CARVER
Living Center

Revised POC - 5/27/16
e-mailed to team by IZ

May 26, 2016

North Carolina Department of Health and Human Services

Division of Health Service Regulation

Nursing Home Licensure and Certification Section

1205 Umstead Drive

Raleigh, North Carolina 27603

Dear Ms. Osabel;

Thank you for your assistance related to revisions of the plan of corrections. If there is any additional information needed please, do not hesitate to call me or Corrie Wilson, DON.

Thank you for your time,

Danute Nykas

Administrator

919-471-3558

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	321 EAST CARVER STREET DURHAM, NC 27704

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, staff interview, and resident interview, the facility failed to resolve grievances promptly and failed to follow their grievance policy for 2 of 3 sampled residents (Residents #100 and #95) reviewed for grievances. The findings included: The facility's " Grievance Policy and Procedure" was reviewed. The policy read, in part: - Grievances will be recorded on a Compliment/Concern Record Form. These forms will be located at the nursing stations and the central business office. Any issue that needs to be addressed, and its resolution, will be indicated on the form. - All grievances will be investigated within 72 hours or sooner, depending on the nature of the concern. - The Administrator and/or designee will inform the parties involved in the grievance of the resolution or outcome of the grievance investigation. The facility will notify all parties interested of the resolution to ensure that the grievance was handled to the satisfaction of the individual(s) who filed the grievance. 1. Resident #100 was admitted to the facility on 1/2/09 with multiple diagnoses that included dementia, anxiety, and depression. The quarterly	F 166	Tag 166 1. Resident #100 grievance resolved 4/27/16 by Social Worker #1. Resident #95 grievance resolved 5/6/16 by SW #2. 2. 100% audit of grievances from March 2016 to current date reviewed for timely resolution and follow up with Resident and or family by Social Worker #1 and 2. No other unresolved grievances were noted on findings. 3. All grievances will be addressed per policy. Grievances will be reviewed daily in Morning Manager's Meeting (Monday-Friday). Weekend Manager on Duty or Weekend Supervisor will address grievances as required or notify appropriate manager. Grievance forms are located at all Nurses Stations, SW Offices, Reception Area, DON Office, and Administrator's Office. All staff including prn educated on grievance process by SDC for nursing, Housekeeping Director for housekeeping staff, Dietary Manager for dietary staff, Administrator for Managers were completed by 5/19.16. Grievance Log and book is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 5/11/16

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.

Revision date 5/26/16

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F 166	Continued From page 1 Minimum Data Set (MDS) assessment dated 1/29/16 indicated Resident #100 had significant cognitive impairment. The grievance forms were reviewed from March 1, 2016 through April 20, 2016. A grievance form dated 4/13/16 indicated multiple concerns reported by a family member of Resident #100. It indicated the Director of Nursing (DON) reviewed the form on 4/13/16 and the resolution stated "will call to attempt to set up a meeting to discuss all concerns". The notifications of resolution section was incomplete. There was no documentation to indicate if the resident/family had been notified of a resolution. An interview was conducted with the DON on 4/21/16 at 8:55 AM. She stated her expectation when a grievance was received was to discuss the grievance in the morning meeting and get a resolution within 72 hours as per facility policy. She indicated if the grievance involved an ongoing issue that required monitoring, the grievance would be kept open. If the grievance had been resolved it would be closed. She stated that if a concern was received verbally by staff that they were expected to fill out a grievance form and hand it in to a Social Worker (SW) or the Unit Coordinator. The DON indicated if she personally received information of a grievance verbally, by email, or in writing that was not on an official grievance form, she may or may not have put it on a grievance form. She stated she had filled out a grievance form in the past, but she had not always done this. She indicated the expectation was to complete a grievance form. The interview with the DON continued. The DON indicated she was aware of one grievance form	F 166	located in Administrators Office and is reviewed daily (Monday–Friday) by Administrator for resolution or new grievances. 4. Social Workers and/or Administrator will present findings monthly to QA Committee for review and/ or revisions. This is a monthly requirement and will be ongoing. 5. Compliance date 5/19/16	

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F 166	Continued From page 2 from April 2016 for Resident #100. She stated she was unable to recall any additional grievances for Resident #100. The grievance form dated 4/13/16 for Resident #100 was reviewed. She stated she was aware of this grievance and she had initially reviewed it on 4/13/16. She indicated she had spoken with Social Worker (SW) #1 to follow up on the resolution. The DON additionally indicated that SW #1 informed her the family member had declined a meeting. She stated she was unsure if this information had been documented by SW #1. She indicated the resolution had not been reevaluated. The DON revealed the facility had a problem with the grievance process and that it was going to be corrected. An interview was conducted with SW #1 on 4/21/16 at 10:05 AM. She reviewed her documentation for Resident #100. SW #1 indicated that sometime in the middle of March (2016), she was unable to recall the exact date, the DON had informed her of a number of concerns from Resident #100's family member. She indicated she was unaware of how the DON became aware of the concerns. She stated she did not know if a grievance form had been completed in March for Resident #100. SW #1 revealed she had contact the family member by phone on 3/28/16 to offer a meeting and the family member declined. The interview with SW #1 continued. She stated she contacted Resident #100's family member by phone on 4/13/16 as a normal call to check in with the family. She indicated the family member shared a number of concerns with her and she then completed a grievance form for Resident #100 on 4/13/16. SW #1 stated she gave the	F 166		

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F 166	Continued From page 3 form to nursing staff and the form was then given to the DON. SW #1 indicated on 4/15/16 the DON asked her to contact the family member to schedule a meeting. She revealed she had not called the family member on 4/15/16. She stated she contacted the family member on 4/18/16. SW #1 indicated she spoke with the family member by phone on 4/18/16 and the family member agreed to a meeting. She stated a meeting was not set up while she was on the phone on 4/18/16 and she was unable to recall why. SW #1 indicated she received a phone message from the family member on 4/19/16. She stated she had not had the opportunity to call the family member back yet. SW #1 indicated she was aware of the facility ' s policy on the timeframe for grievance resolutions. She revealed grievance resolutions were expected to be completed within 72 hours. She indicated the resolution for this grievance had not been completed as of this date (4/21/16). 2. Resident #95 was originally admitted to the facility 10/14/08 and last readmitted to the facility 1/12/15. Cumulative diagnoses included hemiplegia (paralysis on one side), anxiety, depression and bipolar disorder. A Quarterly MDS dated 3/18/16 indicated Resident #95 was cognitively intact. He required extensive assistance with bed mobility, dressing, eating, personal hygiene and total assistance was needed with bathing. Limitations in range of motion was noted on one side for the upper and lower extremities. During stage 1 on 4/18/16 at 4:02 PM, Resident #95 was interviewed. He stated someone on	F 166		

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F 166	Continued From page 4 night shift had taken the call bell out of the wall and put something in the hole so the call bell would not alarm. He also said someone had taken his water pitcher and told him he needed to cut back on his water. Resident #95 said he had informed a nurse on day shift about the call light and water pitcher about two to three weeks ago and that nurse had "written it up" for him. Resident #95 indicated he did not know if anything had been done about it. A review of the grievance logs for the past six months revealed one grievance had been filed on behalf of Resident #95 by his family on 12/21/15. There were no other grievances documented as filed by Resident #95 or grievances filed on his behalf. On 4/20/16 around 10:00AM, an interview was conducted with social worker #2 who stated he had not received any grievances from or on the behalf of Resident #95 but he would check with Nurse #3 about Resident #95's concerns. On 4/20/16 at 3:00PM, social worker #2 stated he had spoken with Nurse #3 and asked him about Resident #95 telling him about the call light and staff taking his water pitcher. He stated the nurse told him that Resident #95 had told him about both problems but Nurse #3 did not write up a grievance form. On 4/20/2016 at 5:51 PM, Nurse #3 was interviewed via telephone. He stated Resident #95's sister and daughter had complained to him about a person on night shift who unplugged Resident #95' call light and put something in the light so it wouldn't go off. Nurse #3 said he talked to Resident #95 who stated he was not sure of	F 166		

