STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY CARE CENTER	3625 WILLARD FARROW DRIVE CHARLOTTE, NC 28215

(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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/8/16

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

Electronically Signed | 08/31/2016

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete Care Area Assessments that addressed underlying causes, contributing factors and risks factors for 1 of 2 residents reviewed for activity of daily living (ADL) assessments (Resident #130). The findings included: Resident #130 had a diagnosis of bilateral hand contractures. The annual, comprehensive Minimum Data Set (MDS) dated 03/25/16 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making. The MDS also specified the resident had upper extremity impairments on both sides. The Care Area Assessment (CAA) dated 04/05/16 for Activities of Daily Living (ADL) was reviewed. The CAA referenced the need for extensive assistance for ADL but failed to address the resident's contractures. On 08/10/16 at 2:42 PM the MDS Coordinator was interviewed and reported that CAA for ADL would need to address contractures. She offered no explanation why the CAA did not include risk factors like contracted hands.	F 272	F272 A. The care plan and resident care sheet for resident #130 was updated immediately to reflect resident□s condition of hand contractures. Interventions were put into place, which included daily cleaning of the palms of the hands, and insertion of rolled washcloths into the hands. Completed on 8/11/2016 by the MDS coordinator and RN Supervisor. B. All residents at Asbury Care Center were assessed for contractures. The resident care plans and resident care sheets of those with contractures were reviewed and updated to ensure accuracy of resident□s condition. Completed on 8/11/2016 by the MDS coordinator. C. On a quarterly basis, the MDS coordinator will complete the contracture assessments for those residents that are due for the assessment. The RN supervisor will check the contracture assessment for accuracy. If the resident has a contracture and is due for an annual (or significant change assessment), the MDS coordinator will reference the contracture on the CAA. The RN supervisor will check that the CAA references the contracture. These quarterly assessments, and annual CAAs, will be audited for accuracy on a weekly basis by the RN supervisor and/or designee. These audits will be submitted to the DON/ADON for review on a weekly and ongoing basis.	

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F 272	Continued From page 2	F 272	D. The audits, as defined above, will be submitted and discussed in Quality Assurance meetings on a monthly basis X 6 months.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money 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:	F 278		8/29/16

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F 278	Continued From page 3 Based on record review, resident and staff interviews the facility failed to accurately document a resident's height on the comprehensive Minimum Data Set for 1 of 3 residents (Resident #197). The findings included: Resident #197 was initially admitted to the facility on 06/02/16 discharged to the hospital on 06/21/16 and readmitted to the facility on 06/29/16. Review of the most recent comprehensive Minimum Data Set (MDS) dated 07/06/16 revealed that Resident #197 was cognitively intact and required extensive assistance of 2 staff members with bed mobility, transfers, toileting, and personal hygiene. The MDS also indicated that Resident #197 was 6 inches (in.) tall. Review of a Nutrition Review/Assessment dated 07/01/16 revealed that Resident #197's height was 5.9 inches and weight was 286 pounds (lbs.). During an interview with Resident #197 on 08/09/16 at 3:47 PM Resident stated that he was 5 feet 9 inches tall. Interview with the MDS nurse #1 on 08/09/16 at 4:16 PM revealed that she had completed the MDS for Resident #197 dated 07/06/16 and the height was auto populated from the vital sign section of the electronic medical record and was inaccurate and just an oversight on her part. Interview with the Registered Dietician on 08/09/16 revealed that when she completed her assessment she talked to Resident #197 and he	F 278	F278 A. A. Resident #197□s height was corrected on the MDS assessment to accurately reflect resident□s height of 5 foot 9 inches. Completed on 8/9/2016 by the MDS Coordinator. B. All resident□s heights were re-measured and checked for accuracy. Resident□s heights were then ensured to be entered into the electronic medical record accurately, which then would populate over to the MDS accurately. Completed on or before 8/29/16 by the RN Supervisors and MDS coordinators. C. Ten percent of resident□s admission assessments will be audited for accuracy, which will include the resident□s height. Completed as an on-going basis by the MDS Coordinator and/or designee. D. Admission assessment audits will be submitted to the Quality Assurance meetings on a monthly basis X 6 months.	

