secured unit with 2.66 ounces (2/3 cup) of scrambled eggs using a #12 serving utensil (green handle). Review of the menu revealed residents were to receive a 4 ounce (½ cup) portion of scrambled eggs. The breakfast menu included the following food options: · Eggs · Grits · Oatmeal · French Toast · Bacon · Toast · Banana · Orange Juice · Milk An interview with the Assistant Foodservice Director (AFSD) on 03/08/16 at 8:12 AM revealed that Residents who ate in the MDR and on the secured unit received the wrong portion of scrambled eggs. The AFSD stated these residents should have received a 4 ounce portion of scrambled eggs. The AFSD instructed DS #1 to change the serving utensil for the scrambled eggs to a 4 ounce utensil. An interview with DS #1 on 03/08/16 at 8:13 AM revealed she provided the 2.66 ounce portion of eggs based on her usual practice and the training she received. DS #1 stated she used the utensil guide for determining the portion of foods to serve, but for the eggs, she was trained to serve scrambled eggs using a "green handled utensil" (2.66 ounces). An interview with the kitchen supervisor on	F 363	POTENTIALLY AFFECTED RESIDENTS: Serving utensils were corrected once identified. Dietary staff were immediately re-educated on using serving utensils to match menu item portion size. SYSTEM CHANGE: Director of Food and Nutrition Services will conduct in-services to all dietary staff and will be completed by April 1, 2016. Education included: - Use serving utensils as required - Use the menu spreadsheet designated serving portion sizes - Follow scoop chart identifying proper utensil to match menu item portion size - Designated dietary staff are to complete serving utensil log for every meal daily - Supervisor/MOD to conduct preservice tray line inspection 15 minutes before start of service and ensure logs are completed to standard. Any other staff member on LOAs or otherwise out will be educated prior to returning to assignment.	

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F 363	Continued From page 30 03/08/16 at 8:14 AM revealed that she started in December 2015 and scrambled eggs were served daily. The kitchen supervisor stated that since she came she was trained to serve eggs using the 2.66 ounce utensil. The kitchen supervisor stated "That's just what we have always used, that was our error; we usually follow the guide in the book for utensils and serving sizes." A delivery cart was observed on 03/08/16 at 08:15 AM with breakfast trays ready for delivery to the secured unit for Residents #21, #30, #38, #57, #68, #75, #79, #120, #134, #146, #150, #161 and #182. The portion of eggs for each Resident was a 2.66 ounce portion instead of the 4 ounce portion according to the menu. An observation on 03/08/16 at 08:20 AM of the MDR revealed Residents #2, #7, #12, #15, #18, #39, #40, #45, #49, #51, #76, #89, #127, #131, #137, #144, #147, #164, #197, #225, #230, #234, #235, #236 and #237 received a 2.66 ounce portion of eggs instead of the 4 ounce portion according to the menu. An interview with Registered Dietitian (RD) Consultant #1 on 03/09/16 at 08:25 AM revealed she provided clinical support, developed and approved menus, but that she did not conduct dietary rounds. RD Consultant #1 stated the facility followed the Dietary Guidelines for persons over the age of 65, which provided approximately 20% of calories from protein or about 100 grams of protein per day. If residents required more protein, they received additional protein from foods or supplements. The RD Consultant #1 stated that she expected residents to receive the portion of foods according to the menu or for	F 363	MONITORING: An audit tool was developed to monitor compliance with utilization of proper utensil to match menu item portion size. Dietary Manager on Duty (or Designee) will conduct audits of every meal daily x four (4) weeks, one (1) meal daily x 8 weeks. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Food and Nutrition Services and during monthly Quality Assurance and Performance Improvement Committee meeting.	

