STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345447	A. BUILDING _____ B. WING _____	C 07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE CENTER	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156		

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal

1) Resident #20 wasn't injured related to this citation. Resident #20 was made aware of the central intake number and where to find information on 8/15/2016 by the Executive Director.
2) On 07/27/2016 the Executive Director reposted the State of North Carolina Complaint Intake Unit phone number.
3) The Executive Director was in serviced by the Regional Director of Clinical Services on 8/08/16 on the posting of the state of North Carolina Complaint Intake Unit phone number. The Executive Director will perform Quality Improvement Monitoring of the availability of the central intake number one time a week for 3 months and then quarterly thereafter for one year.
4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of the audits will be reported to the Quality Assurance Performance Improvement Committee Meeting for monthly then quarterly for a year.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John F Quentin | TITLE: Executive Director | (X6) DATE: 8/19/16

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.

DHSR NH L&C Black Mountain WRO Received AUG 25 2016 by: PRM

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156	The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator. 8/25/16	

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F 156	Continued From page 2	F 156		

This REQUIREMENT is not met as evidenced by:
Based on observations, and resident and family interviews the facility failed to inform residents of their right to file a complaint with the state agency and to post the contact information for filing a complaint with the State Complaint Intake Unit (Resident #20).

The findings included:

1. Resident #20 was admitted to the facility on 12/27/13 with diagnoses which included anemia, heart condition, blood pressure, and depression. Review of the Quarterly Minimum Data Set (MDS) dated 06/26/16 revealed Resident #20 was cognitively intact.

An interview was conducted on 07/28/16 at 10:11 AM with Resident #20. Resident #20 reported she was the President of the Resident Council. Resident #20 stated concerns and issues were discussed in the monthly Resident Council Meetings, but stated the information to formally file a complaint with the state was not discussed. Resident #20 further stated was not aware of the State licensure and certification agency complaint intake unit. Resident #20 explained she was not aware of information posted in the facility and had not seen the name or number posted of the complaint intake unit. Resident #20 further explained she was unsure if other residents knew where to obtain that information.
2. During the initial tour of the facility on 07/25/16 at 10:10 AM observations were made of contact information posted related to resident rights.

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Included in posted information was the following:
-Posted next to a listing of resident rights was "Division of Facility Services is responsible for the enforcement of patient rights." Included with this statement were two phone numbers. The numbers posted were not contact information for the complaint intake unit and there was nothing to indicate the right to file a complaint with the State agency.
-A posting for "Resident grievance/complaint procedures" listed steps to file a grievance/complaint and listed steps the facility would take to resolve the concern. Included with the posting was the statement, "Should you disagree with the finding, recommendations or actions taken you may meet with the executive director or you may file a complaint with any of the agencies listed on the residents' bulletin board." The residents' bulletin board did not include the number of the complaint intake unit or information to indicate the right to file a complaint with the State agency.
-A posting was listed for how to file a complaint with the corporate office.

On 07/27/16 at 8:47 AM the facility administrator stated he was responsible for information posted in the facility. The administrator stated the hallway where contact information was posted had been recently painted and staff may have forgotten to place all information back on the bulletin boards.

On 07/27/16 at 10:13 AM the maintenance director stated the area where the bulletin board containing contact information was posted had been painted a couple months prior.

On 07/27/16 at 1:00 PM the administrator stated

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F 156	Continued From page 4 he located the contact information for posting a complaint with the State agency in a storage closet and posted it along with other contact information on the designated bulletin board. The administrator stated the information had inadvertently been left in the storage closet after the hallway was painted.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to identify and post information regarding the location of the results of the most recent survey by the State agency. The findings included: During the initial tour of the facility on 07/25/16 at 10:10 AM observations were made of contact information posted within the facility. There was not a posting regarding the location of the results of the most recent survey by the State agency. Located on the front entrance hallway of the facility was an unlabelled teal binder inside an	F 167	1) No residents were injured related to this citation. 2) The Executive Director labeled the survey binder and labeled its location in large print on 7/27/2016. 3) The Executive Director was in serviced by the Regional Director of Clinical Services on 8/08/16 on the labeling of survey binder and the labeling of its location. The Executive Director will perform Quality Improvement Monitoring of the survey binder's availability and labeling one time a week for 3 months and then quarterly thereafter for one year. 4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members for monthly for three months then	

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F 167	Continued From page 5 open, wall mounted document holder. There was nothing to identify what documents were inside the teal binder. Review of the content of information inside the teal binder noted the results of the most recent survey by the State agency. On 07/27/16 at 8:47 AM the facility administrator stated he was responsible for information posted in the facility. The administrator stated the entrance hallway where information was posted had been recently painted. The administrator stated if interested parties asked for the location of survey results they would have been directed to the teal binder. The administrator stated the wall mounted document holder had been removed when the hallway was painted. On 07/27/16 at 10:13 AM the maintenance director stated the entrance hallway had been painted a couple months prior. On 07/27/16 at 1:00 PM the administrator stated he was aware interested parties should not have to ask for the location of the survey results. The administrator stated the document holder had now been labeled to indicate the binder contained the most recent survey results by the State agency.	F 167	quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	8/25/16
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225	1) Resident #18 was not injured related to this citation. The facility submitted a 5 day working report on 9/3/2015. Resident #158 no longer resides at the facility. The facility submitted a 5 day working report on 8/31/2015. Resident #72 was not injured related	

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F 225	Continued From page 6 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to submit abuse/neglect allegation investigations to the State's Health Care Personnel Investigation (HCPI) for 2:5 residents for 5 Working Day Report (Residents #18 and #156) and failed to submit neglect allegation	F 225	to this citation. The facility submitted a 24 hour report on 4/15/2016. 2) Review of incidents to ensure incidents have been reported as required by the Executive Director 8/18/2016-8/24/2016. 3) The Executive Director and Director of Clinical Services were in serviced by the Regional Director of Clinical Services on 8/8/2016 on the state of North Carolina reporting requirements for allegations of abuse. The Executive Director will perform Quality Improvement Monitoring of any reportable event for timely submission to the state one time a week for three months and then quarterly thereafter for one year. 4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members	

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F 225	Continued From page 7 investigation's 24 Hour Initial Report for 1:5 residents (Resident #72). The findings included: 1. Resident #18 was admitted to the facility on 01/15/14. An Annual Minimum Data Set dated 06/21/16 indicated Resident #18 was cognitively intact. A review of the incident of abuse dated 08/24/15 indicated that on 08/24/15 the Admission's Coordinator witnessed the Human Resource Director being verbally abusive to Resident #18. The Admission's Coordinator witnessed a "heated conversation" between the Human Resource Director (HRD) and Resident #18 in the hallway with the Executive Director (ED) present. The HRD was pointing her finger at Resident #18 and holding Resident #18's hand down and told Resident #18 to hush. The Admission's Coordinator intervened and the HRD's yelling stopped. The Admission's Coordinator reported the incident to the appropriate corporate staff because the ED was involved in the allegation of abuse. A record review indicated the allegation of abuse for Resident #18 was investigated on 08/24/16 by a corporate staff member. On 07/28/16 at 3:40 PM a telephone interview was conducted with a staff member at the States' HCPI who verified that the HCPI had received a 24 Hour Initial Report for Resident #18 on 08/26/15 and a 5 Working Day Report for Resident #18 on 09/03/15.	F 225	consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator. 8/25/16	

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F 225	Continued From page 8 On 07/28/16 at 4:25 PM an interview was conducted with the Executive Director (ED) who stated he was ultimately responsible for submitting to the HCPI the 24 Hour Initial Report and the 5 Working Day Report for Resident #18. The ED stated the 5 Working Day Report was submitted to the HCPI 1 day late. The ED stated a corporate staff member submitted the 24 Hour Initial Report and the 5 Working Day Report because he had been involved in the allegation of abuse. 2. Resident # 156 was admitted to the facility on 07/03/15. An Admission Minimum Data Set dated 07/10/15 indicated Resident #156 was cognitively impaired. A review of the incident of neglect dated 08/20/15 indicated that on 08/20/15 Resident #156 was not taken to the bathroom on the night shift by Nurse Aide #2. A record review indicated the allegation of neglect for Resident #156 was investigated on 08/20/16 by the Executive Director. On 07/28/16 at 3:40 PM a telephone interview was conducted with a staff member at the States' HCPI who verified that the HCPI had received a 24 Hour Initial Report for Resident #156 on 08/21/15 and a 5 Working Day Report for Resident #156 on 08/31/15. On 07/28/16 at 4:25 PM an interview was conducted with the Executive Director (ED) who stated he was ultimately responsible for submitting to the HCPI the 24 Hour Initial Report and the 5 Working Day Report for Resident #156.	F 225		

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The ED stated the 5 Working Day Report was submitted to the HCPI 1 day late. The ED stated he required a better tracking system for submitting the 5 Working Day Report to the HCPI.

3. Resident #72 was admitted to the facility on 03/19/15.

A Quarterly Minimum Data Set dated 06/04/16 indicated Resident #72 was cognitively impaired and was frequently incontinent of urine and occasionally incontinent of bowel.

A review of a 24 Initial Report indicated Resident #72 had an allegation of neglect. The date of the neglect incident was reported as occurring on 04/12/16 between 2:00 AM and 3:30 AM. A review of the allegation revealed Resident #72 had requested bathroom assistance on 04/12/16 at 2:00 AM and Nurse Aide #1 came into Resident #72's room and shut the light off and did not acknowledge Resident #72's request for bathroom assistance. Resident #72 at a later time on 04/12/16 requested additional assistance from 2 other nurse aides due to having a wet brief and a wet gown and did not receive assistance. Resident #72 indicated she had to change her own wet gown without assistance.