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F 166	Continued From page 5 the date but the incident had happened about two weeks prior to telling Nurse #3. Nurse #3 also stated Resident #95 said staff did not fill up his water pitcher and one of the ladies told him that he needed to cut back on his consumption. Nurse #3 said he filled out a grievance form that day (about two weeks ago) and put it in the alert charting book that was located at the nursing station. He also stated that he verbally told the Director of Nursing the same day he wrote the grievance form. On 4/21/16 at 8:55 AM, an interview was conducted with the Director of Nursing. She stated her expectation when a grievance was received was to discuss the grievance in the morning meeting and get a resolution within 72 hours as per the facility policy. If it was an ongoing issue that required monitoring, the grievance would be kept open. If it was something that was resolved, the facility would close the grievance and move on. If there was a concern received verbally by staff - most of the time they wrote a grievance form out. The expectation was to write a grievance form out. The grievance form would be given to the social worker and/or the unit coordinator to follow up. She stated a grievance would not be placed in the alert charting book. She said she had not been informed verbally by anyone of any grievances that involved Resident #95. The Director of Nursing stated if she personally received a grievance verbally, email, or in writing that was not on a grievance form - she may or may not put it on a grievance form and may or may not put it on the grievance log. She stated she has filled out a grievance sometimes in the	F 166		

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F 166	Continued From page 6 past, but not always. The expectation was to put it on the grievance log and fill out a grievance form. If a meeting was to be set up with the concerned party/ family/ resident as part of the resolution, the social worker was responsible for setting up the meeting. The Director of Nursing stated grievances were supposed to be resolved within 72 hours as per the policy, but if the family was unable to be contacted, resolution may not happen within the 72 hours and she expected staff to document this information somewhere. The Director of Nursing stated she knew they had a problem with the grievance process and this would be corrected.	F 166	Tag 247 1. SW #2 spoke to resident #95, #38, and #87 and their RP regarding roommate notification. No issues resulted with new roommates. Documentation completed in records 5/6/16. 2. 100% room change audit completed 5/2/16. By SW#1 and #2 No issues noted. Some residents did go into private rooms. 3. Social Workers and Admissions Coordinator were educated by Administrator to maintain room change logs and notification with documentation to ensure proper communication on 5/9/2016 Social Workers are responsible for informing resident and responsible family and document outcomes. Audits will be completed by Admissions Coordinator on all new room changes to ensure proper notification and documentation, weekly for four weeks and monthly thereafter. Log will be kept in Admissions Office. 4. Findings will be presented to QA Committee monthly for review and/or revisions by SW#2 times 12 months. 5. Compliance date 5/19/16	
F 247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interview, the facility failed to inform the resident who was receiving a new roommate for 3 (Residents # 95, #38 & #87) of 3 sampled residents reviewed for admission, transfer and discharge. Findings included: 1. Resident # 95 was admitted to the facility on 10/14/08. The quarterly Minimum Data Set (MDS) assessment dated 3/18/16 indicated that Resident #95 had intact cognition with the Brief	F 247		

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F 247	Continued From page 7 Interview for Mental Status (BIMS) score of 15. On 4/18/16 at 4:18 PM, Resident #95 was interviewed. He indicated that he had a new roommate and nobody had informed him. He stated " they just showed up. " On 4/21/16 at 11:15 AM, the admission staff member was interviewed. She stated that she normally informed the resident if a new resident was coming to the room, either a new admit or a transfer from another room and document the conversation on the social work notes. On 4/21/16 at 12:46 PM, the admission staff member confirmed that Resident #95 had a new roommate but she could not find documentation in the social work notes that he was informed about it. On 4/21/16 at 1:20 PM, Social worker #2 was interviewed. He stated that if the resident was informed of the new roommate it should have been documented in the resident's medical records. He added that he could not find any documentation that Resident #95 was informed when he received a new roommate. On 4/21/16 at 5:00 PM, the Director of Nursing was interviewed. She stated that the admission staff and the social worker were responsible in informing the resident of room change or new roommate assignment and document the conversation in the resident's records. 2. Resident #38 was admitted to the facility on 5/29/12. The annual MDS assessment dated	F 247		

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F 247	Continued From page 8 1/29/16 indicated that Resident #38's cognition was moderately impaired with the BIMS score of 9. On 4/18/16 at 4:48 PM, Resident #38 was interviewed. He stated that he had a new roommate and he was not informed about it. On 4/21/16 at 11:15 AM, the admission staff member was interviewed. She stated that she normally informed the resident if a new resident was coming to the room, either a new admit or a transfer from another room and document the conversation on the social work notes. On 4/21/16 at 12:46 PM, the admission staff member confirmed that Resident #38 had a new roommate but she could not find documentation in the social work notes that he was informed about it. On 4/21/16 at 1:20 PM, Social worker #2 was interviewed. He stated that if the resident was informed of the new roommate it should have been documented in the resident's medical records. He added that he could not find any documentation that Resident #38 was informed when he received a new roommate. On 4/21/16 at 5:00 PM, the Director of Nursing was interviewed. She stated that the admission staff and the social worker were responsible in informing the resident of room change or new roommate assignment and document the conversation in the resident's records. 3. Resident #87 was admitted to the facility on	F 247		

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F 247	Continued From page 9 10/10/15. The quarterly MDS assessment dated 2/26/16 indicated that Resident #87's cognition was moderately impaired with the BIMS score of 8. On 4/19/16 at 9:42 AM, Resident #87 was interviewed. She stated that she had a new roommate and she was not informed about it. On 4/21/16 at 11:15 AM, the admission staff member was interviewed. She stated that she normally informed the resident if a new resident was coming to the room, either a new admit or a transfer from another room and document the conversation on the social work notes. On 4/21/16 at 12:46 PM, the admission staff member confirmed that Resident #87 had a new roommate but she could not find documentation in the social work notes that she was informed about it. On 4/21/16 at 1:20 PM, Social worker #2 was interviewed. He stated that if the resident was informed of the new roommate it should have been documented in the resident's medical records. He added that he could not find any documentation that Resident #87 was informed when she received a new roommate. On 4/21/16 at 5:00 PM, the Director of Nursing was interviewed. She stated that the admission staff and the social worker were responsible in informing the resident of room change or new roommate assignment and document the conversation in the resident's records.	F 247		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=D	Continued From page 10 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain a clean and sanitary interior in resident bathrooms and keep the walls and bathroom door in resident rooms in good repair for three of four halls observed (halls 100,200 and 400 halls). The findings included: An observation of room 212 B was conducted on 4/18/16 at 2:27 PM. The sheetrock on the wall behind the bed was scuffed with gouges noted on the wall and sheetrock dust on the floor. An observation of room 107 was conducted on 4/18/16 at 4:05PM. There was a black ring noted in the commode at the water line. An observation of room 114 was conducted on 4/18/16 at 4:50 PM. There was a towel on the floor at the foot of bed B. The wall behind the bed of 114 B was scuffed with gouges in the sheetrock. A tour of the bathroom revealed black material present in the grout of the bathroom floor, dirt in the corners of the bathroom and the floor of room 114 had spits of clear liquid dried on the floor with dirt/ dust noted on the floor of the room. An observation of room 411 was conducted on 4/19/16 at 9:02 AM. Dirt was observed in the corners of the bathroom. There was a hole about	F 253	TAG#253 1. Contracted Vendor hired to assist with room repairs on 100, 200, 300, and 400 halls. Rooms 101, 107, 114, 212, and 411 repairs completed by 5/10/16. Maintenance Director corrected room 411 threshold gap on 5/9/16. Housekeeping Director corrected 107 bathroom black ring in commode and dirt in corners of 411 bathroom on 5/2/16. 2. Environmental Service Director and Maintenance Director completed 100% audits of all rooms in the facility. Audits were completed on 4/27/16. Multiple rooms on all units required patching and multiple rooms required more detailed cleaning in bathrooms. 3. Environmental Service Director educated housekeeping staff on new cleaning and deep cleaning schedules for resident rooms, bathrooms, showers, corners, edges, tiles, and floors on 5/9/and 5/10/16. Maintenance Director educated his employee on 4/25/16 and new employee on room inspections, work orders, PM schedule, and daily rounds to ensure comfortable environment on 5/9/16. SDC educated other staff which was completed by 5/19/16 and will educate new employees in orientation. Departmental Managers and other key personnel are assigned to specific resident care areas to ensure	