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F 363	Continued From page 31 dietary staff to consult with her if a change was made to the menu/portions. The RD Consultant #1 stated that it concerned her that residents potentially received a smaller portion of eggs at breakfast for several months. The RD Consultant #1 reviewed the breakfast menu provided on 03/08/16 and stated that residents who received 2 - 3 slices of French Toast (10 - 16 grams protein) and eggs (6 - 8 grams protein) would have received sufficient protein for breakfast, but for residents who did not receive the French Toast in addition to the eggs, and did not receive a protein supplement, their protein needs may not have been met for the breakfast meal. The RD Consultant #1 stated she would follow up with the dietary staff to ensure the menu/portions were being followed.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to monitor the hot water sanitizing cycle of a high temperature dish machine, while in use, for 1 of 2 dish machines observed. Additionally, the facility failed to remove foods from cold storage	F 371	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	4/7/2016

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F 371	Continued From page 32 with signs of expiration (mold growth) for 1 of 2 walk-in refrigerators observed. The findings included: 1. Review of the facility's dish machine temperature log revealed the following "Corrective Action: If the wash temperature is less than 150 degrees F, the final rinse temperature is less than 180 degrees F, or greater than 194 degrees, or the test strip result indicates less than 160 degrees F, stop using the machine and notify manager/supervisor, Do not use the dish machine until the manager/supervisor tells you that it can be used again." An observation on 03/09/16 at 09:13 AM of the facility's high temperature dish machine, in use by Dietary Aide (DA) #1, revealed a wash cycle temperature of 146 degrees Fahrenheit (F) and the final rinse, hot water sanitizing cycle temperature reached 164 degrees. DA #2 removed plates and trays from the dish machine and stored them for use. Plates were stored in the lowerator (plate warmer) and trays were stacked. DA #1 stated on 03/09/16 at 09:13 AM that the wash cycle temperature should reach a minimum of 170 degrees F, and then said, "The rinse, I'm not sure." DA #2 stated on 03/09/16 at 09:14 AM that the wash cycle temperature should reach 140 degrees F, and then said "The rinse, I'm not sure I'm the wrong person to ask." The kitchen manager stated on 03/09/16 at 09:14 AM that dietary staff recorded dish machine	F 371	CORRECTIVE ACTION: Items from cold storage where removed from coolers and were not used in production. Dish machine water temperature was verified at 180 degrees using the test strips. An emergency call to the facility engineer was placed on 3/9/16 and increased booster setting by 3 degrees. Ecolab was contacted on 3/9/16 to conduct service and confirm the status of the machine temperatures on 3/10/16. A work order to Hobart was also placed on 3/9/16 and had all gauges replaced on 3/11/16. POTENTIALLY AFFECTED RESIDENTS: All residents have the potential to be affected by identified deficient practice. SYSTEMIC CHANGE: Dish machine temperature will be monitored daily. Dietary staff will record temperature six (6) times per day. Products will be rotated, labeled and stored properly. Items close to expiration will be used accordingly. Expired products are removed and disposed of properly. Coolers will be inspected after each meal service by a designated dietary staff member.	

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F 371	Continued From page 33 temperatures on a log, but she was not sure if the dish machine used a high temperature, hot water sanitizing cycle or a chemical sanitizer. The kitchen manager further stated she was new and would get the ADFNS. On 03/09/2016 at 9:15 AM the ADFNS stated that the dish machine used a high temperature cycle for hot water sanitizing. He stated that the wash cycle temperature should range between 140 - 160 degrees F and the hot water sanitizing temperature should reach at least 180 degrees. On 03/09/16 from 9:17 AM to 9:20 AM, the dish machine was observed used with the following wash and rinse temperatures; the ADFNS explained he did not know why the temperatures fluctuated: · 09:17 AM wash - 146 degrees F; rinse - 146 degrees F · 09:19 AM wash - 140 degrees F; rinse - 180 degrees F · 09:20 AM wash - 140 degrees F; rinse - 178; degrees F On 03/09/16 at 09:23 AM a follow up interview with DA #1 revealed she was trained that the dish machine's wash cycle temperature should range between 145-160 degrees F and the rinse cycle temperature should be above 145 degrees F. DA #1 further stated that she looked at the temperature gauge every time she sent dishes though the dish machine and that a final rinse cycle temperature of 164 degrees F was acceptable. On 03/09/16 at 09:25 AM, the ADFNS stated that the dish machine's temperature gauge could malfunction, so whenever there was a question	F 371	Director of Food and Nutrition Services will conduct in-services for all Dietary staff and will be completed by April 1, 2016, regarding dish machine temperature, maintenance of dish machine temperature log, management and maintenance of cold storage items. Education will also include procedure, process and standards on dish machine temperature. Hobart will perform maintenance on dish machine for the next 90 days to verify that all gauges are operational to standards. Caromont Facility Services will conduct maintenance check on dish machine q monthly x 3 months to verify temperature is operational to standards. MONITORING: An audit tool was developed to monitor dish machine temperature and monitoring of items from cold storage. Dietary Manager (or designee) will conduct dish machine temperature check after ever meal daily x four (4) weeks then daily x eight (8 weeks).	