A record review indicated the incident of neglect occurred on 04/12/16 and the investigation into the allegation of neglect conducted by the Executive Director was undated. The investigation indicated Nurse Aide #1 was suspended during the investigation and the allegation of neglect was unsubstantiated. The 24 Hour Initial Report was signed by the former Director of Nursing on 04/14/16 and the 5 Day

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F 225	Continued From page 10 Working Report was signed by the Executive Director on 04/15/16. On 07/28/16 at 3:40 PM a telephone interview was conducted with a staff member at the States' HCPI who verified that the HCPI had received a 24 Hour Initial Report and a 5 Working Day Report for Resident #72 on 04/15/16. On 07/28/16 at 4:25 PM an interview was conducted with the Executive Director (ED) who stated he was ultimately responsible for submitting to the HCPI the 24 Hour Initial Report for Resident #72. The ED stated the 24 Hour Initial Report for Resident #72 was submitted 3 days late to the HCPI and was submitted along with the 5 Working Day Report. The ED assumed the investigation to the allegation of neglect for Resident #72 occurred on 04/12/16. The ED stated he had not dated the allegation investigation of neglect for Resident #72 so he was unsure of the date that he conducted the investigation. The ED stated he had shared the responsibility of submitting the 24 Hour Initial Reports with his former Director of Nursing. The ED stated he required a better tracking system for timely submission of the 24 Initial Reports to the HCPI.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	1) Resident # 121 was seen by the physician on 7/28/2016. No new orders noted. Nurse #3 was in serviced by the Director of Clinical Services on7/28/2016 and 7/29/2016 on reporting any allegation of abuse and/or resident to resident	

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F 226	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to follow their abuse policy and procedure in the areas of reporting, identification, and protection for 1:1 resident (Resident #121). The Findings included: A policy titled "Subject: Resident Abuse and had a revision date of 06/01/15 read in part: Any action that may cause or causes actual physical, psychological or emotional harm, which is not caused by simple negligence constitutes abuse. Furthermore, the Administration of the Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers. Any employee who witnesses or has knowledge of abuse or an allegation of abuse to a resident, is obligated to report such information immediately to their supervisor. If the immediate supervisor is not available, the employee is to notify the designated Nursing Supervisor on duty at the time of the event. Additionally the supervisor must immediately report to the Executive Director (ED), who is the designated abuse coordinator. The ED or Director of Clinical Services (DCS) will ensure notification to the resident's legal guardian, family member, responsible party or significant other of the alleged, suspected or observed abuse, neglect or mistreatment, and notify the resident's attending physician. Immediately upon an allegation of abuse or neglect, the suspect (s) shall be segregated from residents pending the investigation resident of the allegation. The Clinical Nurse in charge or the DCS shall perform and document a through nursing assessment, and notify the attending physician. An incident	F 226	altercations. Nurse #2 was in serviced by the Director of Clinical Services on7/27/2016 on reporting any allegation of abuse and/or resident to resident altercations. 2) All residents have the potential to be affected by this citation. Current residents were interviewed regarding abuse and any potential resident to resident altercations on 7/27/2016 with no negative findings. 3) The Executive Director and Director of Clinical Services were in serviced on the Abuse policy on 8/8/2016 by the Regional Director of Clinical Services. Licensed Nurses, Certified Nurse Assistants, Housekeeping, Dietary, Maintenance, Social Services, Business Office Manager, Human Resources, Admissions, Activities were in serviced by the Director of Clinical Services and/or Nursing Supervisor on Abuse Policy, reporting allegations and resident to resident altercations 8/15/2016-8/24/2016. The Executive Director and or Social Services Director will perform Quality Improvement Monitoring for reporting of resident to resident	

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F 226	Continued From page 12 report shall be filled by the individual in charge who received the report in conjunction with the person who reported the abuse." Resident #121 was admitted to the facility on 05/25/16. An admission Minimum Data Set dated 06/01/16 indicated Resident #121 was cognitively intact and was under Hospice care and required oxygen. Resident #121 was coded as having diagnoses of respiratory failure, cardiopulmonary disease (COPD), post-traumatic stress disorder, psychotic disorder, anxiety disorder, and depression. Resident #121 was coded as requiring supervision for bed mobility and transfers and limited assistance with dressing, toileting, and personal hygiene. A review of a nurse's note created by Nurse #2 and dated 07/17/16 at 1:00 PM indicated Resident #121 had stated that his new roommate became aggressive and semi-combative on Friday evening 07/15/16. Resident #121 stated he was very concerned about his own safety at times. On 07/26/16 at 8:51 AM an interview was conducted with Resident #121 who stated he had been struck in the right shoulder by his roommate. Resident #121 stated he tried to move out of the way of being struck by his roommate but his roommate made contact with Resident #121's right shoulder and further stated if he had not tried to move out of the way of his roommate's strike, he would have received a harder strike. Resident #121 stated he immediately told the nurse of the incident but could not recall the name of the nurse. Resident	F 226	altercations and/or allegations of abuse three times a week for four weeks, two times a week for four weeks and one time a week for four weeks and or until substantial compliance is obtained then quarterly thereafter. 4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	8/25/16

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#121 stated he had not been able to get any rest or sleep with his roommate wandering around the room. Resident stated he thought approximately about 4 days after the incident the facility moved his roommate out of the room. Resident #121 stated he thought the facility should have moved his roommate out of his room sooner because Resident #121 had not felt safe with his roommate wandering around in the room and getting into Resident #121's personal belongings.

On 07/27/16 at 12:45 PM a telephone interview was conducted with Nurse #2 who stated he was informed by Resident #121 on 7/17/16 that his roommate had become aggressive and combative on 07/15/16 Friday evening and had struck Resident #121. Resident #121 informed Nurse #2 that his roommate had made contact with Resident #121's shoulder and Resident #121 had tried to divert away from receiving the strike. Nurse #2 stated Resident #121 had denied any injury from the strike. Nurse #2 stated Resident #121 had informed him that Resident #121's roommate had become aggressive and had been rummaging around in the room. Nurse #2 stated the Social Worker (SW) who he believed was part of administration was informed on 07/17/16 that Resident #121 was not getting along with his roommate. Nurse #2 stated he did not remember if he had informed the SW if Resident #121 had been struck by his roommate on 07/15/16. Nurse #2 stated he was informed by the SW that the incompatible roommate situation involving Resident #121 would be handled on Monday when the Administrator and Director of Nursing (DON) were back in the facility. Nurse #2 stated in his opinion Resident #121 was not in any danger from his roommate or was unsafe by staying in the same room with his roommate until

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administration could address the roommate situation on Monday 07/18/16. Nurse #2 stated he should have informed the DON that Resident #121 had informed Nurse #2 that he had been struck by his roommate on 07/17/16. Nurse #2 further shared that he had not informed the administrator that Resident #121 had been struck by his roommate.

On 07/27/16 at 3:31 PM an interview was conducted with the SW who stated she was informed by Nurse #2 on 07/17/16 that Resident #121's roommate stood over his bed during the night and kept Resident #121 awake. The SW stated she did not recall that Nurse #2 had informed her that Resident #121 had been struck by his roommate. The SW stated she did not inform the DON on 07/17/16 that Resident #121 was having any concerns with his roommate. The SW stated during the clinical portion of the morning standup meeting on 07/18/16 the DON informed the SW that Resident #121 had been kept awake by his roommate. The SW stated nothing was mentioned by the DON that Resident #121 had been struck by his roommate. The SW stated the administrator and DON were aware that she was working on a roommate change for Resident #121's roommate. The SW stated Resident #121 came to the nurse's station to inquire when his roommate would be moved because Resident #121 had not been able to get any rest. The SW stated Resident #121 had not informed her that he had been struck by his roommate.

On 07/27/16 at 4:25 PM an interview was conducted with Nurse Aide #3 who stated on 07/16/16 she worked 7:00 AM to 7:00 PM and was informed by Resident #121 that his

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roommate on Friday evening 07/15/16 had been touching items on Resident #121's bedside table and Resident #121 asked his roommate to go to his own bed. Resident #121 stated his roommate hit Resident #121 in the shoulder. Nurse Aide #3 stated she thought Resident #121 was anxious about staying in the same room with his roommate because Resident #121 kept the curtain closed that divided the room. Nurse Aide #3 stated she informed Nurse #2 that Resident #121 had been struck by his roommate. Nurse Aide #3 informed Nurse #2 that Resident #121 was asking that his roommate be moved out of the room because his roommate was getting into Resident #121's personal belongings and his roommate kept pulling the curtain back. Nurse Aide #3 stated she was present when Nurse #2 informed Resident #121 that Nurse #2 could not remove the roommate from the room and the SW would have to make arrangements to move Resident #121's roommate from the room.

On 07/27/16 at 5:13 PM a telephone interview was conducted with Nurse #3 who stated she worked on 07/16/16 from 7:00 PM to 7:00 AM and was informed by Resident #121 that he had been struck by his roommate on 07/15/16. Nurse #3 stated Resident #121 informed her that his roommate made contact with him but was not a direct hit. Nurse #3 stated Resident #121 informed her that he had told the SW that he had been struck by his roommate. Nurse #3 stated she had not reported to the DON or the administrator that Resident #121 had been struck by his roommate because she thought the SW had informed the DON and administrator of the incident. Nurse #3 stated she had not completed a concern form regarding Resident #121 being struck by his roommate because she believed a

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concern form had already been completed.

On 07/28/16 at 9:05 AM an interview was conducted with the SW who stated she was unaware that Resident #121 had been struck by his roommate until 07/27/16 and was not aware that Resident #121 was struck by his roommate on 07/15/16 and she had no knowledge of the incident until 07/27/16. The SW stated Nurse #2 had not reported to her that Resident #121 had been struck by his roommate on 07/15/16. The SW stated the system of reporting resident to resident altercations needed to be fixed. The SW stated if she had known that Resident #121 had been struck by his roommate on 07/15/16 she would have moved Resident #121's roommate sooner.

An interview was conducted with the Director of Clinical Services (DCS) on 07/28/16 at 9:54 AM who stated if any incidents concerning residents occurred out of the ordinary than staff were to call the DCS. The DCS stated her expectation was that staff were to notify her immediately of any resident to resident altercation and of any unusual resident behaviors. The DCS stated she had not been informed until 07/27/16 that Resident #121 had been struck by his roommate. The DCS stated her expectation was that a Situation Background Assessment Recommendation (SBAR) form should have been filled out and a nursing assessment would have been performed on 07/15/16 or 07/16/17 by the nurse after Resident #121 had been struck by his roommate as per facility protocol. The DCS stated her expectation was that Nurse #2 and Nurse #3 should have immediately notified the DCS when Resident #121 informed Nurse #2 and Nurse #3 that he had been struck by his roommate on

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07/15/16. The DCS stated her expectation was that Nurse #2 and Nurse #3 would have informed the physician, DCS and the Executive Director that Resident #121 had been struck by his roommate. The DCS stated if she had known that Resident #121 had been struck by his roommate she would have immediately came to the facility and made arrangements to have Resident #121's roommate relocated to another room in the facility. The DCS stated there was a system failure in reporting resident to resident abuse. The DCS stated when she found out on 07/27/16 that Resident #121 had been struck by his roommate an investigation into the incident was immediately implemented on 07/27/16

An interview was conducted with the Executive Director (ED) on 07/28/16 at 11:28 AM who stated he was informed on 07/27/16 by another staff member that Resident #121 had been struck by his roommate. The ED stated he was unaware that Resident #121 had been struck by his roommate until 07/27/16. The ED stated his expectation was that the nurse would have notified him immediately that Resident #121 had been struck by his roommate. The ED stated the facility policy indicated that any resident to resident, staff to resident, or any abuse was to be immediately reported to the ED. The ED stated he never received a written report that Resident #121 had been struck by his roommate. The ED stated the physician had not been notified that Resident #121 had been struck by his roommate at the time of the incident.

