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	345126	A. BUILDING _____ B. WING _____	05/26/2016

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MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #IWBX11.	F 000		
F 166 SS=E	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 resident interview, family interview, staff interview, and record review the facility failed to resolve a grievance about late meal trays for 3 of 31 sampled residents (Resident #90, #93, and #144) and failed to resolve a family's grievance about provision of paperwork necessary to complete guardianship proceedings regarding 1 of 31 sampled residents (Resident #123). Findings included: 1. a. Resident #90 was admitted to the facility on 10/22/12. The resident's documented diagnoses included diabetes, hyperlipidemia, hypertension, and congestive heart failure. The resident's 03/31/16 quarterly minimum data set (MDS) documented the resident's cognition was intact. Review of the facility's grievance log revealed on 04/18/16 Resident #90 filed a grievance concerning meal trays coming out late from the kitchen. It was documented the grievance was resolved on 04/20/16 when the registered dietitian	F 166	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Resident # 90 has been interviewed to determine his recent satisfaction with the delivery of his meals. Resident #90 states meals are coming at 8:30 AM for Breakfast, 12:30 PM for Lunch, and 6:30 PM for Supper. Resident #90 is served his meals from Station # 2 □ Cart # 5 which, by schedule, is to be delivered to the unit by 8:35 AM for Breakfast, 12:50 PM for Lunch, and 6:35 PM for Supper.	6/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2016

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F 166	Continued From page 1 (RD) in-serviced dietary staff about the necessity of providing residents with timely meals. The in-service sign-in sheet documented five dietary employees were in attendance. Review of the facility's Meal Delivery Schedule documented the last meal delivery cart (cart #6) should leave the kitchen no later than 8:45 AM for breakfast meals and no later than 6:45 PM for supper meals. A 04/24/16 tray delivery audit slip documented the fifth of six meal carts left the kitchen at 9:19 AM for the breakfast meal. A 04/25/16 tray delivery audit slip documented the fifth of six meal carts left the kitchen at 7:20 PM for the supper meal. On the facility census which was provided to the survey team at 8:35 PM on 05/22/16 the facility highlighted Resident #90 as being interviewable. At 5:12 PM on 05/26/16 nurse supervisor #1 stated she considered Resident #90 to be interviewable and reliable in the information that he provided. At 5:46 PM on 05/26/16 the social worker (SW) stated the purpose of the grievance system was to find solutions to problems so that these problems did not reoccur. She reported it was her responsibility to go back to the resident, staff member, or family member who filed the grievance ten days after a supposed resolution was reached for the concern to make sure the proposed solution continued to be effective. According to the SW, she documented the ten-day follow-up on the front of the	F 166	The Director Dining Services will meet with resident # 90 to advise of the correct timing of meals and to determine if resident # 90 might benefit from a viable alternate delivery schedule. Resident #93 is currently in the hospital and will be interviewed for meal delivery level of satisfaction upon his return. Any issues will be addressed through the Director Dining Services. Resident #144 has been interview and states her issues with meal service have been resolved. Residents #90, #93, and #144 will have follow up interviews twice per week for one month with an interview on Monday to verify weekend service. Identified issues will be addressed by the Director Dining Services. Resident #123 - Consulted with resident□s nephew to discuss what exactly he needed from facility to complete his request. Completed personal letter from MD stating resident□s cognitive status, notarized and certified mailed to resident□s nephew on 6/3/16. Residents in the center have the potential to be affected by the deficient practice. Facility will begin conducting Ad-Hoc QA/QI meeting two times per month meeting on or about the 15th and 30th of each month In an effort to identify and address developing trends with regards to	

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F 166	Continued From page 2 grievance/concern form. Review of the front of Resident #90's grievance/concern form revealed no ten-day follow-up was documented. At 6:02 PM on 05/26/16 the administrator stated carts leaving the kitchen more than 30 minutes after the times documented on the Meal Delivery Schedule was not acceptable. He also reported the RD in-serviced only about half of the dietary staff on 04/20/16, lessening the effectiveness of the intervention to stop the late delivery of meal carts. The administrator commented he was not made aware that there were problems with the timing of meal carts. According to the administrator, his expectation was for the SW to continue to make contact with the person who filed a grievance for two to three weeks after an intervention was put in place to make sure that intervention was effective. At 7:11 PM on 05/26/16 Resident #90 stated late meals were still a problem in the facility, with carts arriving on the halls 30 - 45 minutes late on occasion. b. Resident #93 was admitted to the facility on 12/30/14. The resident's documented diagnoses included anemia, hypertension, and cerebrovascular accident. Review of the facility's grievance log revealed on 04/18/16 Resident #93 filed a grievance concerning the facility taking too long to serve the meal trays. It was documented the grievance was resolved on 04/20/16 after the registered dietitian (RD) in-serviced dietary staff about the necessity of providing residents with timely meals.	F 166	resident grievances and timely resolution. Dietary staff received training on the importance of timely meal service and the appropriate use of the Meal Delivery Schedule on 5/27/16, 5/31/16, 6/1/16 and 6/3/16. Facility staff received training on Grievance Procedures and Reporting during the week of 6/6 thru 6/10. Facility will continue to utilize the Meal Delivery Schedule tools currently in place. Completed forms will be delivered to the Director Dining Services following each meal services who will review for accuracy and timeliness and who will address timing issues with kitchen staff. Completed sheets will be delivered to the NHA for file and reviewed so data can be tracked and trended through the QA/QI process. Information related to the issues cited in F-166 along with any other grievance related issues will be discussed during the scheduled Ad-Hoc meetings and regularly scheduled QA/QI meetings for the next 3 months. The review time will be lengthened as indicated by results.	

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The in-service sign-in sheet documented five dietary employees were in attendance.

Review of the facility's Meal Delivery Schedule documented the last meal delivery cart (cart #6) should leave the kitchen no later than 8:45 AM for breakfast meals and no later than 6:45 PM for supper meals.

A 04/24/16 tray delivery audit slip documented the fifth of six meal carts left the kitchen at 9:19 AM for the breakfast meal.

A 04/25/16 tray delivery audit slip documented the fifth of six meal carts left the kitchen at 7:20 PM for the supper meal.

Resident #93's 04/27/16 quarterly minimum data set (MDS) documented the resident's cognition was intact.

On the facility census which was provided to the survey team at 8:35 PM on 05/22/16 the facility highlighted Resident #93 as being interviewable.

At 5:12 PM on 05/26/16 nurse supervisor #1 stated she considered Resident #93 to be interviewable and reliable in the information that he provided.

At 5:38 PM on 05/26/16 Resident #93 stated he felt there was still a problem with meal trays arriving on the halls 30 - 45 minutes late sometimes.

At 5:46 PM on 05/26/16 the social worker (SW) stated the purpose of the grievance system was to find solutions to problems so that these problems did not reoccur.