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	345350	A. BUILDING _____ B. WING _____	C 03/10/2016

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F 371	Continued From page 34 about dish machine temperatures, a test strip was used, as needed, to verify that the final rinse cycle temperature reached at least 180 degrees F. The ADFNS further stated that he expected staff to monitor dish machine temperatures while the dish machine was being used and to use the test strip any time the water temperatures were in question. On 03/09/16 at 09:47 AM, an interview with a Facility Services Technician (FST) revealed he was called that morning (03/09/16) by the ADFNS to check the dish machine due to fluctuating water temperatures. The FST stated he found that the dish machine's booster temperature was set to 182 degrees F, he increased the temperature to 185 degrees F, which increased the final rinse temperature to 188 degrees F. The FST also stated that when he checked the dish machine, he found 2 dishes (dome lids) were stuck in the machine and stated "This could have had something to do with the fluctuating water temperatures." 2. An observation on 03/07/16 at 10:9 AM of produce cooler #4, in the main kitchen, revealed the following foods stored with signs of expiration: A 25 pound box of cantaloupes contained 5 cantaloupes with discoloration, multiple indentations and white fuzzy hair-like growth (mold) A 25 pound box of honeydew melons contained 2 honeydew melons with discoloration, multiple indentations and white fuzzy hair-like growth (mold) A 10 pound box of grape tomatoes contained multiple tomatoes throughout the box with	F 371	Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Food and Nutrition Services and during monthly Quality Assurance and Performance Improvement Committee meeting.	

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F 371	Continued From page 35 discoloration and white fuzzy hair-like growth (mold) Two boxes, 25 pounds each of tomatoes contained multiple tomatoes throughout the box with discoloration and white fuzzy hair-like growth (mold) An interview on 03/07/16 at 10:12 AM with the Assistant Director of Food Nutrition Services (ADFNS) and the Director of Food Nutrition Services (DFNS) revealed that the refrigeration units were monitored for expired items daily and that these items should have been discarded.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. CORRECTIVE ACTION: Staff Development Coordinator immediately posted the contact precaution sign in infection control caddy when deficient practice was identified.	4/7/2016

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F 441	Continued From page 36 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow contact isolation precautions for 1 of 4 residents reviewed for contact isolation precautions (Resident # 227). The findings included: Review of the facility's Contact Isolation Policy effective on 02/13/2016, revealed contact precautions were used for residents who were suspected or known to be colonized or infected with organisms that could be transmitted by direct contact with the resident. Direct contact was defined as "hand or skin-to-skin contact that occurred when resident care activities were performed, which required touching the resident's dry skin or having indirect contact with environmental surfaces or resident care items in the resident's environment". This type of isolation required the use of gloves and gown to enter the patient's room regardless of resident contact and required posting of an orange colored sign.	F 441	POTENTIALLY AFFECTED RESIDENTS: Staff Development Coordinator conducted a visual audit of all residents on isolation precautions to ensure appropriate isolation sign is posted with the infection control caddy on 3/7/16. SYSTEMS CHANGE: Staff Development Coordinator will conduct in-services on April 6 and 7, 2016 to all staff on isolation precaution policy and procedure. Education included verification of appropriate signage when isolation caddy is utilized, and notification of appropriate staff member including Staff Development Coordinator when isolation precaution signage is not posted or visible on isolation caddy. MONITORING: An audit toll was developed to monitor compliance with posting of signage when isolation caddy is utilized. Staff Development Coordinator (or Designee) will conduct audit for posting of appropriate signage on residents on isolation precaution daily x 4 weeks then two (2) times per week x 8 weeks.	