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F 253	Continued From page 11 mid-center of the bathroom door leading into the bathroom. The threshold leading into the bathroom was not large enough to cover the gap between the bedroom floor and the bathroom floor. There was a gap on either side of the threshold and there was dirt in both gaps. An observation of room 101 was conducted on 4/19/16 at 11:49 AM. There were seven (7) holes in the wall in the sheetrock and a hole that measured approximately 4-5 inches in length behind the bed near the door at the baseboard. Sheetrock dust was noted on the floor at the baseboard area. An observation of room 107 was conducted on 04/19/2016 at 2:08 PM. The black ring noted on the commode at the water line was still present. An observation of room 114 was conducted on 4/19/16 at 4:00PM. The sheetrock walls behind the bed of 114 B remained scuffed with gouges. The grout on the floor in the bathroom was still black in color. Dirt remained in the corners of the bathroom. The floor of room 114 was clean at the time of the observation. An observation of room 101 was conducted on 4/20/16 at 3:00PM. The holes in the sheetrock remained (walls and at the baseboard). An observation of room 107 was conducted on 4/20/16 at 4:30PM. The black ring at the water line in the commode was still present. An observation of room 114 was conducted 4/20/16 at 6:00PM. The sheetrock walls behind the bed remained scuffed with gouges. The bathroom floor had black material noted in the	F 253	rooms are in good repair known as Guardian Angel Rounds. These rounds are also utilized to generate work orders that are located at each nurses station for maintenance to address any repairs required for a comfortable environment. Guardian Angel rounds will assist environmental services in ensuring cleanliness of resident areas are sanitary and orderly. Manager on Duty for the weekend will be rounding to ensure a comfortable interior. Maintenance Director and Environmental Service Director will make weekly rounds to ensure compliance with new QA Tool which reviews physical makeup of room and equipment. Review walls, floors, cove base, doors, beds, windows, corners, edges, sink, toilet, shower conditions, and any other areas not mentioned that constitutes a resident room. 4. Maintenance Director and Environmental Service Director will report any findings daily in Morning Managers Meeting (Monday-Friday). Maintenance Director and Environmental Service Director will present their findings to monthly QA Committee for review and/or revisions for 12 months. 5. Compliance date 5/19/16.	

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	345434	A. BUILDING _____ B. WING _____	04/21/2016

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F 253	Continued From page 12 grout and dirt remained in the corners of the bathroom. An observation of room 114 was conducted on 4/21/16 at 3:45PM. The sheetrock walls behind the bed of 114 B remained scuffed with gouges. The grout on the floor in the bathroom was still black in color. Dirt remained in the corners of the bathroom. An observation of room 212 B was conducted on 4/21/16 at 3:47 PM. The sheetrock on the wall behind the bed was scuffed with gouges noted on the wall and sheetrock dust on the floor. An observation of room 411 was conducted on 4/21/16 at 3:50 PM. Dirt was observed in the corners of the bathroom. There was a hole about mid-center of the bathroom door leading into the bathroom. The threshold leading into the bathroom was not large enough to cover the gap between the bedroom floor and the bathroom floor. There was a gap on either side of the threshold and there was dirt in both gaps. The grout in the bathroom was black in color. On 4/21/16 at 3:50 PM, a tour of 100, 200 and 400 hall rooms was conducted with the housekeeping supervisor and maintenance assistant. The maintenance assistant stated he had not received any work orders to repair the bathroom door, change the threshold or repair any of the sheetrock walls that were observed to have holes in them or scuffed walls/ gouges in the sheetrock. He stated that was not the kind of threshold they normally used and it should be a metal threshold that covered the full gap. He stated the door of the bathroom should have been repaired and the walls should have been	F 253		

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F 253	Continued From page 13 repaired. The maintenance assistant stated they have work order forms at each nursing station and maintenance checked every day to see what repairs needed to be made. He stated they depend on the work orders to do maintenance repairs. He stated the holes in the wall in room 101 were from a television attachment that the prior resident had on the wall and the holes in the wall and at the baseboard should have been repaired. He stated he was aware of the holes in the wall but had forgotten about them and they would be repaired. On 4/21/16 at 4:00PM, a tour of the facility was conducted with the housekeeping supervisor who observed the black ring still present at the water line in the commode in room 107. He stated he expected staff to clean the commodes at least daily whether the resident used the commode or not. On 4/21/16 at 4:50 PM, an interview was conducted with the housekeeping supervisor. He stated he expected his staff to clan the room/ bathroom daily and there should not be dirt behind the commodes or in the corners of the bathroom. The housekeeping supervisor stated they " deep-cleaned " each room once a month and " deep-cleaning ' included cleaning the grout on the bathroom floor. A review of the deep-cleaning schedule revealed room 114 was " deep-cleaned " on 4/12/16 and room 411 on 4/15/16. The housekeeping supervisor stated he expected the grout on the floor to have been cleaned at that time.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 14 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money 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 record review, observation and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments on behaviors (Resident #198), hospice (Resident 148), medications (Resident #181), vision (Resident #95), dental (Resident #95) and Activities of Daily Living (Residents #41, #188 & #139) for 7 of 26 sampled residents reviewed.	F 278	TAG# 278 1. Resident #198, 148, 181, 188, 139, 95, and 41 MDS assessments and coding and submission Completed 5/11-5/16/16.by MDS Director. 2. MDS and Interdisciplinary Team conducted audits for MDS accuracy. This was completed by 5/16/16. Few issues noted related to ADL information, missed diagnosis codes or incomplete IDT information. 3. MDS Director educated IDT for coding and review of entries prior to signing off completed on 4/28/16. MDS Director will audit 25% of completed MDS weekly times four weeks. MDS Director will complete 100% of completed MDS in ninety days. MDS Director will review all MDS completed assessments for accuracy prior to submission and final RN signature. 4. MDS Director will bring results of audits and submission reports to QA Committee monthly for review and/or revisions. 5. Compliance date 5/19/16.	

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F 278	Continued From page 15 The findings included: 1. Resident #198 was admitted to the facility on 2/8/16 with multiple diagnoses including Diabetes Mellitus and Atrial Fibrillation. The quarterly MDS ~~assessment dated 4/7/16 indicated that~~ Resident #198's cognition was intact with the Brief Interview for Mental Status (BIMS) score of 15 and had behaviors of rejection of care and wandering that occurred daily. The assessment also indicated that the resident needed one person physical assist with locomotion. The nurse's notes and the social work progress notes were reviewed. There were no documentation indicating that Resident #198 had reject care or had wandered. On 4/20/16 at 5:05 PM, Nurse Aide (NA) #1 was interviewed. NA #1 stated that he was assigned to Resident #198. NA #1 indicated that Resident #198 did not reject care and did not wander. On 4/20/16 at 5:10 PM, Nurse #2 was interviewed. Nurse #1 stated that she was assigned to Resident #198. She stated that Resident #198 did not refuse care or wander. On 4/20/16 at 5:50 PM, Resident #198 was interviewed and observed. The resident was observed up in wheelchair. She indicated that she did not refuse care. The resident also indicated that she needed assistance with locomotion. On 4/21/16 at 3:10 PM, Social Worker #2 was interviewed. He indicated that he was	F 278		

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F 278	Continued From page 16 responsible in coding behaviors on the MDS assessment. He indicated that it was an error on his part, Resident #198 did not refuse care or wander. On 4/21/16 at 4:55 PM, interview with the Director of Nursing was conducted. She stated that she expected the MDS to be accurate.	F 278		
	2. Resident # 148 was admitted to the facility on 4/18/14 with multiple diagnoses including Dementia. The significant change in status MDS assessment dated 2/10/16 indicated that the resident had memory and decision making problems and was not on hospice. The doctor's orders for Resident #148 were reviewed. On 2/2/16, the attending physician had ordered to admit Resident #148 on hospice care. On 4/21/16 at 2:20 PM, MDS Nurse #1 was interviewed. She stated that it was an error, Resident #148 was on hospice and the MDS assessment should have been coded for hospice. On 4/21/16 at 4:55 PM, interview with the Director of Nursing was conducted. She stated that she expected the MDS to be accurate. 3. Resident # 188 was admitted to the facility on 1/28/16 with multiple diagnoses including End Stage Renal Disease and was on dialysis. The quarterly MDS assessment dated 3/25/16 indicated that Resident # 188's cognition was			