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At 6:02 PM on 05/26/16 the administrator stated carts leaving the kitchen more than 30 minutes after the times documented on the Meal Delivery Schedule was not acceptable. He also reported the RD in-serviced only about half of the dietary staff on 04/20/16, lessening the effectiveness of the intervention to stop the late delivery of meal carts. The administrator commented he was not made aware that there were problems with the timing of meal carts. According to the administrator, his expectation was for the SW to continue to make contact with the person who filed a grievance for two to three weeks after an intervention was put in place to make sure that intervention was effective.

c. Resident #144 was admitted to the facility on 09/04/14 with documented diagnoses that included diabetes and anemia.

The resident's 03/23/16 quarterly minimum data set (MDS) documented her cognition was intact.

Review of the facility's grievance log revealed on 04/18/16 Resident #144 filed a grievance concerning meal trays not coming out of the kitchen on time. It was documented the grievance was resolved on 04/20/16 when the registered dietitian (RD) in-serviced dietary staff about the necessity of providing residents with timely meals. The in-service sign-in sheet documented five dietary employees were in attendance.

Review of the facility's Meal Delivery Schedule documented the last meal delivery cart (cart #6) should leave the kitchen no later than 8:45 AM for breakfast meals and no later than 6:45 PM for

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supper meals.

A 04/24/16 tray delivery audit slip documented the fifth of six meal carts left the kitchen at 9:19 AM for the breakfast meal.

A 04/25/16 tray delivery audit slip documented the fifth of six meal carts left the kitchen at 7:20 PM for the supper meal.

On the facility census which was provided to the survey team at 8:35 PM on 05/22/16 the facility highlighted Resident #144 as being interviewable.

At 5:12 PM on 05/26/16 nurse supervisor #1 stated she considered Resident #144 to be interviewable and reliable in the information that she provided.

At 5:34 PM on 05/26/16 Resident #144 stated she thought meal delivery had gotten better overall in April and May 2016, but there were still occasions when she thought the carts arrived on the halls more than 30 minutes late.

At 5:46 PM on 05/26/16 the social worker (SW) stated the purpose of the grievance system was to find solutions to problems so that these problems did not reoccur. She reported it was her responsibility to go back to the resident, staff member, or family member who filed the grievance ten days after a supposed resolution was reached for the concern to make sure the proposed solution continued to be effective. According to the SW, she documented the ten-day follow-up on the front of the grievance/concern form.

Review of the front of Resident #144's

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grievance/concern form revealed no ten-day follow-up was documented.

At 6:02 PM on 05/26/16 the administrator stated carts leaving the kitchen more than 30 minutes after the times documented on the Meal Delivery Schedule was not acceptable. He also reported the RD in-serviced only about half of the dietary staff on 04/20/16, lessening the effectiveness of the intervention to stop the late delivery of meal carts. The administrator commented he was not made aware that there were problems with the timing of meal carts. According to the administrator, his expectation was for the SW to continue to make contact with the person who filed a grievance for two to three weeks after an intervention was put in place to make sure that intervention was effective.

2. Resident #123 was admitted to the facility on 01/17/14. His documented diagnoses included cerebrovascular accident with left hemiplegia and aphasia.

The resident's 04/10/16 quarterly minimum data set (MDS) documented his cognition was severely impaired, and he required extensive assist to being completely dependent on a staff member for his activities of daily living (ADLs).

A 04/11/16 e-mail documented the facility's social worker (SW) requested the nurse practitioner (NP) with contracted psychiatric services to evaluate Resident #123's cognitive status.

In a 04/13/16 resident assessment this NP documented, "Apparently, family are trying to get some POA (power of attorney) or guardianship papers on him (Resident #123), which I feel is

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prudent given his inability to care for himself and severely impaired cognition." Her recommendations documented, " (I) feel that the resident lacks the capacity to make intelligent, informed decisions concerning his finances and healthcare. (He) would benefit from having an appointed guardian to assist him."

A 04/14/16 e-mail from the facility's SW documented, "Called and spoke to ____ (name of family member) letting him know that _____ (name of NP) had completed her evaluation of resident and she stated that he would benefit from a guardian. ____ (name of family member) stated that he needed it signed and notarized. SS (social services) informed him that it had been e-signed and he stated that he was going to call clerk of court to determine if they would accept an e-signature and get back with this SSD (social services department)."

A 05/16/16 postal service certified mail receipt documented a copy of the NP's assessment of Resident #123's cognition was mailed to the requesting family member.

At 3:25 PM on 05/26/16, during a phone conversation with the family member applying for guardianship of Resident #123, he stated he updated the SW that what he needed to complete the guardianship application process was a cognitive assessment of the resident signed by the primary physician which had been notarized. He commented he still had not received this information.

At 3:41 PM on 05/26/16 the facility's SW stated she had not heard from Resident #123's family about the acceptability of an e-signature, and

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F 166	Continued From page 8 therefore, had mailed all the information she had which would be needed for processing the guardianship. However, she was unable to explain what caused the delay between the 04/13/16 NP cognitive status and mailing the family a copy of the status on 05/16/16. According to the SW, she thought she had a follow-up conversation with Resident #123's family member after she sent the 04/14/16 e-mail, but she explained she could find no documentation of this contact. She stated she had talked to the administrator and acting director of nursing (DON) about the delay, and they advised her that she needed to pick up the pace for providing residents and family what they needed. At 3:50 PM on 05/26/16 the administrator stated he was unable to explain why there was a month delay in getting Resident #123's family member a copy of the resident's 04/13/16 cognitive status. He reported the length of the delay was not acceptable. He commented his expectation was for the SW to come to him and discuss any delays in providing information requested by a family member and for the SW to follow-up with the family member to make sure they had exactly what they needed (in this case a physician signed cognitive assessment which had been notarized) to expedite the guardianship process.	F 166		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		6/13/16

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F 281	Continued From page 9 by: Based on record review and staff and nurse practitioner interviews, the facility failed to transcribe an order for a blood thinner medication from a hospital discharge summary onto the facility's physician orders and medication administration record, leading to 18 missed doses of the medication for one of two residents reviewed for blood thinner medications, Resident # 188. Findings included: The discharge summary from an acute local hospital dated 04/11/2016 revealed Resident #188 had been hospitalized beginning 04/03/2016 through 04/11/2016 to treat multiple conditions which in part included ambulatory dysfunction, coronary artery disease, diabetes mellitus, and hypertension. The discharge medication instructions included with the discharge summary revealed clopidogrel bisulfate (Plavix), 75 milligrams (mg) orally every morning, was to be administered to Resident #188 after discharge from the hospital. (Per the Food and Drug Administration Medication Guide, clopidogrel bisulfate (Plavix) is a blood thinner medication that decreases that chance of blood clot formation and stroke.) A review of the facility's physicians' orders for Resident #188 revealed there was no order present for clopidogrel bisulfate, 75 mg orally every morning upon admission to the facility on 04/11/2016. Resident #188's medication administration record dated 04/11/2016 through 04/29/2016 revealed there was no order present for clopidogrel bisulfate, 75 mg, orally every morning.	F 281	Resident # 188 was discharged on May 4, 2016 An audit for residents that have been admitted or readmitted since March 1, 2016 have had their admission/readmission orders checked for transcription errors by the Unit Supervisors and Center Nurse Executive (CNE)the week of June 7, 2016. Any errors found have been corrected. The Licensed Nurses were reeducated on transcription of admission/readmission orders on June 8, 2016 by the CNE. The admitting nurse that transcript the orders will have another nurses check the transcript orders behind her/him on the day of admission. The Unit Supervisors and the CNE will audit the admission/readmission orders at the Clinical meeting Monday thru Friday. Any errors found, the admitting nurse and nurse checking behind the admitting nurse will be reeducated and an Individual Performance Improvement plan implemented for nurse/nurses that made the error. The CNE will review the audits for trends and present to the Quality Assurance meeting monthly.	