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F 441	Continued From page 37 Special Enteric Contact Precautions (orange sign with a brown bar) included the additional requirement of washing hands with soap and water upon exiting the patient's room. The policy stated the appropriate isolation precaution sign along with an isolation bag was to be hung on the door of a resident's room if the resident is on contact isolation precaution. Review of the Physician's Notes on 03/07/16 revealed Resident #227 was discharged from the hospital and placed on isolation precautions on 02/25/16 (date of admission to the facility). Resident #227 was placed on contact isolation precautions for Extended Spectrum Beta-Lactamases (ESBL), which are enzymes produced by bacteria (such as E-Coli) that can cause serious illness. Resident #227 had also received antibiotic therapy for a urinary tract infection caused by the bacteria. An observation was made on 03/07/16 at 1:41 PM and revealed there were no contact precaution signs on Resident #227's door. There was a Personal Protective Equipment (PPE) bag with gloves and gowns hanging on the door. On 03/07/16 at 1:42 PM an interview was conducted with the Nurse #4 on the hall for Resident #227. Nurse #4 was asked, "How would you know what kind of precautions were needed for the Resident?" Nurse #4 looked at the door and verified there was no signage posted next to the Personal Equipment (PPE) bag on the door. When asked how someone would know what to do before entering the room, Nurse #4 paused and stated she would, "Take care of that". Upon further inquiry, Nurse #4 indicated she would have expected a contact precaution sign to	F 441	Ongoing audits will be determined based on results of prior audits. Audits tools will be reviewed weekly by Administrator and/or Director of Nursing and during monthly Quality Assurance and Performance Improvement Committee.	

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F 441	Continued From page 38 be on the door. An observation made on 03/07/16 at 3:30 PM revealed a contact precaution sign had been placed on Resident #227's door, along with the PPE bag. On 03/10/16 an interview was conducted with the facility's Infection Control Nurse (ICN). She was asked why no contact isolation precaution sign had been placed on the door of Resident #227's room. The ICN stated she had placed the sign on the door next to the PPE bag and did not know why the sign was missing. She stated the contact isolation precaution was for the diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA). The Infection Control Nurse stated she knew what contact isolation precautions needed to be put in place once a resident's labs were reviewed. She knew to remove the contact isolation precautions after antibiotic therapy had been completed and the lab results had once again been reviewed. The lab results indicated when contact isolation precautions were no longer needed. Once lab results determined contact isolation precautions were no longer necessary, the ICN notified the staff. The PPE bag and contact isolation precaution signs were then removed. On 03/10/16 at 4:01 PM an interview was conducted with the Director of Nursing (DON) to see if she was aware there was no contact precaution sign posted for Resident 227's room. She stated there was a contact precaution sign in place and it had been there for a while. The DON was asked about the process for posting contact isolation precaution signs. She stated once the lab results on a resident had been received, the	F 441		

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F 441	Continued From page 39 ICN hung a PPE bag on the resident's door and placed an appropriate sign (depending on the infection or disease) next to the PPE bag. The ICN then notified the staff. The ICN made rounds on a daily basis. In addition, residents on contact isolation precautions were discussed at the staff "Morning Meetings". The PPE bags and signs were usually hung on the resident's doors after the morning meetings.	F 441		4/7/2016
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observation, the facility failed to accurately document the presence of a deep tissue injury (Resident #236) and failed to accurately document a change in skin integrity on a 14 day nutrition assessment (Resident #185) for 2 of 4 sampled residents reviewed changes in skin integrity. The findings included:	F 514	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. AFFECTED RESIDENTS: Resident #185 was discharged from facility on 11/8/2015. RD Consultant note on 11/3/15 documented that Resident #185 received high calories supplement. Resident #236 daily skilled nursing notes were reviewed and no negative outcomes were noted. Appropriate action and follow up was accomplished with the specific staff members involved.	