On 07/28/16 at 2:58 PM a telephone interview was conducted with Nurse #2 who stated he had not informed the physician on 07/17/16 when Resident #121 had informed Nurse #2 that he

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F 226	Continued From page 18 had been struck by his roommate and had not performed a nursing assessment. On 07/29/16 at 7:20 AM an interview was conducted with Nurse #3 who stated on 07/16/16 when she was informed by Resident #121 that he had been struck by his roommate she had not notified the physician or a nursing assessment. Nurse #3 stated she thought someone else had already notified the physician that Resident #121 had been struck by his roommate.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed facility failed to address the residents rummaging behavior, inappropriate elimination habits, wandering behavior and emotional status for 1 of 1 sampled resident for behavior and emotional status (Resident #155). The findings included: Resident #155 was admitted to the facility to a unit that was not locked on 07/12/16 with diagnoses which included blood clots of the deep veins of left lower extremity, muscle weakness, lack of coordination, low back pain and Alzheimer's disease.	F 250	1) Resident #155 no longer resides at the facility. 2) The Social Services Director performed Quality Improvement Monitoring of current residents for any psychosocial needs for their wellbeing, and any concerns for other residents with behaviors 8/17/2016-8/24/2016. 3) The Regional Director of Clinical Services in serviced the Director of Social Services on providing psychosocial services to meet the residents wellbeing and how to follow up with residents with behavior's and update care plans to reflect specific interventions for those residents with behaviors On 8/23/2016. Licensed Nurses,	

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F 250	Continued From page 19 A review of the admission Minimum Data Set (MDS) dated 07/19/16 indicated Resident #155 was severely impaired in cognition for daily decision making and had physical behaviors directed toward others which occurred 1-3 days, verbal behaviors directed toward others which occurred 1-3 days and rejection of care which occurred 1-3 days. The MDS also indicated Resident #155 required extensive assistance with dressing, toileting, hygiene and transfers but limited assistance with locomotion on the unit. A review of documents from a previous facility with a facsimile (fax) stamp dated 07/12/16 at 8:50 AM contained notes by a Social Worker (SW) indicated Resident #155 lived on a secured Alzheimer's unit for a more structured and secure environment. A review of an Admission Data Collection form which included the nursing admission assessment dated 07/12/16 at 3:30 PM revealed Resident #155 was disoriented to person, place and time at all times. The form also revealed Resident #155 was at risk for elopement and had behavioral symptoms which included wandering, resisted care and had poor concentration. A review of an Admission Care Plan dated 07/12/16 indicated the following approaches: redirect resident as needed, always ask for help if resident was abusive or resistive, keep environment calm and relaxed, remove from public area if behavior is improper and encourage diversional activities. There were no handwritten notes related to any specific behaviors or interventions for staff to attempt.	F 250	Certified Nurse Assistants, Housekeeping, Dietary, Maintenance, Social Services, Business Office Manager, Human Resources, Admissions, Activities were in serviced by the Director of Clinical Services and/or Nursing Supervisor on Abuse Policy, reporting allegations and resident to resident altercations 8/15/2016-8/24/2016. The Executive Director and or Social Services Director will perform Quality Improvement Monitoring for reporting of resident to resident altercations and/or allegations of abuse three times a week for four weeks, two times a week for four weeks and one time a week for four weeks until substantial compliance is obtained and then quarterly thereafter for one year. The Social Services Director will monitor residents with behavior's for resident specific interventions and for resident psychosocial needs three times a week for four weeks, two times a week for four weeks and one time a week for four weeks until substantial compliance is obtained and then quarterly thereafter for one year.	

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F 250	Continued From page 20 A review of a nurse's note dated 07/12/16 at 9:00 PM documented by Nurse #1 indicated Resident #155 was re-directed frequently from other resident rooms and had rummaged through their personal things. A review of a nurse's note dated 07/13/16 at 5:45 AM documented by Nurse #1 indicated she was called to Resident #155's room by a Nurse Aide (NA) and Resident #155 was standing on his roommates side of the room between his roommates bed and wall and had urinated a small amount in the floor at the head of his roommates bed and was about to urinate on his roommates head and face. The notes further indicated Resident #155 was redirected to the bathroom by 2 staff. A review of a nurse's note dated 07/14/16 at 7:30 PM documented by Nurse #4 revealed Resident #155 was confused and was easily agitated. The notes further revealed Resident #155 was difficult to redirect and became angry with staff and family and wandered in and out of other resident rooms. A review of a nurse's note dated 07/16/16 during the 7:00 AM to 7:00 PM shift revealed Resident #155 needed constant re-directing and cueing the entire shift because he wandered in and out of other resident's rooms. A review of a nurse's note dated 07/17/16 at 1:00 PM documented by Nurse #2 indicated Resident #155 had become aggressive and semi-combative during the evening of 07/15/16 with his roommate. A review of a nurse's note dated 07/18/16 at 9:00 PM documented by Nurse #1 revealed Resident	F 250	4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	8/25/16

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#155 was sitting on his roommate's bed while his roommate was out of the room and had spilled drinks that were on bedside table all over his roommate's bed. The notes further revealed Resident #155's roommate's bed linens were all tangled and Resident #155 had been drinking his roommates left over ice tea.

A review of nurse's notes dated 07/19/16 at 11:35 AM documented by Nurse #7 revealed Resident #155 was combative and wandered into other resident's rooms and went through their personal things.

A review of a Social Services Admission Evaluation dated 07/19/16 by the facility SW indicated Resident #155 had no short term or long term memory recall and was severely impaired in cognition for daily decision making and never or rarely made decisions. A section labeled mental health diagnosis or behavioral/emotion concerns was indicated yes and a handwritten note indicated Alzheimer's disease. A section labeled resident anticipated discharge plan indicated long term care - secured unit.

A review of a Care Area Assessment (CAA) worksheet dated 07/25/16 completed by the Social Worker (SW) revealed behavioral symptoms triggered due to rejection of care; wandering and presence of at least 1 behavioral symptom.

During an interview on 07/29/16 at 7:16 AM Nurse #3 stated nursing staff talked to Resident #155 and tried to distract him but at least half the time he rummaged through other resident's things and exhibited behaviors. She further

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stated she did not assess Resident #155 for behaviors because she thought that had already been done and she did not notify Resident #155's physician about behaviors because she thought that had already been done.

During an interview on 07/29/16 at 9:21 AM Nurse #1 explained Resident #155 was difficult to re-direct and urinated in the floor. She stated it became harder to re-direct Resident #155 each day and they tried diversional activities but that did not work and they had tried to monitor him at the nurse's station but he would get up and wander off.

During an interview on 07/29/16 at 8:57 AM the SW explained she went to Resident #155's room the next morning after he was admitted because it had been reported he had wandered in other resident's rooms. She stated she was not aware of all the behaviors Resident #155 had exhibited and felt when he was admitted to the facility he would adjust and would get used to his surroundings. She stated she had relied on nursing staff to keep her informed about Resident #155's behaviors but she now realized she needed to be more involved with assessing and monitoring resident behaviors.

During an interview on 07/29/16 at 2:42 PM the Director of Clinical Services stated it was her expectation for nursing staff to assess resident behaviors and communicate with the physician or Administration when a resident was continuing to exhibit behaviors. She stated it was also her expectation for the SW to assess and monitor resident's psychosocial well-being and behaviors on admission and then on a routine basis.

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F 253	Continued From page 23	F 253		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair resident doors with broken and splintered laminate and wood for 6 of 12 resident rooms in the locked dementia unit (Resident room #102, #105, #107, #108, #110 and #114), failed to repair damaged wood and laminate on the edges of 2 of 2 smoke prevention doors in the locked dementia unit, failed to repair a cracked vinyl hand rail in the main hallway across from Resident room #102 in the locked dementia unit, failed to repair stained grout around the base of toilets in 4 of 12 Resident bathrooms in the locked dementia unit (Resident bathroom #102, #105, #108 and #110) and failed to repair the baseboard in the bathroom of Resident Room #108 that had separated from the dry wall in 1 of 12 resident bathrooms in the locked dementia unit. The findings included: 1. a. Observations of Room #102 on 07/25/16 at 5:01 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 07/26/16 at 8:57 AM revealed the door of resident room #102 had broken and splintered laminate on the edges of the bottom half of the door.	F 253	1) The Maintenance Director repaired the broken and/or splintered door laminate on room #102 on 8/15/2016. The Maintenance Director repaired the broken and/or splintered door laminate on room #105 on 8/15/2016. The Maintenance Director repaired the broken and/or splintered door laminate on room #107 on 8/15/2016. The Maintenance Director repaired the broken and/or splintered door laminate on room #108 on 8/15/2016. The Maintenance Director repaired the broken and/or splintered door laminate on bathroom door and resident room door on room #110 on 8/15/2016. The Maintenance Director repaired the broken and/or splintered door laminate on room #114 on 8/15/2016. The Maintenance Director repaired the smoke barrier broken and/or splintered door on the locked dementia unit on 8/15/2016.	

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F 253	Continued From page 24 Observations on 07/27/16 at 9:15 AM revealed the door of resident room #102 had broken and splintered laminate on the edges of the bottom half of the door. b. Observations of Room #105 on 07/25/16 at 5:05 PM revealed the doors of the resident's room and bathroom had broken and splintered laminate on the edges of the bottom half of the doors. Observations on 07/26/16 at 8:59 AM revealed the doors of resident room and bathroom #105 had broken and splintered laminate on the edges of the bottom half of the doors. Observations on 07/27/16 at 9:18 AM revealed the doors of resident room and bathroom #105 had broken and splintered laminate on the edges of the bottom half of the doors. c. Observations of Room #107 on 07/25/16 at 5:18 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 07/26/16 at 9:09 AM revealed the door of resident room #107 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 07/27/16 at 9:20 AM revealed the door of resident room #107 had broken and splintered laminate on the edges of the bottom half of the door. d. Observations of Room #108 on 07/25/16 at 5:30 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 07/26/16 at 9:15 AM revealed the door of resident room #108 had broken and splintered laminate on the edges of the bottom	F 253	The Maintenance Director repaired the vinyl hand rail across from resident room #102 on 8/16/2016. The Maintenance Director and/or Housekeeping Supervisor repaired the grout in the bathroom #105 on 8/16/2016. The Maintenance Director and/or Housekeeping Supervisor repaired the grout in the bathroom #108 on 8/16/2016. The Maintenance Director and/or Housekeeping Supervisor repaired the grout in the bathroom #110 on 8/16/2016. The Maintenance Director repaired the baseboard in resident room #110 on 8/16/2016. 2) The Maintenance Director and/or Housekeeping Supervisor observed doors for broken laminate, splintered wood, loose baseboards, and grout in restrooms for cleaning and repair 8/15/2016-8/24/2016. Issues identified were repaired by the Maintenance Director and/or Housekeeping Supervisor. 3) The Executive Director in serviced the Maintenance Director and the House keeping supervisor on maintaining	