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A review of Resident #188's nursing care plan initiated on 04/12/2016 in the facility included a goal and interventions to address her risk for cardiovascular symptoms related to her diagnosis of atherosclerotic heart disease. The goal was, "Will not experience any complication due to her new diagnosis of TIAs [transient ischemic attacks] through her next nursing care plan review." (Per the National Institute of Neurological Disorders and Stroke, a transient ischemic attack is a transient stroke that lasts only a few minutes with symptoms that may include numbness, weakness confusion, difficulty talking, trouble seeing, dizziness, or loss of balance.) One of the interventions for this goal was to administer medications as ordered and to assess for effectiveness and side effects.

A review of Resident #188's 14-day admission assessment dated 04/25/2016 revealed a partial list of diagnoses which included coronary artery disease, unspecified aftercare, lack of coordination, and disorientation upon her admission to the facility on 04/11/2016.

Review of the facility's physicians' orders revealed an order dated 04/27/2016 to send Resident #188 to the emergency department to be evaluated for altered mental status.

A nurse practitioner's progress note for Resident #188 from the facility dated 04/27/2016 indicated Resident #188 presented with a chief complaint of mental status changes which included confusion and garbled speech with incomprehensible words. The same progress note documented the emergency department's physician attributed Resident #188's mental status changes to a possible transient ischemic

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attack and that the medication clopidogrel bisulfate would be restarted.

The local hospital's history and physical for Resident #188 dated 04/28/2016 revealed Resident #188 was admitted to the hospital with a chief complaint of an altered mental status. The same document indicated the following: "It was noted on yesterday that patient has been off Plavix [clopidogrel bisulfate] for 18 days. Lately there was some confusion at the nursing facility with orders patient was discharged [with] from [local hospital]."

A nurse practitioner's progress note dated 04/28/2016 revealed Resident #188 had a recurrent episode of altered mental status and that she was referred back to the emergency department with the suggestion that an MRI (magnetic resonance image for diagnostic purposes) be completed to rule out a posterior territorial event (stroke in the posterior brain) that could not be seen in a previous scan of her head.

A review of the discharge summary from the local hospital dated 04/29/2016 revealed her admission diagnosis was a transient ischemic attack. The same discharge summary of 04/29/2016 indicated Resident #188 was seen in the emergency department twice within 24 hours for evaluation, once on 04/27/2016 following a brief episode of confusion, and again on 04/28/2016 after an episode of speaking gibberish and confusion. The note further documented that another diagnostic test was performed in the hospital on 04/28/2016 which did not show evidence of a cardiovascular accident. In addition, the discharge summary documented Resident #188 had been restarted

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on the anti-platelet medication, clopidogrel bisulfate.

Further review of the facility's physicians' orders revealed an order dated 04/30/2016 to start clopidogrel bisulfate, 75 mg by mouth once daily.

In an interview with Nursing Supervisor #1 on 05/26/2016 at 4:11 PM, she stated that the nurse on duty received Resident #188's discharge summary with the medications upon her admission to the facility on 04/11/2016 and that the order for clopidogrel bisulfate was inadvertently missed and was not transcribed onto the facility's physician orders or onto the medication administration record. Nursing supervisor #1 stated that both she and the Director of Nursing reviewed the medication order transcription and that the omission of the order was not "caught." She further explained that the facility learned of the omission of the medication order when Resident #188 was sent to the hospital on 04/28/2016. Nursing Supervisor #1 explained the hospital called the facility because the clopidogrel bisulfate was not listed on the medication administration record which had been provided to them from the facility. Nursing Supervisor #1 added that by the time the facility realized the clopidogrel bisulfate had been omitted, Resident #188 was back in the hospital.

In an interview with the acting Director of Nursing (DON) on 05/26/2016 at 5:12 PM, she stated it was her understanding that Nurse #2, who admitted Resident #188, failed to take the clopidogrel bisulfate order from the discharge summary from the hospital. The acting DON explained that the process for checking new medication orders for accuracy included a review

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of the resident's new orders in the daily clinical "stand up"meeting to ensure the orders were printed correctly onto the medication administration record. She stated this process involved a comparison of orders from the discharge summary with the facility's physician orders and medication administration record. The acting DON added that the unit supervisors and the Director of Nursing at that time also missed the omission of the clopidogrel bisulfate on Resident #188's chart. She further stated that after the error was recognized in late April, in-service education was provided to 14 nurses by the Director of Nursing. The acting DON stated the night nurses (11:00 PM to 7:00 AM or 7:00 PM to 7:00 AM nurses) were not included in the in-service education based upon the sign-in sheets. She added that night nurses should also be checking the physician orders during the 24-hour chart checks.

In an interview with Resident #188's nurse practitioner on 05/26/2016 at 5:50 PM, she stated that she did not think the missed 18 doses of clopidogrel bisulfate caused any harm to Resident #188. The nurse practitioner stated the results of the tests performed for the resident in the hospital, including a head scan, a separate brain scan, and an ultrasound, were negative for a transient ischemic attack. She added that tests for her carotid arteries indicated there was very minor stenosis (narrowing) and that it did not warrant treatment with clopidogrel bisulfate. The nurse practitioner stated her symptoms of acute mental status were likely due to her dementia.