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F 278	Continued From page 17 intact with the BIMS score of 15. The assessment further indicated that transfer, personal hygiene and dressing occurred only once or twice and he needed 1 person physical assist. On 4/20/16 at 11:10 AM, Resident #188 was interviewed and observed. He was observed in bed and was able to transfer self from bed to wheelchair. He stated that he bathed and dressed himself daily. On 4/21/16 at 2:25 PM, MDS Nurse #1 was interviewed. She indicated that she utilized the nurse's aides documentation on ADLs (activities of daily living). The ADL documentation indicated that transfer, personal hygiene and dressing had occurred only once or twice. On 4/21/16 at 4:55 PM, interview with the Director of Nursing was conducted. She stated that she expected the MDS to be accurate. 4. Resident # 139 was admitted to the facility on 7/11/14 with multiple diagnoses including Alzheimer's disease. The significant change in status MDS assessment dated 3/3/16 indicated that the resident had severe cognitive impairment and eating had occurred only once or twice. On 4/20/16 at 5:30 PM, Resident #139 was observed up in wheelchair in his room. A staff member was observed to deliver the dinner tray and fed the resident.	F 278		

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F 278	Continued From page 18 On 4/21/16 at 2:25 PM, MDS Nurse #1 was interviewed. She indicated that she utilized the nurse's aides documentation on ADLs (activities of daily living). The ADL documentation indicated that eating had occurred only once or twice. On 4/21/16 at 4:55 PM, interview with the Director of Nursing was conducted. She stated that she expected the MDS to be accurate. 5. Resident #41 was admitted to the facility on 3/9/12 with multiple diagnoses including vascular dementia and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 3/11/16 indicated Resident #41 had significant cognitive impairment. Section G of the MDS described the functional status of Resident #41's Activities of Daily Living (ADLs). Question G0100H indicated the activity of eating had not occurred for Resident #41 during the seven day look back period of the 3/11/16 quarterly MDS. A physician's order dated 2/2/16 indicated Resident #41 was discontinued from tube feeding and was started on a pureed diet. A dietary note dated 2/4/16 indicated Resident #41 was receiving a pureed diet, was assisted with feeding himself, and nursing staff reported his oral intake was good. A physician's progress note dated 2/8/16 indicated Resident #41 was recently switched from a continuous tube feed to a pureed diet and he was tolerating it well.	F 278		

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F 278	Continued From page 19 A physician's progress note dated 3/6/16 indicated Resident #41's appetite was good. Nursing Assistant (NA) documentation dated 3/6/16 indicated Resident #41 ate 100% of breakfast and lunch. NA documentation dated 3/7/16 indicated Resident #41 ate 75% of breakfast and lunch. A dietary note dated 3/10/16 indicated Resident #41 continued to receive a pureed diet, was fed by staff, and intake averaged 87.5% of reported meals during the past week. An interview was conducted on 4/20/16 at 4:00 PM with MDS Nurse #2. She indicated she completed Section G of Resident #41's 3/11/16 quarterly MDS. She stated she reviewed NA and nursing documentation to complete Section G. She reviewed the 3/11/16 quarterly MDS for Resident #41. She indicated she answered the question regarding eating (G0100H) as not having occurred because she had no documentation that indicated Resident #41 had eaten during the seven day look back period. She stated the facility had a computer glitch around the time of this MDS and she believed that could have been why she had no documentation. She stated she had not spoken to any NAs, nursing staff, or dietary staff to assist with completion of Section G for Resident #41's 3/11/16 quarterly MDS. She indicated the assessment was not accurate as Resident #41 had eaten during the seven day look back period. An interview was conducted on 4/21/16 at 4:55 PM with the Director of Nursing. She indicated her expectation was for the MDS to be coded	F 278		

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F 278	Continued From page 20 accurately. 6. a. Resident #181 was admitted to the facility 2/24/16. Cumulative diagnoses included hypertension and transient ischemic attacks (TIA). An Admission Minimum Data Set (MDS) dated 2/11/16 indicated the following medications were administered during the seven day look back period—no injections and seven (7) days of anticoagulant medication had been administered. A review of the admission physician orders revealed an order for Lovenox (anticoagulant medication) 40 milligrams subcutaneous (SQ) daily. A review of the February Medication Administration Record (MAR) for 2/5/16-2/11/16 revealed Resident #181 received a pneumonia vaccine injection on 2/8/16 and also Lovenox injections seven (7) days during the assessment period. On 4/21/16 at 2:05PM, MDS nurse #1 stated she should have documented seven (7) injections on the Admission MDS dated 2/11/16 and said it was an oversight. b. Resident #181 was admitted to the facility 2/24/16. Cumulative diagnoses included hypertension and transient ischemic attacks (TIA). A Quarterly MDS dated 3/31/16 indicated the following medications were administered during	F 278		

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F 278	Continued From page 21 the seven day look back period-- no injections and seven (7) days of anticoagulant medication had been administered. A review of the March physician orders revealed an order for Lovenox (anticoagulant medication) 40 milligrams subcutaneous (SQ) daily. A review of the March Medication Administration Record (MAR) for 3/25/16-3/31/16 revealed Resident #181 received Lovenox injections seven (7) days during the assessment period. On 4/21/16 at 2:05PM, MDS nurse #1 stated she should have documented seven (7) injections on the Quarterly MDS dated 3/31/16 and said it was an oversight. 7. a. Resident #95 was originally admitted to the facility 10/14/08 and last readmitted to the facility 1/12/15. Cumulative diagnoses included hemiplegia (paralysis on one side), anxiety, depression and bipolar disorder. A review of the medical record revealed a dental consult dated 10/29/15 that stated Resident #95 had poor oral hygiene with heavy plaque. Resident #95 had an upper denture and he was not able to clean his teeth or put in the denture. Extractions were required at the hospital. An Annual Minimum Data Assessment (MDS) dated 11/12/15 indicated Resident #95 was moderately impaired in cognition. Vision was documented as being impaired (sees large print, but not regular print in newspapers/ books). No corrective lenses. Also, oral/ dental status was checked as none of the above were present.	F 278		

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F 278	Continued From page 22 An observation conducted on 4/19/16 at 2:06 PM revealed Resident #95 had only a few teeth on the bottom gum and several of those were broken. Resident #95 stated he needed to have some teeth extracted. On 4/20/16 at 11:07 AM, Resident #95 stated he had glasses and wore them on a regular basis. Resident #95 was given his glasses by the nursing assistant and he said he could not see the numbers on the poster that was on the wall but he could see television clearly and he never read but watched television. On 4/21/2016 at 2:28 PM, MDS nurse #1 stated she does a visual check of the resident prior to completing the assessment and also reviews the dental assessments if available at the time. She said Resident #95 did not have his glasses on at the time of the assessment and asked her if she would come back later. She stated Resident #95 was asleep when she went back. MDS nurse #1 stated she could not remember if she had the dental consult available but should have documented the glasses and the dental status as Resident #95 having broken natural teeth. b. Resident #95 was originally admitted to the facility 10/14/08 and last readmitted to the facility 1/12/15. Cumulative diagnoses included hemiplegia (paralysis on one side), anxiety, depression and bipolar disorder. A Quarterly MDS dated 3/18/16 indicated Resident #95 was cognitively intact. He was vision impaired-no corrective lenses. Ambulation in room and corridor occurred 1-2 times and no dental problems were indicated.	F 278		

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F 278	Continued From page 23 An observation conducted on 4/19/16 at 2:06 PM revealed Resident #95 had only a few teeth on the bottom gum and several of those were broken. Resident #95 stated he needed to have some teeth extracted. Resident #95 was lying in bed and stated he was unable to ambulate and was dependent on staff for transfers. On 4/20/16 at 11:07 AM, Resident #95 stated he had glasses and wore them on a regular basis. Resident #95 was given his glasses by the nursing assistant and he said he could not see the numbers on the poster that was on the wall but he could see television clearly and he never read but watched television. The nursing assistant who provided care for Resident #95 stated he was non-ambulatory. On 4/21/2016 at 2:28 PM, MDS nurse #1 stated she did not have Resident #95 put his glasses on when he assessed him for the quarterly assessment. She stated she knew Resident #95 was no ambulatory and the information on the assessment was wrong. MDS nurse #1 stated the dental section should have indicated broken teeth were present and it was an oversight.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279	279 1. Resident #193 Medical Record was reviewed by MDS Director for accuracy to be develop appropriate care plan to address her needs. Care Plan update 4-28-16. 2. Audits on care plans for revisions will accomplished utilizing daily dinical meetings, MD orders and notes, and Nurses documentation with all assessment types.(Quarterly, Annually, New Admissions, Change in conditions). Process will be ongoing and monitor by MDS Director.	