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F 278	Continued From page 4 stated he was 5 feet 9 in. tall, so that was what she used to calculate Resident #197's nutritional needs. Interview with the Director of Nursing (DON) on 08/10/16 at 3:23 PM revealed that her expectation was that all MDS's were completely accurately. Interview with Administrator on 08/10/16 at 3:23 PM revealed that she had identified a concern when she came to this facility and recently hired a consulting agency to provide some oversight to the facility. The next scheduled visit was solely for the purpose of MDS oversight.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assess a resident for constipation and administer physician's standing orders for constipation for 2 of 5 residents (Resident #113 and #140) reviewed for unnecessary medication. Findings included: The facility Standing Orders, dated 12/2015 for "Bowel Protocol" included: "If there is no bowel	F 309	F309 A. Resident #113 and #140□s bowel reports were immediately run to ensure they had a bowel movement in the last 72 hours. Completed on 8/10/2016 by ADON. B. Bowel report was run on every resident at Asbury Care Center and report was reviewed to ensure that all residents	8/31/16

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F 309	Continued From page 5 movement for 2 days, the following corrective action(s) may be initiated by a nurse:" The Protocol specified that on the third day of no bowel movement (BM) the 3PM to 11PM nurse would give Milk of Magnesia 30 cubic centimeters at bedtime. The next day, if the resident had not had a BM, the 7AM to 3PM would do a digital exam of the rectum and give a glycerin suppository. If there was still no BM, the Bowel Protocol indicated the 3PM to 11PM nurse would administer a Dulcolax suppository at the beginning of the shift and on the second medication pass would administer an enema. If there was still no results the physician would be notified. The Protocol also stated the nurse could administer Senokot S 2 tablets everyday as needed if the resident refused to participate in the bowel protocol and was complaining of constipation. 1.Resident #113 was admitted to the facility on 7/1/14 and had diagnoses including arthritis and Alzheimer's disease. The most recent Minimum Data Set (MDS) (dated 7/6/16), indicated the resident was moderately cognitively impaired but was only sometimes understood. The MDS specified that the resident required extensive assistance for toileting and was usually incontinent of bowel and bladder. The Care Plan, most recently updated on 7/16/16, indicated the resident was on medications that put her at risk for constipation. Review of the July and August 2016 Medication Administration Record (MAR) revealed Resident #113 was receiving the following medications, with constipation as a drug-related side effect: Norco Tablet 5-325, 1 tablet twice a day, Depakote Sprinkles 125 mg, 1 capsule by mouth	F 309	identified as not having a bowel movement within 72 hours were initiated on the bowel protocol. Completed on 8/11/2016 by RN Supervisor. C. Licensed Nurses are being educated on bowel protocol and on initiating bowel protocol orders in the electronic administration record. Staff will be educated on this process on or before 8/31/2016. The RN supervisor will audit that the bowel protocol was initiated on residents identified as not having a bowel movement twice weekly X 2 months, and then weekly X 4 months. D. Bowel reports will be audited twice weekly X 2 months by the RN supervisor, and then weekly X 4 months by the RN supervisor. These audits as defined above will be taken to the monthly QA meetings.	

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F 309	Continued From page 6	F 309		

in the morning, and 3 capsules before bed time, Trazadone 50mg 1 tablet at bedtime, and Seroquel 25mg at bedtime.

Review of Resident #113's bowel elimination record revealed that from 7/30/16 through 8/5/16 (7 days) no bowel movement was documented.