In an interview with the facility's admitting nurse, Nurse #2, on 05/26/2016 at 6:20 PM, he stated that he had been responsible for transcribing the

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F 281	Continued From page 14 orders for medications for Resident #188 when she was admitted on 04/11/2016. Nurse #2 stated he had seen a note below the order for clopidogrel bisulfate which documented a previous "hold" for the medication from November 2014, and that he forgot to contact the physician to confirm that the resident should take the medication.	F 281		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to put interventions in place to prevent continued weight loss for 1 of 5 sampled residents (Resident #125) reviewed for nutrition needs. Findings included: Resident #125's Significant Change Minimum Data Set (MDS) dated 04/19/16 revealed she was admitted to the facility on 08/11/15 with diagnoses of dysphagia, cerebrovascular accident (CVA), and aphasia. Resident #125 was severely cognitively impaired and was dependent on one person for eating. Her weight was 115 pounds	F 325	Resident #125 was reviewed by the Interdisciplinary Team (IDT), which includes the Dietician, CNE, Social Worker, Recreational Therapist, and the Unit Supervisor, at the Clinical at Risk (CAR) meeting on June 2, 2016 for weight loss. A new intervention of House shakes twice a day was added for the resident to receive. Residents with significant weight loss were reviewed for interventions to prevent	6/13/16

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F 325	Continued From page 15 and showed a weight loss but that she was not on a weight loss regimen. Review of the monthly weights for Resident #125 revealed the following: 02/02/16 123.5 pounds 02/09/16 122.0 pounds 02/19/16 123.0 pounds 02/28/16 127.5 pounds 03/03/16 120.0 pounds 03/09/16 120.5 pounds 03/15/16 119.0 pounds 03/22/16 119.5 pounds 04/01/16 115.0 pounds 05/09/16 113.5 pounds 05/17/17 114.5 pounds Review of the Nutritional Assessment dated 01/26/16 revealed Resident #125 had a weight loss of 9.6% over four months. Resident #125 consumed an average of 88% of facility meals. A frozen nutritional supplement was recommended to be provided between meals due to unintentional weight loss. Review of the Diet Order and Communication Form dated 02/08/16 revealed a frozen nutritional supplement was to be provided to Resident #125 twice each day. The communication form also showed an undated handwritten note written in red ink to discontinue the supplement due to poor acceptance. Review of the March 2016 Medication Administration Record (MAR) revealed that Resident #125 consumed 100% of 54 out of 62 offered frozen nutritional supplements. There were 7 spaces where a percentage was not listed and one space where 50% was listed. Review of the April 2016 MAR revealed that Resident #125 consumed 100% of 53 out of 60 offered frozen nutritional supplements. There were 3 spaces where a percentage was not	F 325	further weight on June 2, 2016 by the IDT. Residents with significant weight loss had interventions in place. The dietician and CNE will review residents□ weights weekly those resident that are weighed weekly and monthly for any significant and/or gradual weight loss. Residents with gradual or significant weight loss will be presented to the CAR meeting weekly for the IDT to review and make recommendations. The CNE will report any trends in continued weight loss to the QA&A monthly.	

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listed, one space where 50% was listed, one space where 75% was listed and 1 space where R (refused) was listed. One space had an illegible amount listed.
Review of the Nutrition Note dated 04/19/16 revealed the Dietician recommended the frozen nutritional supplement Resident #125 received be discontinued due to poor acceptance.
Review of the Nutritional Assessment dated 04/25/16 revealed Resident #125 had a weight loss of 13.8% over six months. Resident #125 consumed an average of 100% of facility meals. The frozen nutritional supplement was discontinued due to poor acceptance.
In an observation on 05/25/16 at 8:50 AM resident #125 was being fed by a Nursing Assistant (NA). No supplements, snacks, or increased meal portion size were noted on her meal card or on her tray.
In an interview on 05/25/16 at 10:25 AM NA #1, who was Resident #125's usual aide, stated she had been told the frozen nutritional supplement had been discontinued because Resident #125 was not eating it. NA #1 stated Resident #125 always ate 100% of breakfast and lunch. She stated Resident #125 received no other supplements or meal enhancements that she was aware of.
In an interview on 05/26/16 at 2:49 PM Nurse #1 who was Resident #125's nurse stated Resident #125 ate 100% of meals. She indicated Resident #125 also ate 100% of the frozen nutritional supplement she received. She indicated that since Resident #125 ate 100% of meals double portions could be tried to increase her weight.
In an interview on 05/26/16 at 3:44 PM the Registered Dietician stated Resident #125 ate 100% of meals. The Dietician stated she spoke to an unnamed nurse and was told that

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F 325	Continued From page 17 sometimes Resident #125 ate the supplement and sometimes she did not, so she discontinued it. The Dietician indicated she did not look at the MAR to check what percentages of consumption were being recorded for the frozen supplement. She indicated enriched meal programs, large portions, puddings, or ice creams were not attempted. She indicated the estimated nutritional needs of Resident #125 were met even though Resident #125 continued to lose weight. In a telephone interview on 05/26/16 at 3:55 PM the Nurse Practitioner (NP) caring for Resident #125 stated large portions could be tried if the resident was still losing weight while eating 100% of meals. She indicated that although weight loss could be due to general disease progression, if the resident was still eating, other things could be tried. She stated the Dietician should have spoken to her prior to discontinuing the frozen nutritional supplement to see if something else could have been tried. She indicated the Dietician should have reviewed the MAR to see what percentages of the supplement were being consumed. In an interview on 05/26/16 at 6:20 PM the acting Director of Nursing (DON) stated it was her expectation that if a resident's weight continued to decrease other interventions should be looked at and attempted. She indicated the Dietician should have brought Resident 125's information to the Interdisciplinary (IDT) Team to get input on other interventions that could be tried. She indicated she would have expected the Dietician to look into the case more closely.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		6/13/16

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F 329	Continued From page 18 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to decrease a medication dosage which resulted in the administration of 36 doses of the medication at an incorrect dose for 1 of 5 sampled residents (Resident #22) reviewed for unnecessary medications. Findings included: Resident #22's Quarterly Minimum Data Set (MDS) dated 05/13/16 revealed he was moderately cognitively impaired. Resident #22 was admitted to the facility on 10/31/11 with diagnoses of manic depression, anemia and diabetes.	F 329	Resident #22 Cymbalta was decreased as recommended by the Pharmacist and agreed by the physician on 6/2/16 by the nurse on the floor. Residents□ medical records were audited for pharmacist recommendations that orders may not have been written by Unit supervisor the week of June 6 2016. Any recommendations that orders were not written were corrected by the unit supervisors.	

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F 329	Continued From page 19 Review of Resident #22's Medical Record revealed a Consultation Report from the Pharmacist dated 04/11/16. The report revealed that Resident #22 had received 60 milligrams (mg) of Cymbalta once daily for several months. The Pharmacist recommended a gradual dose reduction to Cymbalta 40mg once daily. Under Physician's Response: the area next to "I accept the recommendation above, please implement as written" contained a checkmark. The recommendation was signed by the Physician and dated 04/18/16. There were no initials or a date which showed the order had been noted by nursing. Review of the 04/18/16-04/30/16 Medication Administration Record (MAR) revealed Cymbalta 60mg continued to be given to Resident #22 after the physician requested it be decreased to 40mg daily on 04/18/16. Review of the 05/01/16-05/26/16 MAR revealed Cymbalta 60mg continued to be given to Resident #22 after the physician requested it be decreased to 40mg daily on 04/18/16. In an interview on 05/26/16 at 2:49 PM Nurse #1 who provided medications to Resident #22 in April and May 2016 indicated when the Pharmacist did a review he gave the recommendations to the Nurse Supervisor. She stated that since she was not provided a copy of the Pharmacist recommendations she would not know that there had been an order to decrease Resident #22's Cymbalta unless the MAR had been updated. In a telephone interview on 05/26/16 at 2:55 PM the Pharmacist indicated that after a recommendation was made it was reviewed at the next visit to see if the physician had approved or declined the recommendation and that it had been signed. He indicated that on his visit on 05/02/16 he saw that the Cymbalta had not been	F 329	Reeducation to the licensed nurses by the CNE on June 8, 2016 completing the pharmacist□s recommendations and how to file was completed. The unit supervisors will audit the medical records monthly for follow thru on pharmacist recommendation completion the end of each month. The CNE will report any trends from the audits monthly to the Quality Assurance Committee	