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F 279	Continued From page 24 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a care plan for the use of psychoactive medication and behaviors for one of five residents reviewed for unnecessary medications (Resident #193). The findings included: Resident #193 was admitted to the facility on 7/9/15. Cumulative diagnoses included psychosis, anxiety and depression. Admission physician orders dated 7/9/15 included an order for Risperdal (antipsychotic medication) 2 milligrams by mouth every bedtime. An Admission Minimum Data Set (MDS) dated 7/21/15 indicated Resident #193 was cognitively intact. Mood was documented as Resident #193 feeling down depressed, poor appetite, feeling bad about self, fidgety and restless 1-2 days of the assessment period. Rejection of care was noted as having occurred daily. Medications administered during the assessment period was documented as 7 days of antipsychotic and	F 279	TAG #279 1. Resident #193 care plans were updated for behaviors on 4/28/16 by MDS Director and care plan for psychotropic medications on 5/10/16. 2. MDS Director, MDS coordinators, and IDT completed a 100% audit by 5/19/16. Findings noted were care plans not updated on the annual assessment and revisions of care plan during the quarterly assessment. A closed file could not be corrected. 3. MDS Director educated MDS Coordinators and IDT on care plan revisions and updates 4/28/16. Updates and revisions to care plans will be accomplished utilizing daily clinical meetings (Monday-Friday), MD orders and notes, and nursing notes. MDS Director will audit five random care plans weekly times four weeks and twenty care plans monthly times three months.	

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F 279	Continued From page 25 hypnotic medication. The Care Area Assessment (CAA) for psychotropic medication use stated, in part, Resident #193 received Risperdal 2 milligrams by mouth nightly for mood disorder and Melatonin 3 milligrams nightly for insomnia. There had been no change in her mood, behavior, sleep or thought pattern. No disruptive behavior was exhibited. No auditory or visual hallucinations or delusion were noted. The physician and pharmacist would monitor medication for the lowest effective dosage. A care plan would be developed. A review of the care plan for Resident #193 revealed no care plan had been developed on admission for the use of psychotropic medication. A social worker note dated 11/5/15 indicated the social worker was made aware of Resident #193 having a physical altercation with another resident in the 100 hall dining room during activities. The incident was witnessed by the activity assistant. Resident #193 stated she did not run over the other resident's foot but might have bumped into it. Resident #193 stated the other resident hit her so she hit the resident back. A Quarterly MDS dated 1/15/16 indicated resident #193 was cognitively intact. Mood was documented as feeling down, depressed, feeling bad about herself and poor appetite. Rejection of care was noted as having occurred 1-3 days during the assessment period. Medications received during the assessment period were documented as seven days of antipsychotic, antianxiety, antidepressant and hypnotic medication.	F 279	4. MDS Director will present findings to QA Committee monthly for review and/or revisions. 5. Compliance date 5/19/16.	

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F 279	Continued From page 26 A review of the care plan for Resident #193 revealed a care plan dated 1/19/16 that stated Resident #193 had recently lost her mother and had a sad mood with tearful episodes. Approaches included allow to vent. Make referrals. Encourage activity participation. A care plan dated 2/3/16 indicated Resident was noncompliant as evidenced by not keep her room clean or adhering to the smoking policy at times. Approaches included: inform her of rules and procedures prior to performing task or activity. Provide her with choices when available. Try to keep her on a routine that is as close to her with her lifestyle on the facility as possible. Document all episodes of noncompliance. There was not a care plan for the use of psychotropic medications. Psychiatric progress notes were reviewed and revealed Resident #193 was first seen 8/31/15. A psychiatric note dated 2/4/16 indicated Resident #193 was sad since her mother had passed away. Nursing notes were reviewed and revealed a nursing note dated 2/7/16 that stated Resident #193 got into an argument with another resident. Residents were separated and Resident #193 calmed down. A nursing note dated 2/8/16 indicated Resident #193 allegedly threw an opened can of mountain dew at another resident. A social worker note dated 2/11/16 as a late entry for 2/10/16 indicated the social worker had visited with Resident #193 due to her voicing that she was going to kill herself. When asked if she had	F 279		

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F 279	Continued From page 27 a plan she stated that she did not, but she did want to due to the fact that no one cared about her. The social worker and Director of Nursing spoke to Resident #193 about the positive things in her life and encouraged her to talk to them when she felt sad. Resident #193 agreed that she had some positive things in her life and she did not want to kill herself. A psychiatric note dated 3/18/16 stated Resident #193 said she was upset about her new roommate and her roommate had increased her anxiety. A psychiatric note dated 4/15/16 stated she was anxious and upset over a previous relationship. A review of physician orders for April 2016 included the following psychoactive medications: Risperdal (antipsychotic medication) 1 milligram by mouth every bedtime, Clonazepam (antianxiety medication) 0.5 milligrams by mouth twice daily and Lexapro (antianxiety medication) 20 milligrams by mouth daily for anxiety/ depression. A review of the care plan for Resident #193 revealed there was not a care plan developed following documentation of the behaviors of Resident #193 towards other residents, her desire to end her life or a care plan for psychotropic medications. On 4/21/16 at 2:43 PM, MDS nurse #1 stated a care plan would normally be developed when a resident received psychotropic medications. She stated it was an interdisciplinary team effort to develop the care plan and the care plan was reviewed at least quarterly. She stated there	F 279		

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F 279	Continued From page 28 should have been a care plan developed for the use of psychotropic medications in July 2015 and a care plan should have been initiated for her behaviors towards other residents in November 2015 and February 2016. Also, there should have been a care plan for her depression. She stated she did not know how it got overlooked during the reviews because the MDS coordinator who was responsible for the reviews for Resident #193 was no longer there	F 279	TAG# 280 1. Resident #139, 41, and 66 care plans have been updated for nutrition and hospice by MDS Director on 5/13/16. 2. MDS Director, MDS coordinators, and IDT completed a 100% audit by 5/19/16. Findings noted were care plans not updated on the annual assessment and change in condition, or revisions of care plan during the quarterly assessment. 3. MDS Director educated MDS Coordinators and IDT on care plan revisions and updates 4/28/16. Updates and revisions to care plans will be accomplished utilizing daily clinical meetings (Monday-Friday), MD orders and notes, and nursing notes. MDS Director will audit five random care plans weekly times four weeks and twenty care plans monthly times three months. 4. MDS Director will present findings to QA Committee monthly for review and/or revisions. 5. Compliance date 5/19/16.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 280		