Review of medical record revealed Resident #113 had a physician's order dated 2/16/16, for Senexon S 1 tablet by mouth daily that was given as scheduled. The resident also had physician's orders for Miralax powder (dated 2/15/16) 17 grams, Milk of Magnesia (dated 2/15/16) 30 milliliters and a Glycerin suppository (dated 7/2/16), all to be given as needed for constipation.

There was no documentation in Resident #113's medical record on the July or August 2016 MARs of the implementation of a bowel protocol for constipation from 07/30/16 to 08/04/16. Milk of Magnesia was documented as given on 8/5/16, and on 8/6/16, the resident had a large bowel movement.

On 8/11/16 at 7:55 AM the Director of Nursing stated she felt the problem was with staff. The DON said, " Either the aides are not documenting BMs or the nurses are not following up on results, or not giving Milk of Magnesia or not documenting [the medications for constipation.] "

During an interview on 8/11/16 at 10:22AM, NA #2 stated Resident #113 did not have a BM every day and when she did have a bowel movement it was usually very hard.

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F 309	Continued From page 7	F 309		

Nurse #4 was interviewed on 8/11/16 at 10:28AM. Nurse #4 specified that the evening shift supervisors monitored the resident's bowel status but that the nurses did not routinely check bowel status.

Evening Shift Supervisor #1 was interviewed on 8/11/16 at 11AM. Supervisor #1 stated that when she worked, she had been instructed to pull the bowel records for the 3 previous days and give them to the nurses on each unit. She stated if a resident did not have a BM in 3 days the standing orders for constipation should be implemented. Supervisor #1 said, "I just give it to the nurses and tell them to do the protocol." She could not recall asking about any follow-up for Resident #113's bowel status, or why the protocol had not been implemented but added that the nurses were responsible for following it up by passing the information along in shift report.

During an interview on 8/11/16 at 11:26 AM, The Assistant Director of Nursing said, "I expect the [bowel] report to be pulled by the 3-11 Supervisor. She should disperse the reports to the floor nurses. The nurses should initiate the Standing orders of the bowel protocol. Ideally I'd like the Supervisor to be following through that the nurses are following the protocol. And I would expect the nurses to do a progress note of why the resident is refusing or that the NAs are not documenting the BMs."

2.Resident #140 was admitted to the facility on 8/6/15 with diagnoses including quadriplegia and anemia. The most recent Minimum Data Set (MDS) (dated 5/3/16), indicated the resident was cognitively intact. The MDS specified the resident

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F 309	Continued From page 8	F 309		

required total assistance for toileting and was usually incontinent of bowel. The Care Plan, most recently updated on 7/11/16, did not indicated the resident was at risk for constipation.

Review of the July 2016 Medication Administration Record (MAR) revealed Resident #140 was receiving the following medications, with constipation as a drug-related side effect: Ferrous Sulfate 325milligrams (mg) twice a day, and Tizanidine 2mg at bedtime for muscle spasms.

Review of Resident #140's bowel elimination record revealed that from 7/1/16 through 7/14/16 (14 days) no bowel movement was documented.

Review of medical record revealed Resident #140 had a physician's order dated 2/15/16, for Senexon S 1 tablet by mouth twice daily that was given as scheduled. The resident also had physician's orders for Miralax powder (dated 5/20/16) 17 grams, and a Bisacodyl suppository 10mg (dated 2/15/16), both to be given as needed for constipation.

There was no documentation in Resident #140's July 2016 MAR of the implementation of a bowel protocol for constipation from 7/1/16 to 7/14/16 except that the Miralax powder was administered one time on 7/6/16. The bowel elimination record revealed the resident had a large bowel movement on 7/15/16.