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decreased so he provided a Consultation Report to the facility to make sure they were aware of the change to the order.
In an interview on 05/26/16 at 3:05 PM the acting Director of Nursing (DON) stated she had been unable to find the 05/02/16 recommendation from the pharmacist that addressed the dosage of Resident #22's Cymbalta.
In an interview on 05/26/16 at 3:30 PM the acting DON stated she was not in the DON position in April 2016 and did not know what happened regarding the change in dosage to Resident #22's medication. She indicated the recommendation should not have been filed without being noted. She stated when the Physician signed a recommendation from the Pharmacist it became an order. The acting DON stated it was her expectation that when an order was received it should be noted by a nurse and placed in the computer. She then expected the order to be transcribed to the MAR and carried out.
In an interview on 05/26/16 at 4:00 PM Nursing Supervisor #1 stated when she received the Pharmacist recommendations she divided them up and put them in each nursing station for physician review. She indicated once they were signed they should be returned to her but sometimes they did not get back to her. Nursing Supervisor #1 stated she had not seen the recommendation that decreased Resident #22's Cymbalta. She indicated since the order was not noted it must have been filed before she had seen it.
In an interview on 05/26/16 at 6:12 PM the Medical Records clerk indicated she checked the recommendations prior to filing and if they were not noted she would not put them in a resident's chart. She indicated she was not the only person who filed the recommendations. She stated the

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F 329	Continued From page 21 nursing staff also put the recommendations into the charts. The Medical Records clerk stated she would not have filed a recommendation that had not been noted.	F 329		
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). - 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.	F 356		6/13/16

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F 356	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to post accurate, updated staffing information. Findings included: At 7:07 PM on 05/22/16 (Sunday), on the door of the director of nursing (DON) office, the most updated staff posting was for 05/19/16 (Thursday). The census for 05/19/16 was filled in, and the staffing numbers and hours were updated. To the right of the 05/19/16 staffing sheet the staffing sheets for 05/20/16 (Friday) through 05/22/16 (Sunday) were stapled together, but did not have the census filled in or have the staffing updated to reflect changes that occurred when staff members called out, arrived late, or left early. At 4:20 PM on 05/22/16 the acting director of nursing (DON) stated staffing sheets were posted on the door of the DON office. She reported these sheets were required to document the date, the census, the number of staff, and the number of resident contact hours they provided. She commented on Friday copies of proposed staffing sheets were left on the door for Saturday and Sunday, but they were supposed to be updated by an nurse with that day's census and the number of staff/hours worked by the staff who actually showed up for work. According to the acting DON, when the survey team arrived around 7:00 PM on 05/22/16 (Sunday) staffing for that day should have been posted and reflected the census for that day and an updated number of staff and hours worked on first and second shifts. At 4:28 PM on 05/22/16 the facility's scheduler	F 356	The daily staffing is posted on the CNE door daily. Residents that are in the center have the potential to be affected. The CNE was educated on the daily staffing posting by the Clinical Quality Specialist on June 2, 2016. The CNE educated the licensed nurses, the center□s scheduler on completion and posting of the daily staffing form. The scheduler is responsible for completing the posting and placing it on the CNE□s door. The scheduler corrects the census and staffing numbers if needed for first and second shift Monday- Friday with the CNE checking each shift for completeness. The nurse on station one will complete the census and number of staff for the 11-7 shift each night at the beginning of the shift. For the week-end and holiday posting, the nurse on Station I, front cart, will complete the staffing numbers and census at the beginning of the first shift and second shift. The CNE will audit the completion of the posting of the daily census daily Monday-Friday and the assigned nurses will audit for posting on the week-end and holidays. The CNE will present the trends from the daily audit to the Quality Assurance Committee monthly.	

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F 356	Continued From page 23 stated when she did not work on the weekends, a nurse was supposed to unstaple sheets left on Friday for the weekend (Saturday and Sunday) and update them by hand each day of the weekend with the census, number of staff worked, and resident contact hours. She explained when she arrived on Monday she used the hand corrected staffing sheets for Saturday and Sunday to update the staff postings stored in the computer so that the facility would have clean copies which reflected actual rather than proposed staffing information.	F 356		
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 observation and staff interview the facility failed to maintain potato salad made with mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline, failed to maintain final rinse temperatures at 180 degrees Fahrenheit or higher at the dish machine, failed to discard compromised kitchenware, failed to clean kitchen equipment, and failed to monitor storage areas to ensure food quality. Findings included:	F 371	There we were no specific residents identified as having been affected by the stated deficient practices but such practices had the potential to affect all residents. The stated deficient practices had the potential to affect all residents of the facility. In-service training was provided by the NHA on 5/27/16, 5/31/16, 6/1/16 and	6/13/16

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F 371	Continued From page 24 1. At 12:32 PM on 05/23/16 there were two pans of potato salad on the trayline. The cook placed potato salad on two resident plates from the traypan on his right side. The food and nutrition services (FNS) regional manager for the east division used a calibrated thermometer to check the temperature of the potato salad. The traypan on the cook's left registered 38 degrees Fahrenheit, but the traypan on the cook's right registered 48 degrees Fahrenheit. At this time the cook stated the first resident trays left the kitchen about 12:00 noon, and there were more resident meal trays that needed to be prepared. The cook stated the temperature recorded for potato salad was 38 degrees Fahrenheit when the trayline started, but he was unsure if this was the beginning temperature for one or both of the traypans of potato salad. At 2:57 PM on 05/25/16 the FNS regional manager stated ideally cold salads made with mayonnaise were supposed to be prepared a day before serving, but in some cases preparation at least six hours before serving was acceptable as long as the salads registered 41 degrees Fahrenheit at the beginning and throughout the trayline operation. She reported the best way to make sure appropriate temperatures were maintained was to keep the salads over ice on the trayline while resident plates were being served. At 10:38 AM on 05/28/16 the cook who prepared the potato salad stated he finished the preparation between about 7:15 AM and 7:30 AM on 05/23/16. He reported all the ingredients were chilled and included potatoes, mayonnaise, relish, onion, and egg. He commented the traypans of potato salad were stored in the walk-in	F 371	6/3/16 for Dietary Staff covering the deficient practices listed in F-371. The following procedures have been put into place to assure that proper sanitation standards are maintained in the kitchen: 1. Staff will assure that foods to be served cold will be prepared in advance to allow proper cooling before service. Temperatures will be recorded prior to, during and following service to assure proper/safe temperatures were maintained throughout the service process. 2. Staff members who wash dishes have been trained to allow the booster heater for the machine to recover allowing the machine to reach proper rinse temperature. 3. Staff will constantly inspect kitchenware during each meal at service and washing and will remove compromised articles from service and will advise the manager to assure required replacements are obtained to assure adequate supplies are maintained. 4. Staff will assure all kitchen equipment is kept clean and will assure all sides of the microwave oven are cleaned daily. The convection oven will be cleaned weekly as required or more often if use or inspection warrants. 5. Staff have labeled and dated all open food items in the dry storage area, freezer	