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F 280	Continued From page 29 facility failed to review and revise care plans regarding nutrition (Residents #41 and #66) and hospice (Resident #139) for 3 of 26 sampled residents. The findings included: 1. Resident #41 was admitted to the facility on 3/9/12 with multiple diagnoses including vascular dementia and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 3/11/16 indicated Resident #41 had significant cognitive impairment. The care plan for Resident #41 indicated the problem area of swallowing. It indicated Resident #41 had a physician's order for no oral food or fluids and that all nutrition was received through gastronomy tube (G-tube). The care plan had a review date of 4/12/16. A physician's order dated 2/2/16 indicated Resident #41 was discontinued from tube feeding and was started on a pureed diet. A dietary note dated 2/4/16 indicated Resident #41 was receiving a pureed diet, was assisted with feeding himself, and nursing staff reported his oral intake was good. A physician's progress note dated 2/8/16 indicated Resident #41 was recently switched from a continuous tube feed to a pureed diet and he was tolerating it well. A dietary note dated 3/10/16 indicated Resident #41 continued to receive a pureed diet. An interview was conducted on 4/20/16 at 4:04 PM with the Dietary Technician. She indicated that revising care plans was a group effort. She	F 280		

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F 280	Continued From page 30 stated there was not one sole person who was responsible, but that all staff were expected to revise a care a plan when a change was needed. The care plan for Resident #41 regarding swallowing was reviewed with the Dietary Technician. The medical record for Resident #41 was reviewed with the Dietary Technician. She revealed the care plan regarding swallowing was not accurate. She indicated Resident #41 was no longer receiving nutrition through a G-tube. She stated Resident #41 was on a pureed diet as of 2/2/16. She indicated the care plan should have been revised when the physician's order dated 2/2/16 discontinued tube feeding and initiated a pureed diet. An interview was conducted with MDS Nurse #1 on 4/21/16 at 2:50 PM. MDS Nurse #1 stated that care plans were reviewed at least once every quarter and as needed. She stated the care plans were reviewed by an interdisciplinary team that included the MDS nurses, social workers, dietary staff, nursing staff, and activities staff. She indicated care plan revisions were a group effort. She stated all staff members were able to revise care plans. An interview was conducted on 4/21/16 at 5:00 PM with the Director of Nursing. She indicated her expectation was for care plans to reviewed and revised quarterly and as needed. 2. Resident #66 was admitted to the facility on 9/5/15 and readmitted on 11/12/15 with multiple diagnoses that included end stage renal disease (ESRD), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes mellitus, and hypertension. The admission Minimum Data Set (MDS) assessment dated	F 280		

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F 280	Continued From page 31 11/19/15 indicated Resident #66 was cognitively intact. A care plan for Resident #66 indicated she was at risk for weight loss with the potential for weight fluctuations. Interventions included the nutritional supplement prostat twice daily. A physician's order dated 11/13/15 indicated a discontinuation of the nutritional supplement prostat sugar free 30 ml twice daily for Resident #66. A physician's order dated 1/17/16 indicated the nutritional supplement ensure was to be provided with all meals for Resident #66. An interview was conducted on 4/20/16 at 4:04 PM with the Dietary Technician. She indicated that revising care plans was a group effort. She stated there was not one sole person who was responsible, but that all staff were expected to revise care plans when a change was needed. An interview was conducted with MDS Nurse #1 on 4/21/16 at 2:50 PM. MDS Nurse #1 stated that care plans were reviewed at least once every quarter and as needed. She stated the care plans were reviewed by an interdisciplinary team that included the MDS nurses, social workers, dietary staff, nursing staff, and activities staff. She indicated care plan revisions were a group effort. She stated all staff members were able to revise care plans. The care plan for Resident #66 was reviewed with MDS Nurse #1. The physician's orders for nutritional supplements for Resident #66 were reviewed with MDS Nurse #1. She revealed the care plan was not accurate. She indicated the care plan for Resident #66	F 280		

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F 280	Continued From page 32 should have been revised when the physician's order for the nutritional supplement prostat was discontinued on 11/13/15. She additionally indicated the care plan should have been revised when the physician ' s order for the nutritional supplement ensure was initiated on 1/17/16. An interview was conducted on 4/21/16 at 5:00 PM with the Director of Nursing. She indicated her expectation was for care plans to reviewed and revised quarterly and as needed. 3. Resident #139 was admitted to the facility on 7/11/14 with multiple diagnoses including Alzheimer's disease. The significant change in status Minimum Data Set (MDS) assessment dated 3/3/16 indicated that Resident #139's cognition was severely impaired and he was not receiving hospice care. The care plan dated 2/23/16 was reviewed. The care plan problem was " potential for adverse medication side effects related to the use of psychotropic medications, Seroquel (antipsychotic) and Zoloft and Trazodone (antidepressant). " The approaches included " unable to request psych consult with all behaviors and changes as resident is being followed by hospice, report and document all behaviors and changes to doctor, hospice and family as needed, assess level of consciousness, mood, behavior, sleep or thought pattern, report changes to doctor, hospice and family. " On 4/20/16 at 3:05 PM, a hospice staff member was interviewed. She stated that Resident #139 had been discharged from hospice care on 11/2/15.	F 280		

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F 280	Continued From page 33 On 4/21/16 at 2:27 PM, MDS Nurses #1 & #2 were interviewed. MDS Nurse #2 stated that it was her fault, she was aware that Resident #139 had been discontinued from hospice and she should have revised the care plan when she reviewed it. On 4/21/16 at 5:00 PM, the Director of Nursing was interviewed. Her expectation was for the MDS nurses to review and revise the care plan quarterly and as needed.	F 280		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced	F 322	F322 1. Licensed Nurse #1 educated on checking for placement of g tube prior to administration of medications, with return demonstration by ADON/SDC on 4/20/16. 2. All licensed nurses educated on checking placement of g tubes prior to administration of medications with return demonstration by ADON/SDC. Completed 5/19/16. 3. 2 licensed nurses will be observed for appropriately checking g tube placement daily x5 days, then weekly x4 weeks, then monthly x3 months by ADON/SDC and/or Unit Coordinators. Checking of g tube placement will be reviewed with return demonstration for licensed nurses in orientation and annually by ADON/SDC. 4. All audit findings will be reviewed in QA monthly by DON. 5. Compliance date 5-19-16	

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F 322	Continued From page 34 by: Based on observation, staff interview and facility policy review, the facility failed to check gastrostomy tube placement and check for residual prior to the administration of medication through the gastrostomy tube for one of two residents observed for gastrostomy tube medication administration (Resident #98). The findings included: A facility policy, undated, titled "Lesson 52: Administering Medications via the Gastrostomy tube (G-tube) or Jejunal tube (J-tube). L. Check placement by auscultating the resident ' s abdomen about 3 inches below the sternum with the stethoscope; gently insert 10 cc (cubic centimeters) of air into the tube. You should hear the bubble entering the stomach. 1. If you hear this sound, gently draw back on the piston of the syringe. The appearance of gastric content implies that the tube is patent and in the stomach." During a medication pass observation on 4/20/16 at 11:40AM, Nurse #1 was observed administering G-tube (gastrostomy tube) medications. She prepared the medications and entered the resident ' s room. Nurse #1 placed her stethoscope on Resident #98 ' s abdomen and listened to stomach sounds. She affixed the syringe to the gastrostomy tube and proceeded to administer a water flush, give the medications and ended with a water flush. Nurse #1 did not check for gastrostomy placement or check for residual prior to the administration of the medication. On 4/20/16 at 11:41 AM, Nurse #1 stated she had checked for gastrostomy tube placement when	F 322		

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F 322	Continued From page 35 she administered the morning medications but should have checked for placement and residual before giving the medications. On 4/21/16 at 9:00AM, the Director of Nursing stated she expected nursing staff to follow the policy for medication administration through the gastrostomy tube and should check for placement and residual before giving the medication.	F 322		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical	F 334	F334 1. Resident #41 and #150 and RP have been educated on pneumavaccine risk/ benefits completed 4-28-16 by ADON/SDC. 2. 100% chart audit for education/consent for pneumavaccine completed 5-19-16 by ADON/SDC. 3. New admissions will be educated on pneumavaccine/ flu on admission by Admissions Coordinator and /or Unit Coordinator/ADON/SDC. New admissions will be reviewed daily 5x/week by Unit Coordinator and/or ADON/DON. All residents/RP will be educated on pneumavaccine/flu annually by ADON/SDC. Licensed nurses educated on pneumavaccine/flu risk/benefits for residents by ADON/SDC. Completed 5-19-16. Pneumavaccine/flu risk/benefits for residents will be incorporated into orientation. 4. Audit finding will be reviewed in QA monthly by DON. 5. Compliance date 5-19-16	