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F 253	Continued From page 25 half of the door. Observations on 07/27/16 at 11:20 AM revealed the door of resident room #108 had broken and splintered laminate on the edges of the bottom half of the door. e. Observations of Room #110 on 07/25/16 at 5:35 revealed the doors of the resident's room and back of bathroom door had broken and splintered laminate on the edges of the bottom half of the doors. Observations on 07/26/16 at 9:19 AM revealed the doors of resident room and back of bathroom door of #110 had broken and splintered laminate on the edges of the bottom half of the doors. Observations on 07/27/16 at 11:25 AM revealed the doors of resident room and back of bathroom door of #110 had broken and splintered laminate on the edges of the bottom half of the doors. f. Observations of Room #114 on 07/25/16 at 5:40 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 07/26/16 at 9:29 AM revealed the door of resident room #114 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 07/27/15 at 11:30 AM revealed the door of resident room #114 had broken and splintered laminate on the edges of the bottom half of the door. 2. a. Observations of a set of smoke barrier doors in the locked dementia unit on 07/25/16 at 5:15 PM revealed 2 doors with broken and splintered laminate on the edges of the lower half of each door. Observations on 07/26/16 at 9:35 AM revealed	F 253	hand rails, doors and grout on 8/19/2016. The Director of Clinical Services in serviced licensed nurses, certified nurse aides on notifying Maintenance should they find any area that needed repair 8/15/2016-8/24/2016. The Maintenance Director and/or Housekeeping Supervisor will perform Quality Improvement Monitoring of resident room doors, bathroom doors for broken or chipped laminate or wood, baseboards in need of repair, handrails in need of repair and grout in need of repair three times a week for eight weeks, two times a week for four weeks until substantial compliance is obtained and then quarterly thereafter for one year. 4) The Maintenance Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of the audit will be reported to the Quality Assurance Performance Improvement Committee members monthly then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but	

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F 253	Continued From page 26 the smoke barrier doors in the locked dementia unit had broken and splintered laminate on the edges of the lower half of each door. Observations on 07/27/16 at 11:35 AM revealed the smoke barrier doors in the locked dementia unit had broken and splintered laminate on the edges of the lower half of each door. 3. a. Observations of the vinyl hand rail across from resident room #102 in the main hallway of the locked dementia unit on 07/25/16 at 5:20 PM revealed a large v shaped crack on the front side of the hand rail that was rough to touch. Observations on 07/26/16 at 9:40 AM of the vinyl hand rail across from resident room #102 revealed a large v shaped crack on the front side of the hand rail that was rough to touch. Observations on 07/27/16 at 11:40 AM of the vinyl hand rail across from resident room #102 revealed a large v shaped crack in the front side of the hand rail that was rough to touch. 4. a Observations in the bathroom of Resident room #102 on 07/25/16 at 5:07 PM revealed dark, brown stains in the grout around the base of the toilet. Observations on 07/26/16 8:57 AM in the bathroom of resident room #102 revealed dark brown stains in the grout around the base of the toilet. Observation on 07/27/16 at 9:17 AM in the bathroom of resident room #102 revealed dark brown stains in the grout around the base of the toilet. b. Observations in the bathroom of Resident room #105 on 07/25/16 at 5:03 PM revealed dark, brown stains in the grout around the base of the toilet.	F 253	not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	9/25/16

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Observations on 07/26/16 9:02 AM in the bathroom of resident room #105 revealed dark brown stains in the grout around the base of the toilet.
Observation on 07/27/16 at 9:19 AM the bathroom of resident room #105 revealed dark brown stains in the grout around the base of the toilet.

c. Observations in the bathroom of Resident room #108 on 07/25/16 at 4:47 PM revealed dark, brown stains in the grout around the base of the toilet.
Observations on 07/26/16 9:05 AM in the bathroom of resident room #108 revealed dark brown stains in the grout around the base of the toilet.
Observation on 07/27/16 at 9:22 AM in the bathroom of resident room #108 revealed dark brown stains in the grout around the base of the toilet.

d. Observations in the bathroom of Resident room #110 on 07/25/16 at 4:47 PM revealed dark, brown stains in the grout around the base of the toilet.
Observations on 07/26/16 9:08 AM in the bathroom of resident room #110 revealed dark brown stains in the grout around the base of the toilet.
Observation on 07/27/16 at 9:25 AM in the bathroom of resident room #110 revealed dark brown stains in the grout around the base of the toilet.

5. a. Observations in the bathroom of Resident room #110 on 07/25/16 at 4:47 PM revealed the baseboard along the wall on the right side of the toilet had pulled away from the dry wall and

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exposed a large hole along the line where it had separated from the wall.
Observations on 07/26/169:08 AM in the bathroom of resident room #110 revealed the baseboard along the wall on the right side of the toilet had pulled away from the dry wall and exposed a large hole along the line where it had separated from the wall.
Observation on 07/27/16 at 9:25 AM in the bathroom of resident room #110 revealed the baseboard along the wall on the right side of the toilet had pulled away from the dry wall and exposed a large hole along the line where it had separated from the wall.

An interview and environmental tour was conducted in the locked dementia unit with the Maintenance Director and Administrator on 07/29/16 at 4:30 PM. The Maintenance Director stated the facility used a work order system and explained there was a black box that was labeled work orders at the nurse ' s station. He explained staff were expected to fill out the work order with the problem and date and sign it and place it in the box and he and his assistant made rounds throughout the day to check them. He stated staff also called him or stopped him in the hall to tell him about things that needed to be fixed. He confirmed he was not working on any large projects at the current time because they had just finished painting in the facility. During the tour he acknowledged the splintered doors on resident rooms, bathrooms and smoke protection doors and stated they needed to be sanded and some needed to have wood putty applied. He stated he had not received any work orders to repair splintered doors. He confirmed the hand rail was cracked in the main hallway of the dementia unit across from Resident Room #102 and stated he

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F 253	Continued From page 29 was not aware of it. He verified the grout needed to be replaced around the toilets inn Resident rooms #102, #105, #108 and #110 and he had not received any work orders to repair these. He confirmed the baseboard had separated from the wall in the bathroom of Resident room #110 and he was unaware it had happened. During an interview on 07/29/16 at 4:40 PM the Administrator explained the Maintenance Director would go through every doors and toilet to make the repairs. He stated it was his expectation if staff saw things that needed repair they should report them to him or to the Maintenance Director. He further stated if staff saw anything that was a potential safety hazard report staff should report it immediately.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278	1) Resident #155 no longer resides at the facility. 2) Residents with behaviors have the potential to be affected by this citation. The Minimum Data Set Coordinator reviewed the last 30 days of CAA's of current residents to ensure that strengths and weaknesses related to behaviors or psychosocial status was addressed 8/17/2016-8/24/2016. 3) The Social Services Director was In serviced on completing accurate CAA's related to resident behaviors with identifying specific strengths and weakness's by the Regional Case	

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F 278	Continued From page 30 $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 reviews and staff interviews the facility failed to accurately assess a resident's psychosocial problems and failed to identify strengths and weaknesses related to behaviors or psychosocial status for 1 of 21 residents sampled for Care Area Assessment Summaries (Resident #155). The findings included: Resident #155 was admitted to the facility on 07/12/16 with diagnoses which included blood clots of the deep veins of left lower extremity, muscle weakness, lack of coordination, low back pain and Alzheimer's disease. A review of the admission Minimum Data Set (MDS) dated 07/19/16 indicated Resident #155 was severely impaired in cognition for daily decision making and had physical behaviors directed toward others which occurred 1-3 days, verbal behaviors directed toward others which occurred 1-3 days and rejection of care which occurred 1-3 days. The MDS also indicated Resident #155 required extensive assistance with dressing, toileting, hygiene and transfers but limited assistance with locomotion on the unit.	F 278	Mix/MDS Coordinator on 8/22/2016. The Director of Clinical Services and/or the Minimum Data Set Registered Nurse will audit CAA's of residents with behavior's based on the MDS schedule for accuracy two times a week for twelve weeks or until substantial compliance is obtained then quarterly thereafter for one year. 4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members for 6 months and/or until compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	8/25/16

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A review of a Care Area Assessment (CAA) worksheet dated 07/25/16 completed by the Social Worker (SW) revealed behavioral symptoms triggered due to rejection of care; wandering and presence of at least 1 behavioral symptom. A review of the sections listed in the CAA worksheet indicated the following:
a. Analysis of Findings indicated "Actual" and a section labeled seriousness of the problem/condition indicated progressive dementia.
b. Nature of the behavioral disturbance (resident interview, if possible or staff observations) revealed nothing was checked or documented.
c. Medication side effects that can cause behavioral symptoms revealed nothing was checked or documented.
d. Illness or conditions that can cause behavior problems indicated pain was checked.
e. Factors that can cause or exacerbate the behavior revealed nothing was checked or documented.
f. Cognitive status problems indicated Alzheimer's disease and a section labeled other considerations revealed nothing was checked or documented.
g. Will behavioral symptoms and functional status be addressed in the care plan? The documentation indicated yes.
h. If care planning for this problem, what is the overall objective? The areas checked included improvement, slow or minimize decline, avoid complications, maintain current level of functioning and minimize risks.
i. Describe impact of the problem/need on the resident and your rationale for care plan decisions (include complications and risk factors and the need for referral to other health

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professionals) revealed the following: related to the resident's diagnosis the resident would continue to have a cognitive decline and would monitor for signs and symptoms of an acute change in condition but would not proceed to care plans at this time.
j. A section labeled referral to other disciplines indicated psychiatric services.

During an interview on 07/29/16 at 2:42 PM with the Director of Clinical Services she stated she was familiar with CAA worksheets but she was not involved in the MDS or CAA summaries or worksheets.

During an interview on 07/29/16 at 8:57 AM the SW confirmed she had completed the CAA worksheet for behaviors. She stated she had not had any formal training in completion of the CAA worksheets but had been trained by the person who was the SW who preceded her. She further stated she had not assessed Resident #155's psychosocial status and had relied on nursing staff to report any concerns to her. She stated she realized she should have assessed Resident #155's behaviors so she could have included the information on the CAA worksheet.

During an interview on 07/29/16 at 4:05 PM the MDS Coordinator confirmed the CAA worksheet for behaviors completed by the SW did not contain an accurate assessment of Resident #155's psychosocial status or behaviors. He stated he did not realize the CAA worksheet did not contain an accurate assessment for psychosocial status and the SW would need additional training since she had not received any formal training on completion of CAA summaries or worksheets.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 reviews and staff interviews the facility failed to reassess the effectiveness of interventions and review the plan of care to meet the needs of a resident who was admitted with behaviors to a unit that was not locked and wandered in and out of other residents rooms, touched them, rummaged through their personal items and spilled liquids on their bed for 1 of 1 sampled resident for behavior and emotional status (Resident #155). The findings included:	F 280	1) Resident # 155 no longer resides at the facility. 2) The Social Services Director, Director of Clinical Services and/or Supervisor reviewed care plans of resident's with behaviors for affective resident specific behaviors 8/17/2016-8/24/2016. 3) The Regional Director of Clinical Services in serviced the Director of Social Services on providing psychosocial services to meet the residents wellbeing and how to follow up with residents with behavior's and update care plans to reflect specific interventions for those residents with behaviors on 08/23/2016. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of residents with behaviors care plan's for resident specific interventions to meet residents psychosocial needs two times a week for twelve weeks until substantial compliance is obtained then quarterly thereafter for one year.	