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F 514	Continued From page 40 1. Resident #236 was admitted on 03/02/2016 with right side weakness, infarct of the insular cortex and sub insular region, chronic atrial fibrillation, and metabolic encephalopathy. A deep tissue injury to the right heel was present on admission. Physician orders dated 03/08/2016 documented the order to discontinue the skin prep and a foam dressing to the right heel every 3rd day and as needed. A review of the care plan dated 03/08/2016 revealed a deep tissue injury to the right heel with an intervention to off load the heel. An observation of wound care was made on 03/09/2016 at 9:32 AM. The Wound Consultant (WC) measured the wound on the right heel and it was 0.7 centimeters (cm) X 0.6 cm. The Wound Nurse (WN) wiped the wound with normal saline and applied a foam dressing to the right heel. She stated it was to be changed every 3 days and as needed. She stated that weekly skin assessments are done and measurements are done. She charted the dressing change on the treatment record. A review of the skilled nursing daily assessment sheets revealed that no deep tissue injury was documented in the skin section completed 03/03/2016 - 03/09/2016. An interview on 03/10/2016 at 1:24 PM with the Director of Nursing (DON) revealed her expectation was documentation was done on the required shift with the frequency per policy and procedure. The daily skilled nursing assessments were done based on the time the resident was admitted to the facility.	F 514	POTENTIALLY AFFECTED RESIDENTS: Residents throughout the facility have the potential to be affected by the alleged deficient practice. SYSTEMIC CHANGE: Staff Development Coordinator will conduct in-services on April 6 and 7, 2016 to all nursing staff on policy and procedure on documentation and completion of daily skilled nursing notes. Education also included notification of Registered Dietitian Consultant by writing a physician order for "RD consult" when skin integrity issue or pressure ulcer is identified. RD will maintain a log to document date wound was identified, date of RD documentation, and RD documentation in place. Wound Care Rounds was moved to every Tuesday. At-Risk Meetings was moved to every Thursday. During this At-Risk meeting, wound care rounds conducted on Tuesday of same week will be discussed including recommendations.	

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F 514	Continued From page 41 2. Resident #185 was admitted to the facility on 10/20/15. Diagnoses included left pleural effusion, hypertension, coronary artery disease, and atrial fibrillation. Review of the medical record revealed a nurse's note dated 11/03/15 at 10:00 AM written by Nurse #2 (wound nurse) which documented an open area to the coccyx of Resident #185, treated per physician's order with Aquacel (a sterile dressing for acute/chronic wounds with drainage) and covered with a foam dressing. A second nurse's note, also dated 11/03/15, written at 4:00 PM, documented an open area to Resident #185's coccyx. A 14 day follow up progress note dated 11/03/15 written by registered dietitian (RD) Consultant #2 documented that Resident #185 had "no skin breakdown." The progress note also documented that Resident #185 received high calorie supplements due to weight loss. An interview with Nurse #2 on 03/08/16 at 5:12 PM and again on 03/10/16 at 3:54 PM revealed Resident #185 was admitted with intact skin, developed diarrhea, and on 11/03/16 was noted with an open area to the coccyx. Nurse #2 further stated that the typical practice for communicating changes in skin integrity included a risk meeting each Tuesday afternoon which discussed residents with wounds that were identified the week prior. Nurse #2 stated that during the 11/03/16 risk meeting, Resident #185 was not discussed because the wound report for that meeting only reflected residents with wounds noted the week of 10/26/16. Resident #185's wound was not noted until 11/03/16. Nurse #2 stated that Resident #185's medical record did	F 514	MONITORING: An audit tool was developed to monitor accuracy documentation on daily skilled nursing notes. Licensed Nurse (or Designee) will conduct audits of randomly selected residents two (2) times per week for four (4) weeks, then 10% of randomly selected residents one (1) time per week for 8 weeks. Director of Food and Nutrition Services (or designee) will conduct audit on RD referrals log weekly x four (4) weeks then monthly x 3 months. Director of Food and Nutrition Services (or designee) will also conduct 10% of randomly selected residents for accuracy of RD assessments one (1) time per week, then 10% of randomly selected residents for accuracy of RD assessments one (1) time per month x 3 months. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Nursing and during monthly Quality Assurance and Performance Improvement Committee meeting.	