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F 334	Continued From page 36 contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to document in the resident's medical record that education regarding the benefit and potential side effects of the pneumococcal vaccine was provided to the resident or legal representative for two of five residents reviewed for flu/ pneumonia immunization (Resident #41 and #150). The findings included: 1. Resident #41 was admitted to the facility on 3/9/12. Cumulative diagnoses included dementia. A Quarterly Minimum Data Set (MDS) dated 3/11/16 indicated Resident #41 was severely impaired in cognition. It was documented that the pneumonia vaccine was not given and reason indicated " not offered. A review of the medical record revealed the pneumococcal vaccine was declined in 2012. There was no documentation that Resident #41 or the Responsible Party had received any education regarding the benefit and potential side effects of the pneumonia vaccine in 2015. The infection control nurse reviewed the facility records and could not find any documentation regarding the pneumococcal vaccine for Resident #41. On 04/21/16 at 5:03 PM, the Director of Nursing stated she knew that the letters for the influenza and pneumonia vaccines had gone out together but they could not find any documentation that the pneumonia vaccine was offered to Resident #41. She stated the facility had identified there was a	F 334		

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	345434	A. BUILDING _____ B. WING _____	04/21/2016

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F 334	Continued From page 38 problem with immunization documentation. 2. Resident #150 was admitted to the facility on 2/1/13. Cumulative diagnoses included heart failure. An Annual Minimum Data Set (MDS) dated 12/24/15 indicated Resident #150 was cognitively intact. The MDS indicated Resident #25 had received the pneumococcal vaccine. A review of the medical record revealed Resident #150 had declined the pneumococcal vaccine in 2013. There was no documentation that Resident #150 had received any education regarding the benefit and potential side effects of the pneumococcal vaccine or had received the pneumococcal vaccine in 2015. The infection control nurse reviewed the facility records and could not find any documentation regarding the pneumococcal vaccine for Resident #150. On 04/21/16 at 5:03 PM, the Director of Nursing stated she knew that the letters for the influenza and pneumonia vaccines had gone out together but they could not find any documentation that the pneumonia vaccine was offered to Resident #150. She stated the facility had identified there was a problem with immunization documentation.	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to discard expired food items, failed to label and date food items and failed to monitor temperatures in two of two nourishment refrigerators (100/200 Hall refrigerator and 300/400 Hall refrigerator). The findings included: A review of the Refrigerators and Freezers Policy revised September 2004 was conducted. The policy stated refrigerator temperatures were to be maintained between 35 to 40 degrees Fahrenheit. Monthly tracking sheets for all refrigerators were to be posted to record temperatures. The monthly tracking sheets were expected to include the time, temperature, initials and any action taken if the temperature was not within the acceptable range. Employees were expected to check and record refrigerator temperatures twice a day. The policy stated all food items were expected to be appropriately dated to ensure proper rotation by expiration dates. Supervisors were responsible for ensuring that food items in the refrigerators were not expired or past perish dates. An observation of the 100/200 Hall nourishment refrigerator was made on 4/21/16 at 1:39 PM. The refrigerator temperature was observed to be 30 degrees Fahrenheit. A temperature log with documented refrigerator temperatures was not observed in the nourishment room. 1 opened, undated and unlabeled can of Mountain Dew, 1	F 371	TAG# 371/520 1. Thermometers were replaced in four nourishment room refrigerators by Dietary Manager on 4/21/16. All outdated food and undated/unlabeled items removed by Dietary Manager on 4/21/16. 2. Dietary Manager conducted an audit of the four nourishment room refrigerators on 4/21/16. Findings were few outdated food storage items and missing temperature log in nourishment rooms. 3 . Dietary Manager educated dietary staff on4/2 5/16 and on 5/6/16 on proper labeling and storage of food in the nourishment room refrigerators and accurate record keeping of refrigerator temperatures and documentation in temperature log. Staff Development Coordinator educated remainder of nursing staff by 5/13/16. Dietary Manager and Supervisor will be responsible recording temperatures and removing outdated or unlabeled food items. Daily monitoring of temperatures and outdated/unlabeled food items will be performed by Dietary Manager and Supervisor when he is not here. Administrator will	

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F 371	Continued From page 40 4-ounce container of vanilla pudding with a use by date of 4/1/16, 1 8-ounce carton of Lactaid with an expiration date of 3/21/16, 2 4-ounce containers of Thick and Easy iced tea with a use by date of 12/3/15 and 1 undated and unlabeled container of approximately 2 ounces of dark brown liquid were observed in the refrigerator. 1 opened, undated and unlabeled bottle of Dr Pepper containing approximately 15 ounces, 1 undated and unlabeled container of banana pudding and 1 undated and unlabeled box of Kentucky Fried Chicken were observed in the refrigerator. 1 thawed, unopened, undated and unlabeled piece of marinated fish approximately 4.0 x 2.5 inches in size with a manufacturer ' s recommendation to keep frozen until used was observed in the refrigerator. An interview was conducted with the 100/200 Unit Coordinator on 4/21/16 at 1:45 PM. She stated the night shift nursing assistants were expected to monitor the nourishment refrigerator for expired, unlabeled and undated food items. She stated did not know who was responsible for monitoring and recording the refrigerator temperatures. She was unable to locate a temperature log for the refrigerator. The Unit Coordinator stated the residents were expected to ask the nursing staff to label all food items with their name and date all food items prior to placing in the nourishment refrigerator. An observation of the 300/400 Hall nourishment refrigerator was made on 4/21/16 at 2:08 PM. A thermometer was not observed to be located on or within the refrigerator. A temperature log with documented refrigerator temperatures was not observed in the nourishment room. 1 undated and unlabeled container of pineapple cubes, 1	F 371	audit nourishment rooms weekly to ensure logs are accurate and outdated and unlabeled food is removed. 4. Dietary Manager will present findings to QA Committee monthly. If discrepancies continue to be identified the QA Committee will revise plan accordingly. 5. Compliance date is 5/19/16.	

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F 371	Continued From page 41 undated and unlabeled Styrofoam cup of ice and 1 undated bag containing grapes, 1 apple and 1 orange labeled with room number 310 and the name Jeff were observed in the refrigerator. 1 unlabeled carton dated March 5th containing a bologna sandwich and 1 undated and unlabeled 20 ounce Styrofoam cup containing a pink liquid were observed in the refrigerator. An interview was conducted with the 300/400 Unit Coordinator on 4/21/16 at 2:10 PM. She stated that all of the nurses and nursing assistants were expected to monitor the nourishment refrigerator for expired, undated and unlabeled food items. She stated did not know who was responsible for monitoring and recording the refrigerator temperatures. She was unable to locate a temperature log for the refrigerator. The Unit Coordinator was unable to locate a thermometer on or within the refrigerator. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/21/16 at 2:35 PM. The ADON stated the nursing assistants were expected to monitor the nourishment refrigerators for expired, undated and unlabeled food items. She stated she did not know who was expected to monitor and record the temperatures of the nourishment refrigerators. The ADON stated the residents were expected to ask the nursing staff to label all food items with their name and date all food items prior to placing in the nourishment refrigerator.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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F 431	Continued From page 42 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired medication in 1 (400 hall) of 4 medication rooms observed. On 4/21/16 at 1:55 PM, the 400 hall medication	F 431	F431 1. The 2 expired bottles of multivitamins with iron were removed by the Unit Coordinator 4-21-16. 2. 100% audit of all medication rooms and medication carts for expired medications completed by Unit Coordinators 4-25-16. 3. Medication rooms and medication carts are to be checked daily by licensed nurses, weekly x4 week's then monthly x3months by Unit Coordinators/Pharmacy. Licensed nurses educated on removal of expired medications from medication rooms and carts by ADON/SDC. Completed 5-19-16. Removal of expired medications from medication rooms and carts to be reviewed with new employed licensed nurses in orientation ADON/SDC.. 4. Audit findings to be reviewed in QA monthly by DON. 5. Compliance date 5-19-16.	