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F 280	Continued From page 34 Resident #155 was admitted to the facility on 07/12/16 with diagnoses which included blood clots of the deep veins of left lower extremity, muscle weakness, lack of coordination, low back pain and Alzheimer's disease. A review of the admission Minimum Data Set (MDS) dated 07/19/16 indicated Resident #155 was severely impaired in cognition for daily decision making. A review of the behavior section of the MDS revealed Resident #155 had physical behaviors directed toward others which occurred 1-3 days, verbal behaviors directed toward others which occurred 1-3 days and rejection of care which occurred 1-3 days. The MDS also indicated Resident #155 required extensive assistance with dressing, toileting, hygiene and transfers but limited assistance with locomotion on the unit. A review of documents from a previous facility with a facsimile (fax) stamp dated 07/12/16 at 8:50 AM contained notes by a Social Worker (SW) which indicated Resident #155 had poor safety awareness and did not understand to call for assistance. The notes further revealed Resident #155 was considered to be an elopement risk due to wandering and had exit seeking behaviors and in the evenings had increased behaviors of wandering and resisted care. The notes indicated Resident #155 lived on a secured Alzheimer's unit for a more structured and secure environment. A review of an Admission Care Plan dated 07/12/16 indicated directions as follows: A care plan problem titled Behavioral Symptoms was circled and the goal was Resident #155 would have fewer episodes of and was left incomplete. The approaches were checked with a check mark next to each as follows: redirect	F 280	4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	8/25/16

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resident as needed, always ask for help if resident was abusive or resistive, keep environment calm and relaxed, remove from public area if behavior was improper and encourage diversional activities. There were no notes related to any specific behaviors or interventions for staff to attempt.

A review of an Admission Data Collection form which included the nursing admission assessment dated 07/12/16 at 3:30 PM revealed Resident #155 was disoriented to person, place and time at all times. The form also revealed Resident #155 was at risk for elopement and had behavioral symptoms which included wandering, resisted care and had poor concentration.

A review of a Care Area Assessment (CAA) worksheet completed by the SW dated 07/25/16 indicated behavior symptoms triggered due to rejection of care, wandering and the presence of at least 1 behavioral symptom and a psychiatric services referral was indicated. A question as to whether behavioral symptoms and functional status would be addressed in the care plan was answered yes. However a section to describe the impact of the problem or need on the resident and rationale for care plan decisions indicated the facility would not proceed to care plans at this time.

During an interview on 07/29/16 at 7:16 AM Nurse #3 explained Resident #155 rummaged through other resident's things. She stated they talked to him and tried to provide diversional activities but he was hard to redirect. She stated she did not recall any specific care plan interventions for Resident #155 and she had not reassessed the effectiveness of care plan

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interventions.

During an interview on 07/29/16 at 8:01 AM Nurse #6 stated resident care plans were kept in a notebook at the nurse's station and staff referred to them as needed. She further stated care plans were initiated when a resident was admitted to the facility and nursing staff were supposed to come up with interventions on the care plan to provide interventions that best suited the resident. She stated she was aware nurses were expected to play a role in making changes on the residents care plans and care plans were supposed to be updated as needed however she did not recall Resident #155's care plan. She further stated she had not reassessed the interventions on the care plan to determine specific interventions for Resident #155's behaviors.

During an interview on 07/29/16 at 9:21 AM with Nurse #1 she stated Resident #155 had behaviors and wandered into other resident rooms and rummaged in their personal things. She explained resident's care plans were kept in a notebook at the nurse's station but was not sure what Resident #155's care plan indicated for interventions related to his behaviors other than to redirect him but he was very difficult to re-direct. She stated she had not reassessed the interventions on Resident #155's care plan and had not added any other specific interventions related to his behaviors.

During an interview on 07/29/16 at 9:25 AM Nurse #4 stated Resident #155 was confused and there was no way to re-direct him because it usually was not effective. She stated the only other intervention she recalled was to provide

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diversional activities to distract him but that only worked temporarily. She further stated she did not recall looking at a care plan for Resident #155 and had had not reassessed the interventions on his care plan.

During an interview on 07/29/16 at 8:57 AM the SW explained she completed the CAA worksheet dated 07/25/16 but had not received any formal training to complete CAA summaries or CAA worksheets and had made a mistake when she stated to care plan behaviors in one section but would not proceed to care plan behaviors in another section. She further stated she had not provided any input on the Admission Care Plan for Resident #155's behaviors.

During an interview on 07/29/16 at 4:00 PM MDS Nurse #1 confirmed she was responsible for resident care plans. She stated the Admission Care Plan which was also referred to as an interim care plan was placed in a resident's medical record on admission and nurses were expected to add to them and revise them as needed. She stated for the behavior care plan, nurses were expected to document interventions specific to the resident and if they were not effective they were supposed to reassess and revise the care plan. She explained after the care plan was initiated they should be updated so staff would know what specific interventions were needed for the resident. She stated the Admission Care Plan was initiated for Resident #155 with the standard interventions for behaviors but it had not been revised to include interventions specific to his behaviors.

During an interview on 07/29/16 at 5:44 PM the Director of Clinical Services stated it was her

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F 280	Continued From page 38 expectation to see resident care plans individualized. She further stated she would have expected to see specific interventions listed and updated for Resident #155's behaviors.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide a safe environment for residents and a resident wandered in and out of other residents rooms, touched them, rummaged through their personal items and spilled liquids on their bed for 3 of 3 residents sampled for behavioral and emotional status (Resident #155, #121 and #28) and failed to ensure the side rail on 1 resident's bed was secured (Resident #99) and failed to ensure dycem (a non-skid material) was placed on the seat cushion in a recliner for 1 resident (Resident #78) for safety to prevent accidents for 3 of 3 residents sampled for accidents. The findings included: a. Resident #155 was admitted to the facility on 07/12/16 with diagnoses which included blood clots of the deep veins of left lower extremity,	F 323	1) Resident #155 no longer resides in the facility. Resident #121 was assessed by the physician on7/28/2016. With no new orders noted. Resident #28 was interviewed b y the Social Services Director on 7/28/2016 to determine any concerns or psychosocial needs. No issues identified. Resident #99 side rail was tightened on 7/25/2016 by the Maintenance Director. Resident #78 had the dycem discontinued by the interdisciplinary team on 7/29/2016 and care plan was updated. 2) Side rails on current residents were checked for being secure on 7/26/2016 by the Maintenance Director. Current residents utilizing dycem for fall prevention were reviewed, and care plans and clinical monitoring tool were updated.	

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F 323	Continued From page 39 muscle weakness, lack of coordination, low back pain and Alzheimer's disease. A review of the admission Minimum Data Set (MDS) dated 07/19/16 indicated Resident #155 was severely impaired in cognition for daily decision making. A review of a section in the MDS for behaviors revealed Resident #155 had physical behaviors directed toward others which occurred 1-3 days, verbal behaviors directed toward others which occurred 1-3 days and rejection of care which occurred 1-3 days. The MDS also indicated Resident #155 required extensive assistance with dressing, toileting, hygiene and transfers but limited assistance with locomotion on the unit. A review of documents from a previous facility with a facsimile (fax) stamp dated 07/12/16 at 8:50 AM contained notes by a Social Worker (SW) which indicated Resident #155 had poor safety awareness and did not understand to call for assistance. The notes further revealed Resident #155 was considered to be an elopement risk due to wandering and had exit seeking behaviors and in the evenings had increased behaviors of wandering and resisted care. The notes indicated Resident #155 lived on a secured Alzheimer's unit for a more structured and secure environment. A review of an Admission Care Plan dated 07/12/16 with a problem statement of behaviors indicated a goal that Resident #155 would have fewer episodes of and the sentence was not finished. The approaches were listed with a check mark next to each as follows: redirect resident as needed, always ask for help if resident was abusive or resistive, keep environment calm and relaxed, remove from public area if behavior was improper and	F 323	Interdisciplinary team reviewed residents using dycem for fall management to determine continued use. Residents with falls are reviewed weekly in falls meeting for appropriate fall interventions. The interdisciplinary team observed residents with fall interventions 8/9/2016-8/24/2016. The Social Services Director performed Quality Improvement Monitoring of current residents for any psychosocial needs for their wellbeing, and any concerns for other residents with behaviors 8/17/2016-8/24/2016. 3) The Maintenance Director was in serviced by the Executive Director on maintaining the side rails on beds on 8/19/2016. The Regional Director of Clinical Services in serviced the Director of Social Services on providing psychosocial services to meet the residents wellbeing and how to follow up with residents with behavior's and update care plans to reflect specific interventions for those residents with behaviors On 8/23/2016. Licensed Nurses, Certified Nurse Assistants were in serviced by the Director of Clinical Services on keeping fall interventions in place or	

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F 323	Continued From page 40 encourage diversional activities. A review of an Admission Data Collection form which included the nursing admission assessment dated 07/12/16 at 3:30 PM revealed Resident #155 was disoriented to person, place and time at all times. The form also revealed he was at risk for elopement and had behavioral symptoms which included wandering, resisted care and had poor concentration. A review of a nurse's note dated 07/12/16 at 9:00 PM documented by Nurse #1 indicated Resident #155 was re-directed frequently from other residents ' rooms and it was difficult to talk to Resident #155 and he declined to change out of day clothes into night clothes. A review of a nurse's note dated 07/13/16 during the 7:00 AM to 3:00 PM shift documented by Nurse #6 revealed Resident #155 was observed going into another resident's room and was redirected. A review of a progress note by a Nurse Practitioner dated 07/13/16 indicated Resident #155 was alert and oriented to person only and required a significant amount of redirection. The note further indicated Resident #155 had been wandering in other residents' rooms. A review of a nurse's note dated 07/14/16 at 6:00 PM documented by Nurse #4 revealed Resident #155 wandered throughout the facility and in and out of other residents' rooms and had tried to go out an exit door. The notes further revealed a Wanderguard was in place. A review of a nurse's note dated 07/14/16 at 7:30	F 323	replacing items when not found. The Maintenance Director will perform Quality Improvement Monitoring of resident 's with side rails for being secure three times a week for eight weeks, two times a week for four weeks until substantial compliance is obtained and then quarterly thereafter for one year. The Social Services Director will monitor residents with behavior's for resident specific interventions and for resident psychosocial needs three times a week for four weeks, two times a week for four weeks and one time a week for four weeks and/or until substantial compliance is obtained and then quarterly thereafter for one year. The Director of Clinical Services and/or Nursing Supervisor will do Quality Improvement Monitoring of fall interventions in place five times a week for four weeks, three times a week for four weeks and two times a week for four weeks until substantial compliance is obtained then quarterly thereafter for one year.	