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F 514	Continued From page 42 document the open area to the coccyx identified on 11/03/16 An interview on 03/09/16 at 11:10 AM with RD Consultant #2 revealed when completing an assessment she reviewed nurses progress notes, weekly wound reports, physician orders and interviewed staff. RD Consultant #2 stated that at the time she completed Resident #185's 14 day assessment, she did not see the nurses' progress note dated 11/03/15 that indicated Resident #185 had an open area to his coccyx. RD Consultant #2 stated had she been aware of the open area to Resident #185's coccyx she would have reviewed the status of the wound regarding improvement and discussed further plans with the treatment nurse. An interview on 03/10/16 at 6:25 PM with the Director of Nursing (DON) revealed she attended a Risk Meeting on Tuesdays each week that discussed residents with wounds that were identified from the previous week's wound care assessments/report. The DON stated that the RD Consultant #2 did not have the most current wound report when she completed the 14 day assessment for Resident #185. The DON expressed that the weekly wound care report discussed each Tuesday did not include residents with wounds identified for the current week, but rather residents previously identified with wounds. The DON further stated that she would need to take a look at the current system for review of wounds and consider reviewing all residents with current wounds identfied for the current week.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 43 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 and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place March of 2015. This was for one recited deficiency which was originally cited in February of 2015 on a Recertification survey. The deficiency was in the area of supervision to prevent accidents. The continued failure of the facility during two federal surveys of record show	F 520	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 facility has taken or will take the actions set forth in the following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The facility maintains a Quality Assurance and Performance Improvement Committee that meets monthly to identify issues with respect to which quality assurance activities are necessary, develop and implements appropriate plans of action to correct identified quality deficiencies. AFFECTED RESIDENT: Corrective actions as described in Plan of Correction were taken for Resident #18, relative to use of dependent lift required to safely transfer resident	4/7/2016

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F 520	Continued From page 44 a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F 323: Supervision to Prevent Accidents: Based on staff interviews, and record review the staff failed to use a dependent lift required to safely transfer 1 of 3 sampled residents reviewed for accidents resulting in an assisted fall without injury to Resident #15. During the survey of February 2015 the facility failed to secure hazardous chemicals out of reach of cognitively impaired residents. On the current survey the facility failed to use a dependent lift required to safely transfer a resident resulting in an assisted fall. During an interview with the Administrator and Director of Nursing on 03/10/2016 at 5:30 PM, the Administrator stated that the Quality Assessment and Assurance Committee meets monthly. Their action plans were driven by the results of the previous survey and any new concerns they identify. He added every member brought something up. An example was dietary brought up meal satisfaction; we identified key indicators or anything that falls short of our expectation for good quality service. All items that are in the Performance Improvement Plan (PIP) are substandard. They are in the PIP and that drills down into areas we want to improve on and we monitor the substandard item until it gets back into standard practice. We review progress every month on any items that fall below our recognized standard. The process failed by the employee not following the care plan. Going forward all items that were cited will be taken to the Quality Assessment Performance Improvement committee and Plan of Correction (POC) will focus on the deficient practice.	F 520	POTENTIALLY AFFECTED RESIDENTS: As all residents could be affected, the following corrective action(s) have been taken. SYSTEMS CHANGE: Administrative staff has reviewed the current Quality Assurance and Performance Improvement committee procedures and processes. An audit tool was developed to identify potential quality issues, including but not limited to utilization of appropriate lifts to transfer residents safely. Administrator and/or Director of Nursing shall be responsible to conduct and/or delegate said audits in an effort to identify quality care area of concern and address with QAPI committee in an effort to formulate an action plan should deficient practice be identified. As means of quality assurance, the Director of Nursing shall report findings of aforementioned audits and immediate corrective actions taken to the QAPI committee during monthly meetings. Further corrective action shall be planned/executed by the committee as warranted with follow-up reporting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. BUILDING _____ B. WING _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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			provided and reviewed at the next QAPI meeting in an effort to continually identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies.	