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F 431	Continued From page 43 room was observed. There were 2 bottles of Multivitamin with iron tablets observed with an expiration date of 3/16. On 4/21/16 at 3:05 PM, the central supply staff member was interviewed. She stated that she checked the medication rooms twice a week and she might have missed the expired bottles of Multivitamin. On 4/21/16 at 5:00 PM, the Director of Nursing was interviewed. She stated that the staff had been checking the medication carts and medication rooms for expired medications and could not understand why the expired bottles of Multivitamin were missed.	F 431	TAG# 514 1. Resident #98 and 99 wound documentation corrected by wound nurse on 4/21/16. SW#1 corrected service discontinuing Hospice and revised care plans and assessments 4/22/16. 2. DON, ADON, and Unit Managers completed 100% audit of wound documentation by 5/13/16. No other findings were identified. SW#2 reviewed records of all hospice residents for accuracy and completeness of records. No discrepancies noted. 3. DON educated wound nurse on accuracy of documentation on 4/22/16. DON, ADON, and Unit Manager's will review accuracy of wound documentation weekly at clinical wound meeting. MDS Director educated SW#1 on 4/28/16 on accuracy of documentation. MDS Director will monitor accuracy of documentation when reviewing completed assessments prior to submission. 4. MDS Director will present findings to QA Committee monthly for review and/or revisions. 5. Compliance date 5/19/16.	
F 514 SS=B	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 and staff interview, the facility failed to maintain an accurate clinical records for 2 (Residents #98 & #99) of 3 sampled residents reviewed with pressure ulcer and 1 .	F 514		

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F 514	Continued From page 44 (Resident #139) of 2 sampled residents reviewed for hospice. Findings included: 1. Resident #139 was admitted to the facility on 7/11/14 with multiple diagnoses including Alzheimer's disease. The significant change in status MDS assessment dated 3/3/16 indicated that Resident #139's cognition was severely impaired and he was not receiving hospice care. On 4/20/16 at 3:05 PM, a hospice staff member was interviewed. She stated that Resident #139 had been discontinued from hospice care on 11/2/15. The front cover of Resident #139 chart was observed to have a sticker. The sticker read " please notify (name of the hospice) regarding changes in condition, resident/family concerns, possible hospitalization and time of death. " The doctor's progress notes for Resident #139 were reviewed. The notes dated 12/10/15 indicated to continue hospice care. The notes dated 2/11/16 indicated that Resident #139 was a hospice patient and the plan of care per hospice. The notes dated 3/7/16 indicated to refer the resident to hospice if needed and the notes dated 4/7/16 indicated that the resident appeared stable on hospice care. The monthly drug regimen review notes by the pharmacist were reviewed. The notes dated 1/26/16 and 2/24/16 indicated that the resident was a hospice patient. The social work progress notes were reviewed. The notes dated 2/12/16 indicated that the resident continued on hospice. On 4/21/16 at 4:45 PM, Social Worker #1 was interviewed. She stated that she was not aware	F 514		

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F 514	Continued From page 45 that Resident #139 had been discontinued from hospice. She stated that on 2/18/16 she called hospice to schedule a care plan meeting and she was informed that the resident had been discharged from hospice. 2. Resident #98 was admitted to the facility 12/3/08 and readmitted 3/5/16. Cumulative diagnoses included a stage 4 pressure ulcer of the sacrum. Physician orders were reviewed and revealed an order dated 4/8/16 to cleanse the sacrum with normal saline, pack the wound with silver alginate, apply a debriding agent around the wound edges (necrotic area); then cover with dry dressing daily for stage 4 pressure ulcer. Weekly wound charting dated 4/14/16 stated the following: stage 4 sacrum with measurements of 4.7 centimeters x 4.2 centimeters x 2.8 centimeters with undermining of 2.6 centimeters at o ' clock. Wound treatment was (name)-a crystalline sodium chloride impregnated nonwoven gauze dressing daily. On 4/20/16 at 5:22 PM, the wound care nurse stated she copies the information from the previous week when she begins her weekly charting and changes the measurements of the wound. She stated she neglected to change the treatment on 4/14/16 and it was an honest mistake. 3. Resident #99 was admitted to the facility on 8/1/14 with multiple diagnoses including a history of wounds, diabetes mellitus and peripheral vascular disease.	F 514		

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F 514	Continued From page 46 The Quarterly Minimum Data Set dated 2/17/16 indicated the resident was assessed with one stage 4 pressure ulcer. The Plan of Care dated 3/30/16 indicated the resident was assessed with impairment of skin integrity related to a history of pressure ulcers manifested by a stage 4 pressure ulcer. A review of the Wound Care Specialist Evaluation dated 4/13/16 revealed the resident was assessed with a stage 4 pressure ulcer of the coccyx. A review of the Weekly Wound Charting for wound #1 located on the coccyx was conducted. The assessment dated 3/1/16, 3/2/16, 3/9/16, 3/18/16, 3/24/16, 4/1/16, 4/8/16 and 4/14/16 indicated Resident # 99 was assessed with a stage 3 pressure ulcer on his coccyx. An interview was conducted with the Wound Care Nurse on 4/20/16 at 3:35 PM. The Nurse stated the resident had been assessed with a stage 4 pressure ulcer on his coccyx. She stated she incorrectly documented the stage of the pressure ulcer as a stage 3 in the Weekly Wound Charting. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/21/16 at 2:40 PM. The ADON stated she expected the Wound Care Nurse to accurately document the stage of the pressure ulcer for Resident # 99 as a stage 4.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 47 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 record review, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 6/11/15 recertification survey. This was for the recited deficiency in the area of food procurement/storage (F371). This deficiency was cited again on the current recertification survey of 4/21/16. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance	F 520	TAG# 371/520 1. Thermometers were replaced in four nourishment room refrigerators by Dietary Manager on 4/21/16. All outdated food and undated/unlabeled items removed by Dietary Manager on 4/21/16. 2. Dietary Manager conducted an audit of the four nourishment room refrigerators on 4/21/16. Findings were few outdated food storage items and missing temperature log in nourishment rooms. 3. Dietary Manager educated dietary staff on4/2 5/16 and on 5/6/16 on proper labeling and storage of food in the nourishment room refrigerators and accurate record keeping of refrigerator temperatures and documentation in temperature log. Staff Development Coordinator educated remainder of nursing staff by 5/13/16. Dietary Manager and Supervisor will be responsible recording temperatures and removing outdated or unlabeled food items. Daily monitoring of temperatures and outdated/unlabeled food items will be performed by Dietary Manager and Supervisor when he is not here. Administrator will	

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F 520	Continued From page 48 program. The findings included: This tag is cross referenced to: F371 Food Procurement/Storage: Based on record review, staff interviews and observations, the facility failed to discard expired food items, failed to label and date food items, and failed to monitor temperatures in two of two nourishment refrigerators (100/200 Hall refrigerator and 300/400 Hall refrigerator). During the recertification survey of 6/11/15 the facility was cited F371 for failing to maintain kitchen equipment in a clean and sanitary condition to prevent food borne illness by failing to clean tray steam table shelves and failing to clean a staff hand sink. On the current recertification survey of 4/21/16, the facility failed to discard expired food items, failed to label and date food items, and failed to monitor temperatures in nourishment refrigerators. An interview was conducted with the Administrator on 4/21/16 at 5:13 PM. He indicated he was the head of the facility's QAA Committee. He stated the QAA Committee consisted of the Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Supervisor, Activities Director, Social Worker, Maintenance Director, Marketing Director, and the Pharmacy Consultant. He stated the committee met monthly. The Administrator indicated he was not aware food procurement/storage was a repeat deficiency from the previous recertification survey. He stated he was not working at the facility at the time of the previous recertification	F 520	audit nourishment rooms weekly to ensure logs are accurate and outdated and unlabeled food is removed. 4. Dietary Manager will present findings to QA Committee monthly. If discrepancies continue to be identified the QA Committee will revise plan accordingly. 5. Compliance date is 5/19/16.	

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F 520	Continued From page 49 survey and was unaware of the specific action plan that was put into place. He indicated he was not sure why it was a repeat deficiency.	F 520		