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F 323	Continued From page 41 PM documented by Nurse #4 revealed Resident #155 was confused and was easily agitated. The notes further revealed Resident #155 was difficult to redirect and became angry with staff and family and wandered in and out of other resident rooms. A review of a nurse's note dated 07/16/16 during the 7:00 AM to 7:00 PM shift revealed Resident #155 needed constant re-directing and cueing the entire shift. The note further revealed Resident #155 wandered in and out of the other resident rooms. A review of a nurse's note dated 07/18/16 at 7:00 PM documented by Nurse #1 revealed Resident #155 wandered into resident rooms and in the hall. A review of a nurse's note dated 07/18/16 at 8:00 PM documented by Nurse #1 revealed Resident #155 had been redirected twice from other resident rooms. A review of nurse's notes dated 07/19/16 at 11:35 AM documented by Nurse #7 revealed Resident #155 wandered into resident rooms and went through his roommate's personal things. The note indicated he would be moved to the locked dementia unit after lunch. During an interview on 07/27/16 at 4:16 PM Nurse #8 explained Resident #155 was difficult to redirect. During an interview on 07/29/16 at 8:57 AM the SW explained when Resident #155 was admitted to the facility she thought he would adjust and would get used to his surroundings and it wouldn't have problems. She further stated if staff had	F 323	4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	8/25/16

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concerns about his wandering behaviors and about his going into resident's rooms and in their personal belongings after a day or so they should have reported to the Director of Clinical Services and then to the SW.

During an interview on 07/29/16 at 9:21 AM Nurse #1 explained Resident #155 was difficult to re-direct. She stated Resident #155 couldn't communicate and had combative behaviors. She confirmed he went into other resident's rooms and rummaged through their things and that bothered them.

During an interview on 07/29/16 at 9:25 AM Nurse #4 confirmed she had provided care to Resident #155 and described him as confused and there was no way to re-direct him. She stated staff tried to re-direct him but usually it was not effective. She explained he rummaged around in other resident's stuff and wandered in and out of resident's rooms. She further explained she recalled having a conversation with the SW about her concerns of Resident #155 wandering in and out of other resident's room. She stated nursing staff re-directed and provide activities to residents who had wandering behaviors but approximately 85 percent of the time Resident #155 was difficult to redirect.

During an interview 07/29/16 at 11:39 AM with NA #3 she explained she had provided care to Resident #155 before he was moved to the locked dementia unit. She further explained he wandered into a female resident's room and tried to sit on her bed and she started yelling to get him out of her room. NA #3 stated she had to get another NA to assist her with getting him out of the room because he said the residents had told

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him he could come in and sit there. She explained when Resident #155 wandered they tried to get him to sit in a chair next to the nurse's medication cart so they could watch him but he got up and walked when he wanted to.

During an interview on 07/29/16 at 2:42 PM with the Director of Clinical Services she explained she met with Resident #155 the day he was admitted to the facility. She further explained he was admitted from another facility because his RP wanted him transferred. She stated the first time she heard any concerns about Resident #155's behaviors was from Nurse #1 on 07/18/16 when she reported she had problems with him wandering. She explained she did not feel the staff had communicated with her about Resident #155's behaviors because she was not made aware until 07/18/16.

b. Resident #121 who was Resident #155's roommate was admitted to the facility on 05/25/16 with diagnoses which included chronic lung disease, anxiety and depression. A review of the admission Minimum Data Set (MDS) indicated he was cognitively intact for daily decision making.

A review of a nurse's note dated 07/12/16 at 9:00 PM documented by Nurse #1 indicated Resident #121 was upset that Resident #155 had been going through his things.

A review of a nurse's note dated 07/13/16 at 5:45 AM documented by Nurse #1 indicated she was called to Resident #155's room by a Nurse Aide (NA) and Resident #177 was standing on Resident #121's side of room between the bed and wall and had urinated a small amount in the floor at the head of the bed and was about to

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urinate on Resident #121's head and face. The notes further indicated Resident #155 was redirected to the bathroom by 2 staff and he urinated a large amount in the toilet.

A review of a nurse's note dated 07/17/16 at 1:00 PM documented by Nurse #2 indicated Resident #155 had been aggressive and semi-combative during the evening of 07/15/16 with Resident #121.

A review of a nurse's note dated 07/18/16 at 9:00 PM documented by Nurse #1 revealed Resident #155 was sitting on Resident #121's bed while Resident #121 was out of the room and had spilled drinks that were on bedside table all over the bed. The notes further revealed Resident #121's bed linens were all tangled and Resident #155 had been drinking Resident #121's left over ice tea. The note indicated Resident #155 was redirected back to his bed with the assistance of 2 staff assist but he declined to get ready for bed.

A review of a nurse's note dated 07/18/16 at 10:00 PM documented by Nurse #1 revealed Resident #155 was redirected from Resident #121's side of the room and put in to bed but then got out of bed and re-arranged Resident #121's bed covers.

A review of nurse's notes dated 07/19/16 at 11:35 AM documented by Nurse #7 revealed Resident #155 went through Resident #121's personal things.

During an interview on 07/26/16 at 8:51 AM with Resident #121 he confirmed he had been struck in the right shoulder by Resident #155. He stated he tried to move out of the way of being struck

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but Resident #155 made contact with his right shoulder and further stated if he had not tried to move out of the way of Resident #155's strike, he would have received a harder strike. He further stated he immediately told the nurse of the incident but could not recall the name of the nurse. He explained he had not been able to get any rest or sleep when Resident #155 wandered around the room. He stated he thought approximately about 4 days after the incident the facility staff moved Resident #155 out of the room but he thought the facility staff should have moved Resident #155 out of his room sooner because he had not felt safe with Resident #155 wandering around in the room and getting into his personal belongings.

During a telephone interview on 07/27/16 at 12:45 PM Nurse #2 stated he was informed by Resident #121 on 07/17/16 that Resident #155 had become aggressive and combative during the evening of 07/15/16 and had struck him. He explained Resident #121 informed him that Resident #155 had made contact with his shoulder and he had tried to divert away from receiving the strike. Nurse #2 stated Resident #121 had denied any injury from the strike and had informed him Resident #155 had become aggressive and had been rummaging around in the room. Nurse #2 stated the Social Worker (SW) who he believed was part of Administration was in the facility and was informed on 07/17/16 that Resident #155 was not getting along with Resident 121 but did not remember if he had informed the SW if Resident #155 had struck him on 07/15/16. Nurse #2 further stated he was informed by the SW that the incompatible roommate situation would be handled on 07/18/16 when the Administrator and Director of

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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
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Nursing (DON) were back in the facility. Nurse #2 stated he should have informed the Director of Nursing and the Administrator that Resident #155 had struck Resident #121.

During an interview on 07/29/16 at 7:16 AM Nurse #3 explained Resident #155 rummaged through other resident's things and went into Resident #121's closet. She stated staff talked to Resident #155 and tried to distract him but at least half the time he rummaged through other resident's things and exhibited behaviors. She further stated she did not assess Resident #155 for behaviors because she thought that had already been done and she did not notify Resident #155's physician about behaviors because she thought that had already been done.

During an interview on 07/29/16 at 8:57 AM the SW explained she went to Resident #155's room the next morning after he was admitted because it had been reported he had wandered some. She stated she didn't document Resident #155's wandering behavior and she didn't hear any other concerns about behaviors until it was reported to her by Nurse #2 that Resident #121 was upset that Resident #155 had wandered around the room the night before and kept him awake. She further stated it was discussed in the morning meeting on 07/18/16 to look for a bed for Resident #155 in the locked dementia unit. She explained after the meeting she was at the nurse's station and Resident #155's roommate wanted to know if she was working on a room change. She stated she worked on the room change that day but the locked dementia unit was full. She stated on 07/19/16 a family agreed for a resident to move out so Resident #155 could be moved into the locked dementia unit.

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During an interview on 07/29/16 at 9:21 AM Nurse #1 explained one night Resident #155 got on Resident #121's bed and poured drinks on the bed. She stated Resident #121 finally put a lock on his closet door to keep Resident #155 from rummaging through his things.

During an interview on 07/29/16 at 2:42 PM with the Director of Clinical Services she explained the first time she heard any concerns about Resident #155's behaviors was from Nurse #1 on 07/18/16 when she reported she had problems with him wandering and he had been standing over Resident #121 who was in bed.

c. Resident #28, who lived next door to Resident #155, was admitted to the facility on 05/02/15 with diagnoses of rheumatoid arthritis, paralysis of left side and type II diabetes. A review of the most recent quarterly MDS revealed she was moderately impaired in cognition for daily decision making.

A review of a nurse's note dated 07/12/16 at 11:50 PM documented by Nurse #1 indicated Resident #155 wandered into the room next door by going through the bathroom and picked and poked at Resident #28 who was still sitting up in a wheelchair. The notes revealed Resident #155was redirected back to his room and was assisted with getting into bed and he was slightly confused.

During an interview on 07/29/16 at 8:57 AM the SW explained she was not aware Resident #155 had walked into Resident #28's room next door and had touched her.

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During an interview on 07/29/16 at 9:21 AM Nurse #1 explained she recalled the night Resident #155 went through the bathroom door into Resident #28's room next door. She stated a NA had reported to her that Resident #155 was pulling at her clothes and had touched her. Nurse #1 further stated she went to Resident #28's room and assessed her but did not see any scratches or bruising. She stated she felt at the time Resident #155 was looking for his wife and thought if Resident #28 had felt threatened she would have yelled because that's what she usually did if she wanted to get staff's attention.

During an interview on 07/29/16 at 2:42 PM with the Director of Clinical Services she stated staff had to keep their eyes on Resident #155 and Nurse #1 had told her he went through the bathroom into Resident # 28's room but did not feel staff had communicated with her in a timely manner about Resident #155's behaviors because she was not made fully aware until 07/18/16.

2. Resident #99 was admitted to the facility on 08/19/15 and readmitted on 04/14/16 with diagnoses which included history of stroke, generalized muscle weakness, hemiplegia left side, lack of coordination, muscle wasting, and debility.

A quarterly Minimum Data Set (MDS) dated 07/07/16 indicated Resident #99 was cognitively intact. The MDS specified Resident #99 required extensive assistance with activities of daily living (ADL) including transfers and bed mobility. The MDS further specified Resident #99 was impaired to one side of her upper extremities and both sides of her lower extremities.

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Review of a fall risk assessment dated 05/21/15 revealed Resident #99 used bilateral ¼ side rails which were indicated for safety and as an enabler to promote mobility independence.

Review of the re-admission data collection form dated 04/14/16 revealed Resident #99 was alert and oriented, had left sided weakness, and required extensive assistance with bed mobility and transfers.

Review of the quarterly data collection form dated 07/28/16 revealed Resident #99 expressed the desire to have bilateral ¼ side rails. The quarterly data form further revealed bilateral ¼ side rails were indicated for safety and as an enabler to promote mobility independence.

During an observation on 07/25/16 at 12:09: PM the bilateral ¼ side rails on Resident #99's bed were observed up. The right side rail was noted to be loose, wobbled back and forth and was cocked outwards with enough room to fit between the bed and the rail.