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F 371	Continued From page 25 refrigerator until about 11:25 AM on 05/23/16 when they were transferred and placed over ice in the steam wells. According to the cook, the temperature of cold salads was taken once during serving, and that was as the trayline began operation. 2. During observation of the dish machine on 5/25/16 between 9:14 AM and 9:33 AM the final rinse temperature as 6 of 12 racks of kitchenware were run through the dish machine did not reach 180 degrees Fahrenheit. The final rinse temperatures for these racks ranged from 166 degrees to 176 degrees Fahrenheit. The two dietary employees operating the dish machine were not monitoring the wash and rinse gauges as they ran kitchenware through. The employee removing clean kitchenware from the dish machine and placing it in storage stated in order for kitchenware to be sanitized final rinse temperatures needed to reach 180 degrees Fahrenheit. He reported when he began operation of the dish machine about 9:10 AM on 05/25/16 the final rinse gauge was registering over 180 degrees Fahrenheit, and he commented he was told to check the final rinse temperatures periodically after that to make sure this rinse temperature was maintained. At 2:57 PM on 05/25/16 the food and nutrition services (FNS) regional manager for the east division stated the the service representative was called out multiple times to check the dish machine, and nothing was found to be wrong. However, she reported the dietary staff was educated not to run a lot of racks of kitchenware through the dish machine immediately following one another. Instead they were instructed to allow a time break between the racks.	F 371	and cooler. Staff received training to promptly label opened items and to use the Use By Date appropriate for the food product. A list is maintained on the door of the walk-in cooler to use as reference as necessary. The NHA and RD each have a Food Safety and Sanitation Audit that will be completed according to the schedule listed below to assure continued compliance with proper Kitchen Sanitation Procedures. The Administrator will be using a subject specific checklist developed to monitor the deficient practices cited under F-371. The tool will be used 3 times per week for 2 weeks and then weekly for 3 months to assure training and practice has achieved the desired level of compliance. o The Food Safety and Sanitation Audit will continue to be completed weekly for an indefinite period of time to assure continued compliance with required sanitation standards. o RD will continue to complete the Food Safety and Sanitation Audit monthly. Sanitation Checklists and the completed Staff Cleaning Assignments Checklist will be reviewed by the facility QAPI Committee monthly for 3 months and the review period may be extended based on results and progress with sanitation improvement and maintenance of acceptable levels of sanitation and the	

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F 371	Continued From page 26 3. During kitchenware inspection on 05/25/16, beginning at 10:08 AM, 13 of 20 coffee mugs (65%) were found to be stained dark brown and abraded inside. At 2:57 PM on 05/25/16 the food and nutrition services (FNS) regional manager for the east division stated chipped, cracked, and abraded kitchenware should be presented to the dietary manager so it could be discarded and reordered. She reported from a visual and safety standpoint compromised kitchenware should not be used for serving food to residents. At 10:38 AM on 05/26/16 a cook stated kitchenware compromised with chips, cracks, and abrasions should be pulled out of stock so it would not pose a risk to resident health. Before disposing of it, however, the cook reported the damaged kitchenware was to be presented to a supervisor who could decide whether it was necessary to order replacements. The cook commented the facility tried to soak and de-stain kitchenware on a weekly basis. However, he could not recall when the last time this procedure was carried out for coffee mugs. 4. During the initial tour of the kitchen, beginning at 7:13 PM on 05/22/16, the inside top of the microwave was coated with yellow, tan, and brown food particles. The convection oven had 1/4 to 1/2 inch of brown/black build-up inside, and its glass doors were coated with a thick, sticky, dark brown substance. At this time the administrator stated in his weekly audits he encouraged staff to clean kitchen surfaces and equipment as they went along during their food preparation tasks.	F 371	PIP plan will be updated as necessary to address any continuing systemic problems.	

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F 371	Continued From page 27 During a follow-up tour of the kitchen, at 9:32 AM on 05/25/16, the inside top of the microwave was still coated with yellow, tan, and brown food particles. At 2:57 PM on 05/25/16 the food and nutrition services (FNS) regional manager for the east division stated there was a cleaning schedule posted on a bulletin board in the kitchen. She reported she had encouraged the dietary staff to use a de-greasing solution on the convection oven routinely, and her expectation was the microwave was to be wiped down after preparation of each meal in the kitchen. At 10:38 AM on 05/26/16 a cook stated the convection oven was supposed to be cleaned weekly, but he thought it was two or three weeks ago that it was last cleaned prior to survey. He also reported all surfaces inside the microwave should be cleaned, including the top, immediately after each use. He reported dried food particles on the inside top could fall into food products as they were heating and cause cross-contamination. 5. During initial tour of the kitchen, beginning at 7:13 PM on 05/22/16, 35-ounce bags of sugar frosted flakes, crisp rice, raisin bran, and corn flakes cereal were found open in the dry storage room, but were without labels and dates. In addition, in the dry storage room a box of lasagna noodles was open to the air, a 2-pound bag of confectioner's sugar was opened but without label and date, three bags of vanilla wafers were opened but without labels and dates, a 3-ounce jar of salad dressing was opened but not	F 371		

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refrigerated as directed on the label, and 16 15-ounce boxes of raisins had a "best before" date of 01/13/16. In the walk-in refrigerator a pitcher contained a thick red substance was not labeled, half of a tomato wrapped in plastic was not labeled and dated, and a bag of opened celery hearts was not labeled and dated. In the walk-in freezer three bags of chicken breast, which were removed from their original packaging, were without labels and dates.

During a follow-up tour of the kitchen, beginning at 9:35 AM on 05/25/16 opened bags of toasted oats and sugar frosted flakes cereal were without labels and dates, three opened bags of vanilla wafers were without labels and dates, and an opened 160-ounce bags of macaroni pasta was without a label and date. In the walk-in refrigerator an opened 5-pound container of grated Parmesan cheese was without label and date.

At 2:57 PM on 05/25/16 the food and nutrition services (FNS) regional manager for the east division stated the dietary staff was in-serviced about maintaining storage areas in the kitchen including the importance of labeling and dating opened food items, leftovers, and foods removed from their original packaging. She reported staff were also instructed to make sure foods were sealed in their packaging to prevent compromising their appearance and taste and to make sure food items were not past their "use by" and "best by" dates. At this same time the administrator stated he monitored the storage areas in his weekly kitchen audits, and used visual reminders to dietary staff about the need to label and date foods.