During an observation on 07/25/16 at 4:43 PM the right side rail remained loose as previously observed.

An interview was conducted on 07/25/16 at 4:45 PM with Nurse Aide (NA) #4 who was familiar with the care of Resident #99. NA #4 stated Resident #99 was able to turn herself and used the side rail as an assistive device to turn. NA #4 further stated the ¼ side rail for this bed had been tightened at least 3 times that she remembered. NA #4 explained she had completed a work order to tighten this side rail just last Thursday 07/21/16 and the maintenance man came and tightened it.

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An interview was conducted on 07/25/16 at 5:08 PM with the Administrator. He observed the side rail and stated the side rail should be tight and would have the maintenance man fix it right away. The Administrator further stated he now knows the rails for Resident #99's bed required tightening as well as side rails for other beds in the facility of the same kind. The Administrator revealed the facility maintenance supervisor reported to him that Resident #99's side rails actually had a loosened metal bracket that attaches the rail to the bed. The Administrator further revealed the facility was replacing the side rails to Resident #99's bed related to this loose bracket. The Administrator confirmed the side rail was loose and needed repaired. The Administrator further confirmed it was expected for all side rails to be attached correctly to beds to prevent accidents from occurring.

An interview was conducted on 07/28/16 at 11:15 AM with the Facility Maintenance Supervisor (FMS). The FMS stated he tightened the side rails on Resident #99's bed and he had a work order from 07/21/16 for side rails to be tightened. The FMS stated staff will complete work orders for side rails and he fixes them right away. The FMS further revealed he had tightened Resident #99's side rails without a work order in the past a number of times when he was out on the halls and staff would notify him. The FMS confirmed Resident #99's side rail was loose and needed repaired. The FMS further confirmed it was expected for all side rails to be attached correctly to beds to prevent accidents from occurring.

An interview was conducted on 07/28/16 at 3:10 PM interview with Nurse #4 who was familiar with

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the care for Resident #99. Nurse #4 stated she was unaware they were loose on Monday and further stated she was aware that Resident #99's rails had required maintenance to tighten them multiple times in the past.

An interview was conducted on 07/28/16 at 3:35 PM with the Director of Nursing (DON). The DON stated it was expected for all side rails to be attached correctly to beds to prevent accidents from occurring. The DON stated he was unaware that the side rail required tightening multiple times.

3. Resident #78 was admitted to the facility on 12/05/12 and readmitted on 08/24/15 with diagnoses which included arthritis, lack of coordination, generalized muscle weakness, dementia, history of falls, deformed fingers, osteoporosis, cervical disc disorder, orthostatic hypertension, syncopal episodes, and difficulty walking.

A quarterly Minimum Data Set (MDS) dated 04/03/16 indicated Resident #78 was cognitively intact. The MDS specified Resident #78 limited one person assistance with activities of daily living (ADL) including transfers and bed mobility. The MDS further specified Resident #78 was not steady and required a walker for ambulating.

Review of the care plan for Resident #78 initiated on 05/19/16 and last updated 07/08/16 identified the potential risk for falls related to impaired balance. The goals indicated for Resident #78 would be free of accident related injuries. The interventions included assist with transfers, keep room free of clutter, nonskid strips on the floor in front of chair, and dycem (a nonskid material

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F 323	Continued From page 52 used in chairs) to recliner seat cushion. Review of Resident#78's information kardex sheet for staff revealed under safety for dycem to be placed on recliner chair cushion. During an observation on 07/27/16 at 6:45 PM nonskid strips were noted on floor in front of the recliner for Resident #78. Further observation revealed no dycem was in place to Resident #78's recliner chair. During an observation on 07/28/16 at 9:19 AM nonskid strips were noted on floor in front of the recliner for Resident #78. Further observation revealed no dycem was in place to Resident #78's recliner chair. An interview was conducted on 07/28/16 at 4:48 PM with Unit Manager Nurse #5. Nurse #5 stated that interventions from falls investigations were reviewed in the morning team meetings. Nurse #5 stated as a team interventions were implemented and ensured the interventions and devices were in place for the residents as care planned. An interview was conducted on 07/28/16 at 4:55 PM with Nurse Aide (NA) #4 who was familiar with the care for Resident #78. NA #4 revealed Resident #78 was alert and oriented but forgetful at times. NA #4 further revealed Resident #78 required reminders to use her walker and had dizzy spells which we checked her blood pressures frequently for. NA #4 stated the strips in front of Resident #78's recliner were helpful to prevent her feet from slipping. NA #4 further revealed she was aware that dycem was used but was unsure why there wasn't any dycem in her	F 323		

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F 323	Continued From page 53 recliner. During an observation on 07/29/16 at 1:42 PM nonskid strips were noted on floor in front of the recliner for Resident #78. Further observation revealed no dycem was in place to Resident #78's recliner chair. An interview was conducted on 07/29/16 at 4:29 PM with the Director of Nursing (DON). The DON stated Resident #78 was being monitored for dizziness and falls related to decreased blood pressures and vertigo. The DON verified the dycem was not on the recliner chair cushion and further verified it was found in Resident #78's drawer. The DON stated it was her expectation that the dycem should be in place in the chair as care planned in order to decrease the risk of falls related to sliding out of the chair.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to 1) discard expired cottage cheese, 2) have a working system in place to	F 371	1) The Dietary Manager discarded expired Cottage cheese on 7/25/2016. The Dietary Manager discarded thawed milkshakes on 7/25/2016. The Director of Maintenance repaired the exterior door sweep in the kitchen on 7/27/2016. The Dietary Manger discarded the open container of dry cereal on 7/25/2016.	

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F 371	Continued From page 54 ensure thawed milkshakes were used before expiration 3) identify and correct a damaged exterior door sweep in the facility kitchen and 4) store an open container of dry cereal to prevent contamination. The findings included: 1. During the initial tour of the facility kitchen on 07/25/16 at 9:40 AM a 5 pound plastic container of cottage cheese was observed stored on shelving in the walk in refrigerator. Handwritten on top of the container of cottage cheese was "opened 06/28/16, use by 08/28/16." A manufacturer expiration date on the 5 pound container of cottage cheese was 07/17/16. The Food Service Director was present at the time of the observation and stated the cottage cheese was used in the lasagna. The Food Service Director acknowledged the cottage cheese was stored past expiration and stated the dates handwritten on the container were wrong. The lid was removed and approximately 3/4 of the cottage cheese had been used. Some of the remaining curds inside the 5 pound container of cottage cheese were pink tinged. The Food Service Director stated the pink tinge on some of the curds could have been tomato sauce residue from the last time the cottage cheese was used to make lasagna. Review of the facility preplanned menus noted lasagna was the planned lunch entree on 07/26/16. The Food Service Director discarded the outdated 5 pound container of cottage cheese. 2. During the initial tour of the facility kitchen on 07/25/16 at 9:40 AM an open case of thawed 4 ounce vanilla milkshakes was observed on shelving in the reach in refrigerator. The	F 371	2) The Dietary Manager performed observations of food storage areas for expired, undated open items and thawed milkshakes on 8/17/2016. The Dietary Manager has put a system in place to insure that each house shake that leaves the Dietary department has a 'used by' date. The Dietary Manager has put a system in place to insure that there are no products that are undated or outdated per manufacture recommendations. This will be done by dating every product with a 'use by' sticker that will correspond with a date that is previous to the manufactures expiration date. The Maintenance Director performed observations of doors with sweeps on 8/19/2016. 3) The Dietary Manager and Dietary Staff were in serviced by the District Dietary Manager on proper storage and disposal of expired food products on 8/19/2016. The Maintenance Director was in serviced by the Executive Director on maintaining	

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F 371	Continued From page 55 individual cartons of milkshakes included a manufacturer label noting the milkshakes were good for 14 days after thawed. The thawed vanilla milkshakes did not have anything written on the individual carton to indicate when they had thawed or the expiration date. The box housing the thawed vanilla milkshakes had handwritten on the outside of the cardboard container, "pulled 7/21, use by 8/3." On 07/25/16 at 10:25 AM and 07/26/16 at 8:35 AM a thawed 4 ounce strawberry milkshake was observed inside the nourishment pantry refrigerator. The individual carton of strawberry milkshake included a manufacturer label noting the milkshake was good for 14 days after it was thawed. There was nothing written on the strawberry milkshake to indicate when it had thawed or the expiration date. On 07/29/16 at 11:20 AM the Food Service Director stated kitchen staff dated the cardboard box housing the 4 ounce carton of milkshakes when the box was removed from the freezer. The Food Service Director stated the box was dated when it was pulled and included a "use by" date 14 days from the pull date. The Food Service Director stated she had not thought about the system to know the "use by" date of the 4 ounce milkshakes once they left the facility kitchen if the milkshakes were stored by staff in the nourishment pantry. 3. On 07/29/16 at 11:30 AM observations were made of the area surrounding the exterior exit door inside the facility kitchen. A rodent trap was observed in close proximity of the exit door, just inside the door. Daylight could be seen under the door in an approximate 1 1/2 foot section of the door sweep. The exterior door sweep of the exit door was observed and the 1 1/2 foot section of the door sweep appeared to be damaged. The Food Service Director stated she had not noticed	F 371	door sweeps on 8/19/2016. The Dietary Manager and/or Executive Director will perform Quality Improvement Monitoring of food storage areas for expired, undated open items and thawed milkshakes five times a week for four weeks, three times a week for four weeks, two times a week for four weeks until substantial compliance is obtained then quarterly thereafter for one year. 4) The Executive Director and Dietary Manager introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	8/25/16

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F 371	Continued From page 56 the damaged area of the door sweep and it was something that should be reported to maintenance for repair. The Food Service Director stated there had not been any evidence of rodents or rodents trapped in the kitchen area. 4. On 07/29/16 at 12:00 PM a 15 ounce box of dry cereal was observed stored on shelving in the dry storage area of the kitchen. The box of cereal had been previously opened and cereal was observed in the open manufacturer bag inside the box. The Food Service Director was present at the time of the observation and stated food product should not be stored open to air and her expectation was for manufacturer bags to be placed inside a resealable plastic bag once opened.	F 371		
F 514 SS=E	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 reviews and staff interviews the	F 514	1) Resident #77 was not injured related to this citation. Resident #40 was not injured related to this citation. 2) The Director of Nursing and/or Nursing Supervisor performed Quality Improvement Monitoring of medication administration records for completion of effectiveness of medications 8/9/2016-8/24/2016. 3) The Director of Nursing and/or Nursing Supervisor In serviced Licensed Nurses on completion and accurate charting of as needed medications when administered 8/9/2016-8/24/2016. The Director of	

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F 514	Continued From page 57 facility failed to complete medical record documentation for effectiveness or response of medications or nurse signatures for as needed (PRN) medications for 9 of 12 months for 2 of 5 residents reviewed for unnecessary medications (Resident #77 and #40). The findings included: 1. Resident #77 was admitted to the facility on 11/01/13 with diagnoses which included heart disease, dementia with behavioral disturbances, anxiety, mood disorder, psychosis and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 06/18/16 indicated Resident #77 was severely impaired in cognition for daily decision making and required extensive assistance with transfers, toileting and bathing but only required supervision with locomotion. A review of the monthly physician's orders dated 09/01/15 through 09/30/15 indicated Ativan 0.5 milligrams (mg) by mouth every 5 hours as needed (PRN) for anxiety state. A review of the medication administration record (MAR) dated 09/01/15 through 09/30/15 revealed the following: 09/01/15 at 1:30 PM Ativan 0.5 mg was given by mouth for increased agitation but there was no results or response documented and there was no nurse's signature. 09/02/15 at 1:30 PM Ativan 0.5 mg was given by mouth for increased agitation and anxiety but there was no results or response documented. 09/05/15 at 1:30 PM Ativan 0.5 mg was given by mouth for increased agitation but there was no results or response documented and there was	F 514	Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of medication administration record being filled out completely three times a week for four weeks, two times a week for four weeks and one times a week for four weeks until substantial compliance is obtained then quarterly thereafter. 4) The Clinical Services Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	8/25/16

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EMERALD RIDGE REHAB AND CARE CENTER	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

(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
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no nurse's signature.
09/10/15 at 4:30 PM Ativan 0.5 mg was given by mouth for increased agitation but there was no results or response documented and there was no nurse's signature.