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F 371	Continued From page 29 At 10:38 AM on 05/26/16 a cook stated all dietary employees were supposed to check for label and dating, proper storage, and removal of items past expiration dates each and every time they entered storage areas. He reported this practice helped to make sure the food was the freshest and best quality possible for the residents.	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 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	F 431		6/13/16

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F 431	Continued From page 30 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to date ophthalmic agents when opened and to discard and replace ophthalmic agents that were found opened and undated during the annual recertification on 2 of 5 medications carts reviewed for medication storage. Findings included: A review of the policy titled "Storage and Expiration of Medication, Biologicals, Syringes and Needles", most recently revised on 01/01/13, read in part that the facility should ensure that medications and biologicals have an expiration date on the label, have not been retained longer than recommended by manufacturer or supplier guidelines, or have not been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. It further stated that once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. In an observation of the medication cart for Station 3 on 05/26/16 at 10:40 AM, Lumigan eye drops were dated as filled on 05/22/16, and Travatan Z eye drops were dated as filled on	F 431	The opened undated eye drops on medication carts, Lumigan, Travatan and Brimonide Tartrate, were wasted and reordered from pharmacy on 5/26/16 by the nurses working the medication cart. Audit was complete on the 5 medication carts and medication room including the refrigerators on 6/7&8/16 by the unit Supervisors for undated/out of date medications. Any medications found were destroyed and new medication ordered from the pharmacy. The licensed nurses were reeducated on dating eye drops when opened by the CNE on June 8, 2015. The unit supervisors will audit the medication carts, medication room including the refrigerators 3 times a week for one week, 2 times a week for one week, then weekly for a month. The CNE will review the audits of medication carts and report any trends to the Quality Assurance Committee for 3 months	

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05/24/16, but both were undated when opened. A review of the medication administration record verified that the residents for whom they were filled were currently ordered and receiving both eye drops.

On 05/26/2016 at 10:43 AM, Nurse # 1, the nurse working the cart for Station 3, stated that both eye drops should have been dated when opened and that it was facility protocol that staff should have called the pharmacy to reorder the medication and dispose of the medication if it was unclear when it was opened.

In an observation of the front medication cart for Station 2 on 05/26/16 at 11:15 AM, Brimonide Tartrate eye drops, dated as filled on 05/02/16, were opened and undated. A review of the medication administration record verified that the resident for whom it was filled was currently ordered and receiving the eye drops.

At 11:17 AM on 05/26/16, Nurse #3, the nurse working the front medication cart for Station 2, stated that eye drops should be dated when opened and disposed of 28 days after being opened.

On 05/2616 at 2:05 PM, a review of manufacturer guidelines for storage and disposal of each of the eye drops observed opened and undated revealed that each of the medications should have been dated upon opening and disposed of 28 day from the date of first use.

In an interview on 05/26/16 at 4:15 PM, the acting Director of Nursing (DON) stated it was her expectation that if the manufacturer guidelines stated there was an expiration other than what

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F 431	Continued From page 32 was listed on the bottle, the eye drops should have been labeled with an open date. Otherwise, the expiration on the bottle would have been sufficient. She stated that she understood that the eye drops that were observed opened and undated should have had an open date because the manufacturer guidelines stated that they should be disposed of 28 days after opening.	F 431		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520		6/13/16

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F 520	Continued From page 33 by: Based on staff interview and record review, the facility's Quality Assessment and Assurance (QA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for two recited deficiencies which were originally cited in May of 2015 on a Recertification survey. The deficiencies were in the areas of grievance resolution, nutritional and therapeutic diet implementation, posted staffing information, and food procurement, storage, preparation and distribution. This continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: 1 a. F 166: Resolve Grievances: Based on resident interview, family interview, staff interview, and record review the facility failed to resolve a grievance about late meal trays for 3 of 31 sampled residents (Resident #90, #93, and #144) and failed to resolve a family's grievance about provision of paperwork necessary to complete guardianship proceedings regarding 1 of 31 sampled residents (Resident #123). During the recertification survey in May of 2015, the facility failed to follow-up on grievances expressed by 3 of 3 sampled residents regarding disruptive behaviors by another resident. During the current recertification survey, the facility failed to resolve a grievance regarding late meal trays for 3 of 31 sampled residents and failed to resolve a grievance regarding guardianship paperwork assistance for 1 of 31 sampled residents.	F 520	Facility Administrator and the QA/QI Committee will continue to meet monthly with a continued focus on improving overall quality performance in the areas of the previously cited deficiencies. Repeated issues in the areas of F-166, F-325, F-356 and F-371 will remain as critical focal point moving forward. As indicated in the corrective measures listed in the accepted POCs for these tags, we will be completing a series on daily, weekly, monthly audits to assure compliance has been achieved and is being maintained. The Plans of Correction included here and listed below will resolve the issues cited with the oversight of the responsible manager and the facility administrator. Current managers have been trained on proper processes and through daily validation checks, use of established audit tools, routine inspections and daily discussions of recent corrective action compliance/progress. The results of these checks and audits will be reviewed daily, weekly, monthly as is appropriate and an Ad-Hoc QA/PI meeting will be held any time a negative trend is identified. F-166 E Resident # 90 has been interviewed to determine his recent satisfaction with the delivery of his meals. Resident #90 states meals are coming at 8:30 AM for	

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F 520	Continued From page 34 b. F 325: Nutritional/Therapeutic Diet: Based on observation, record review and staff interviews the facility failed to put interventions in place to prevent continued weight loss for 1 of 5 sampled residents (Resident #125) reviewed for nutrition needs. During the recertification survey in May of 2015, the facility delayed the administration of a nutritional supplement for one of two residents reviewed for significant weight loss. During the current recertification survey, the facility failed to implement interventions to prevent weight loss for 1 of 5 residents reviewed for nutritional needs. c. F 356: Posted Staffing: Based on observation and staff interview the facility failed to post accurate, updated staffing information. During the recertification survey in May of 2015, the facility failed to post daily the total number or actual number of hours worked by licensed and unlicensed nursing staff on the Daily Nurse Staffing Form for 5 of 6 days of review. During the current recertification survey, the facility failed to post accurate and updated staffing information. d. F 371: Food Storage/Sanitation: Based on observation and staff interview the facility failed to maintain potato salad made with mayonnaise at or below 41 degrees Fahrenheit during operation of the tray line, failed to maintain final rinse temperatures at 180 degrees Fahrenheit or higher at the dish machine, failed to discard compromised kitchenware, failed to clean kitchen equipment, and failed to monitor storage areas to ensure food quality. During the recertification survey in May of 2015, the facility failed to clean the face of a wall fan blowing into the dish machine area where	F 520	Breakfast, 12:30 PM for Lunch, and 6:30 PM for Supper. Resident #90 is served his meals from Station # 2 □ Cart # 5 which, by schedule, is to be delivered to the unit by 8:35 AM for Breakfast, 12:50 PM for Lunch, and 6:35 PM for Supper. The Director Dining Services will meet with resident # 90 to advise of the correct timing of meals and to determine if resident # 90 might benefit from a viable alternate delivery schedule. Resident #93 is currently in the hospital and will be interviewed for meal delivery level of satisfaction upon his return. Any issues will be addressed through the Director Dining Services. Resident #144 has been interview and states her issues with meal service have been resolved. Residents #90, #93, and #144 will have follow up interviews twice per week for one month □ with an interview on Monday to verify weekend service. Identified issues will be addressed by the Director Dining Services. Resident #123 - Consulted with resident□s nephew to discuss what exactly he needed from facility to complete his request. Completed personal letter from MD stating resident□s cognitive status, notarized and certified mailed to resident□s nephew on 6/3/16. Residents in the center have the potential	