A review of the monthly physician's orders dated 11/01/15 through 11/30/15 indicated Ativan 0.5 mg by mouth every 6 hours PRN for anxiety and agitation.

A review of the MAR dated 11/01/15 through 11/30/15 revealed the following:
11/15/15 at 11:25 AM Ativan 0.5 mg was given by mouth for increased agitation but there was no results or response documented and there was no nurse's signature.

A review of the monthly physician's orders dated 12/01/15 through 12/31/15 indicated Ativan 0.5 mg by mouth every 6 hours PRN for anxiety and agitation.

A review of the MAR dated 12/01/15 through 12/31/15 revealed the following:
12/04/15 at 1:00 PM Ativan 0.5 mg was given by mouth for increased agitation but there was no results or response documented and there was no nurse's signature.

A review of the monthly physician's orders dated 01/01/16 through 01/31/16 indicated Ativan 0.5 mg by mouth every 6 hours PRN anxiety and agitation.

A review of the MAR dated 01/01/16 through 01/31/16 revealed the following
01/02/16 at 3:25 PM Ativan 0.5 mg was given by mouth for kicking doors and increased anxiety but

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there was no results or response documented.
01/17/16 at 6:00 AM Ativan 0.5 mg was given by mouth for anxiety but there was no results or response documented.
01/31/16 at 3:50 PM Ativan 0.5 mg was given by mouth for increased restlessness but there was no results or response documented.

A review of the monthly physician's orders dated 02/01/16 through 02/08/16 indicated Ativan 0.5 mg by mouth every 6 hours PRN anxiety and agitation and was discontinued on 02/08/16.

A review of the MAR dated 02/05/16 at 2:00 PM revealed Ativan 0.5 mg was given by mouth for anxiety and pacing but there was no results or response documented.

A review of a physician's order dated 02/08/16 indicated Ativan 1.0 mg by mouth daily as needed for anxiety.

A review of the MAR dated 02/14/16 at 4:30 PM revealed Ativan 1.0 mg was given by mouth for increased anxiety and there was no results or response documented.

A review of monthly physician's orders dated 04/01/16 through 04/30/16 indicated Ativan 1.0 mg by mouth daily PRN anxiety

A review of the MAR dated 04/01/16 through 04/30/16 revealed on 04/09/16 Ativan 1.0 mg was given for increased agitation but no route was indicated, no result or response was documented and there was no nurse signature.

A review of the monthly physician's orders dated 05/01/16 through 05/31/16 indicated Ativan 1.0

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mg PO daily PRN anxiety

A review of the MAR dated 05/01/16 through 05/31/16 revealed on 05/17/16 at 3:30 PM Ativan 1.0 mg was given by mouth for increased anxiety but there was no results or response and no nurse signature documented.

A review of the monthly physician's orders dated 06/01/16 through 06/30/16 indicated Ativan 1.0 mg by mouth daily PRN anxiety

A review of the MAR dated 06/01/16 through 06/30/16 revealed on 06/28/16 at 4:30 PM Ativan 1.0 mg by mouth given for increased agitation and pacing but there was no results or response and no nurse signature was documented.

During an interview on 07/28/16 at 4:07 PM Nurse #8 stated nurses were expected to document on the back of the MAR when PRN medications were given and the documentation should include the date and hour given, the route, the reason for the medication, the results or response of the medication and the nurse's signature.

During an interview on 07/29/16 at 7:16 AM Nurse #3 explained nurses were expected to document the reason a resident requested PRN medications and nurses were supposed to document the effectiveness or the results of the medication. She further stated this documentation should be documented on the back of the MAR.

During an interview on 07/29/16 at 8:01 AM Nurse #6 stated nurses were expected to reassess the resident after a PRN medication

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was given to see if it was effective or not. She stated if the medication was not effective they were expected to write a note in the physician's communication book so the medication would be re-evaluated by the physician or nurse practitioner. She explained if a PRN medication was given for anxiety they were expected to document the behavior prior to administration and the effectiveness of the medication after it had been given and if the medication was not effective nurses were expected to notify the physician. She stated nurses were supposed to document effectiveness or the results of medications on the back of the MAR and they were supposed to document their signature.

During an interview on 07/29/16 at 1:59 PM the Director of Clinical Services stated it was her expectation for nurses to document on the back of the MAR when PRN medications were given and it should include date, the time of day, route the medication was given, name of medication, response or effectiveness of the medication and the nurse's signature. She explained she recognized there was a problem with nurses not documenting effectiveness of medications or their signatures and the Unit Coordinator would review documentation and leave notes for staff to complete their documentation.

2. Resident #40 was admitted to the facility on 04/15/14 with diagnoses which included dementia with behavioral disturbance, communication deficits, anxiety and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 06/17/16 revealed Resident #40 was severely impaired in cognition for daily decision making and required extensive

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F 514	Continued From page 62 assistance with activities of daily living. A review of monthly physician's orders dated 07/01/16 through 07/31/16 revealed Ativan 0.5 milligrams (mg) by mouth twice a day as needed for agitation and anxiety A review of a Medication Administration Record (MAR) dated 07/01/16 through 07/31/16 revealed the following: 07/11/16 at 6:30 PM Ativan 0.5 mg was given by mouth for increased agitation. There was no results or response documented and there was no nurse's signature. 07/18/16 at 5:45 PM Ativan 0.5 mg was given by mouth for increased agitation. There was no results or response documented. 07/20/16 at 5:10 PM Ativan 0.5 mg was given by mouth for increased agitation. There was no results or response documented and there was no nurse's signature. During an interview on 07/28/16 at 4:07 PM Nurse #8 stated nurses were expected to document on the back of the MAR when PRN medications were given and the documentation should include the date and hour given, the route, the reason for the medication, the results or response of the medication and the nurse's signature. During an interview on 07/29/16 at 7:16 AM Nurse #3 explained nurses were expected to document the reason a resident requested PRN medications and nurses were supposed to document the effectiveness or the results of the medication. She further stated this documentation should be documented on the back of the MAR.	F 514		

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F 514	Continued From page 63 During an interview on 07/29/16 at 8:01 AM Nurse #6 stated nurses were expected to reassess the resident after a PRN medication was given to see if it was effective or not. She stated if the medication was not effective they were expected to write a note in the physician's communication book so the medication would be re-evaluated by the physician or nurse practitioner. She explained if a PRN medication was given for anxiety they were expected to document the behavior prior to administration and the effectiveness of the medication after it had been given and if the medication was not effective nurses were expected to notify the physician. She stated nurses were supposed to document effectiveness or the results of medications on the back of the MAR and they were supposed to document their signature. During an interview on 07/29/16 at 1:59 PM the Director of Clinical Services stated it was her expectation for nurses to document on the back of the MAR when PRN medications were given and it should include the date, time of day, route the medication was given, name of medication, response or effectiveness of the medication and the nurse's signature. She explained she recognized there was a problem with nurses not documenting effectiveness of medications or their signatures and the Unit Coordinator would review documentation and leave notes for staff to complete their documentation.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	1) Facility has QAPI committee in place and implements plans for improvement and monitors and	

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F 520	Continued From page 64 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: The facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2015. This was for one recited deficiency which was originally cited in August of 2015 on a recertification survey and subsequently recited on the current recertification survey. The deficiency was in the area of accuracy of assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance	F 520	revises as needed through the QAPI process. 2) The RDCS re-educated the interdisciplinary team members on regulation F520 and the facility's policy and procedures for Quality Assurance Performance Improvement on 8/8/2016. The Minimum Data Set Coordinator reviewed the last 30 days of CAA's of current residents to ensure that strengths and weaknesses related to behaviors or psychosocial status was addressed 8/17/2016-8/24/2016 3) The Social Services Director was in serviced on completing accurate CAA's related to resident behaviors with identifying specific strengths and weakness's by the Regional Case Mix/MDS Coordinator on 8/22/2016. The Director of Clinical Services and/or the Minimum Data Set Registered Nurse will audit CAA's of residents with behavior's based on the MDS schedule for accuracy two times a week for twelve weeks or until substantial compliance is obtained then quarterly thereafter for one year. The Regional Vice President of Operations and/or RCDS will conduct Quality Improvement monitoring of	

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F 520	Continued From page 65 Program. Findings included: This tag is cross referred to: F 278 Accuracy of Assessment: Based on observations, record review, resident interview, and staff interviews the facility failed to accurately assess a resident's psychosocial problems and failed to identify strengths and weaknesses related to behaviors or psychosocial status for 1 of 21 residents sampled for Care Area Assessment Summaries (Resident #155). The facility was recited for F 278 for failing to accurately assess a resident's psychosocial problems and failed to identify strengths and weaknesses related to behaviors or psychosocial status. F 278 Accuracy of Assessment was originally cited during the August 13, 2015 recertification survey for failing to accurately assess a resident's dental needs on the admission, a significant change and 2 quarterly assessments for 1 of 1 resident. (Resident #84). During the recertification survey of July 29, 2016 the facility was cited again for failure to accurately assess a resident's psychosocial problems and failed to identify strengths and weaknesses related to behaviors or psychosocial status. During an interview on 07/29/16 at 6:12 PM the facility Administrator explained they monitored quality assurance activities in monthly and quarterly meetings. He stated they followed the plan of correction from the previous survey and they monitored the deficiencies from previous citations. He explained it was an ongoing	F 520	the facility's QAPI process and monitoring of cited deficiencies to ensure that cited deficiencies identified through the survey process attain and maintain compliance. 4) The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	8/25/16

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F 520	Continued From page 66 process and they tried to audit the things they had failed at in the past but it was difficult to monitor and keep everything in compliance because there was so much to monitor.	F 520		