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F 520	Continued From page 35 sanitized kitchenware was unloaded, failed to air dry and remove food particles from kitchenware before stacking it in storage, failed to monitor wash/rinse gauges during the operation of the dish machine, failed to clean walls/corners/floors in the kitchen, and failed to label and date opened food items. During the current recertification survey, the facility failed to maintain safe food temperatures, maintain dishwasher rinse water temperature within required range, discard old and worn kitchenware, clean kitchen equipment, and ensure food quality. In an interview with the facility's Administrator on 5/26/16 at 8:20 PM, he stated that he had been made aware of the issues that were identified during this year's annual recertification survey related to the unresolved grievances, implementation of interventions to prevent weight loss, lack of accurate and up to date staffing information, concerns in the kitchen including safe food temperatures, effective dish rinsing temperatures, cleanliness of kitchen equipment, compromised kitchenware, and storage to maintain food quality and would be including those items in the facility's QA process. He acknowledged that the issues being cited under F 325 and F 371 were different from the issues previously cited under the same regulations during the recertification survey in May 2015, but understood that it was considered a QA program concern by federal standards when there were repeat citations regardless of the specific reasons for the deficiencies.	F 520	to be affected by the deficient practice. Facility will begin conducting Ad-Hoc QA/QI meeting two times per month meeting on or about the 15th and 30th of each month In an effort to identify and address developing trends with regards to resident grievances and timely resolution. Dietary staff received training on the importance of timely meal service and the appropriate use of the Meal Delivery Schedule on 5/27/16, 5/31/16, 6/1/16 and 6/3/16. Facility staff received training on Grievance Procedures and Reporting during the week of 6/6 thru 6/10. Facility will continue to utilize the Meal Delivery Schedule tools currently in place. Completed forms will be delivered to the Director Dining Services following each meal services who will review for accuracy and timeliness and who will address timing issues with kitchen staff. Completed sheets will be delivered to the NHA for file and reviewed so data can be tracked and trended through the QA/QI process. Information related to the issues cited in F-166 along with any other grievance related issues will be discussed during the scheduled Ad-Hoc meetings and regularly scheduled QA/QI meetings for the next 3 months. The review time will be lengthened as indicated by results. F 325 D Resident #125 was reviewed by the Interdisciplinary Team (IDT), which includes the Dietician, CNE, Social	

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	345126	A. BUILDING _____ B. WING _____	05/26/2016

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F 520	Continued From page 36	F 520	Worker, Recreational Therapist, and the Unit Supervisor, at the Clinical at Risk (CAR) meeting on June 2, 2016 for weight loss. A new intervention of House shakes twice a day was added for the resident to receive. Residents with significant weight loss were reviewed for interventions to prevent further weight on June 2, 2016 by the IDT. Residents with significant weight loss had interventions in place. The dietician and CNE will review residents weights weekly those resident that are weighed weekly and monthly for any significant and/or gradual weight loss. Residents with gradual or significant weight loss will be presented to the CAR meeting weekly for the IDT to review and make recommendations. The CNE will report any trends in continued weight loss to the QA&A monthly. F 356 C The daily staffing is posted on the CNE door daily. Residents that are in the center have the potential to be affected. The CNE was educated on the daily staffing posting by the Clinical Quality Specialist on June 2, 2016. The CNE educated the licensed nurses, the centers scheduler on completion and posting of the daily staffing form. The	

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F 520	Continued From page 37	F 520	scheduler is responsible for completing the posting and placing it on the CNE□s door. The scheduler corrects the census and staffing numbers if needed for first and second shift Monday- Friday with the CNE checking each shift for completeness. The nurse on station one will complete the census and number of staff for the 11-7 shift each night at the beginning of the shift. For the week-end and holiday posting, the nurse on Station I, front cart, will complete the staffing numbers and census at the beginning of the first shift and second shift. The CNE will audit the completion of the posting of the daily census daily Monday-Friday and the assigned nurses will audit for posting on the week-end and holidays. The CNE will present the trends from the daily audit to the Quality Assurance Committee monthly. F-371 E There we were no specific residents identified as having been affected by the stated deficient practices but such practices had the potential to affect all residents. The stated deficient practices had the potential to affect all residents of the facility. In-service training was provided by the NHA on 5/27/16, 5/31/16, 6/1/16 and 6/3/16 for Dietary Staff covering the deficient practices listed in F-371. The following procedures have been put into place to assure that proper sanitation	

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F 520	Continued From page 38	F 520	standards are maintained in the kitchen: 1. Staff will assure that foods to be served cold will be prepared in advance to allow proper cooling before service. Temperatures will be recorded prior to, during and following service to assure proper/safe temperatures were maintained throughout the service process. 2. Staff members who wash dishes have been trained to allow the booster heater for the machine to recover allowing the machine to reach proper rinse temperature. 3. Staff will constantly inspect kitchenware during each meal at service and washing and will remove compromised articles from service and will advise the manager to assure required replacements are obtained to assure adequate supplies are maintained. 4. Staff will assure all kitchen equipment is kept clean and will assure all sides of the microwave oven are cleaned daily. The convection oven will be cleaned weekly as required or more often if use or inspection warrants. 5. Staff have labeled and dated all open food items in the dry storage area, freezer and cooler. Staff received training to promptly label opened items and to use the Use By Date appropriate for the food product. A list is maintained on the door of the walk-in cooler to use as reference	

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F 520	Continued From page 39	F 520	as necessary. The NHA and RD each have a Food Safety and Sanitation Audit that will be completed according to the schedule listed below to assure continued compliance with proper Kitchen Sanitation Procedures. The Administrator will be using a subject specific checklist developed to monitor the deficient practices cited under F-371. The tool will be used 3 times per week for 2 weeks and then weekly for 3 months to assure training and practice has achieved the desired level of compliance. o The Food Safety and Sanitation Audit will continue to be completed weekly for an indefinite period of time to assure continued compliance with required sanitation standards. o RD will continue to complete the Food Safety and Sanitation Audit monthly. Sanitation Checklists and the completed Staff Cleaning Assignments Checklist will be reviewed by the facility QAPI Committee monthly for 3 months and the review period may be extended based on results and progress with sanitation improvement and maintenance of acceptable levels of sanitation and the PIP plan will be updated as necessary to address any continuing systemic problems.	