On 8/11/16 at 7:55 AM the Director of Nursing stated she felt the problem was with staff. The DON said, "Either the aides are not documenting BMs or the nurses are not following up on results, or not giving Milk of Magnesia or not documenting

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F 309	Continued From page 9 [the medications for constipation.]" During an interview on 8/11/16 at 10:43AM, NA #3 stated Resident #140 had regular BMs. Nurse #5 was interviewed on 8/11/16 at 10:52AM. Nurse #5 stated she didn't always work with the resident but that when she had changed his sacral dressing, he had loose stools. Evening Shift Supervisor #1 was interviewed on 8/11/16 at 11AM. Supervisor #1 stated that when she worked, she had been instructed to pull the bowel records for the 3 previous days and give them to the nurses on each unit. She stated if a resident did not have a BM in 3 days the standing orders for constipation should be implemented. Supervisor #1 said, "I just give it to the nurses and tell them to do the protocol." She could not recall asking about any follow-up about Resident #140's bowel status, or why the protocol had not been implemented but added that the nurses were responsible for following it up by passing the information along in shift report. During an interview on 8/11/16 at 11:26 AM, The Assistant Director of Nursing said, "I expect the [bowel] report to be pulled by the 3-11 Supervisor. She should disperse the reports to the floor nurses. The nurses should initiate the Standing orders of the bowel protocol. Ideally I'd like the Supervisor to be following through that the nurses are following the protocol. And I would expect the nurses to do a progress note of why the resident is refusing or that the NAs are not documenting the BMs."	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		9/8/16

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F 318	Continued From page 10 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to implement hand rolls for a resident with bilateral hand contractures for 1 of 2 sampled residents (Resident # 130). The findings included: Resident #130 was admitted to the facility on 01/19/15 with diagnoses that included muscle contractures of left and right hands, dementia and others. The most recent Minimum Data Set (MDS) dated 06/25/16 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making. The MDS also specified the resident had physical behaviors directed towards others and did not reject care, required extensive assistance with activities of daily living (ADL) and had impaired functional limitation in range of motion on both sides of his upper extremities. A document titled "Occupational Therapy Discharge Summary" dated 01/27/16 specified Resident #130 did not tolerate palm guard and to be discharged for a Functional Maintenance Program (FMP). A care plan updated on 07/07/16 identified the resident had an ADL deficit related to dementia and contractures. Resident #130 was to have skin care daily to keep hands clean and prevent	F 318	F318 A. The care plan and resident care sheet was updated immediately to reflect resident #130□s condition of hand contractures. Interventions were put into place, which included daily cleaning of the palms of the hands, and insertion of rolled washcloths into the hands. Completed on 8/11/2016 by the MDS coordinator and RN Supervisor. B. All residents at Asbury Care Center were assessed for contractures. The resident care plans and resident care sheets of those with contractures were reviewed and updated to ensure accuracy of resident□s condition. Completed on 8/11/2016 by the MDS coordinator. C. On a quarterly basis, the MDS coordinator will complete the contracture assessments for those residents that are due for the assessment. The RN supervisor will check the contracture assessment for accuracy. If the resident has a contracture and is due for an annual (or significant change assessment), the MDS coordinator will reference the contracture on the CAA. The RN	

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F 318	Continued From page 11 skin breakdown. On 08/09/16 at 2:06 PM Resident #130 was in bed with his hands clinched. During the observation, there were no interventions in place to the resident's hands. On 08/09/16 at 3:01 PM nurse aide (NA)# 1 was interviewed and stated she routinely cared for Resident #130 and was aware his hands were contracted. She explained that she did not make attempts to place hands rolls or wash cloths in the resident's hands because at times he would refuse. She added that she wasn't aware if Resident #130 was supposed to have hand rolls in place because the resident "daily sheet" (a sheet with individualized instructions for caring for residents) did not specify the use of hand rolls. On 08/09/16 at 3:12 PM Nurse # 3 observed Resident #130's hands and reported they were contracted. The nurse opened Resident #130's right hand and his fingernails were noted to have left indentions in his palm. The Nurse stated she wasn't sure if the resident should have palm protection in place for the contractures and/or to prevent skin breakdown. On 08/09/16 at 4:14 PM the Director of Nursing (DON) was interviewed and reported that she would expect staff to try to apply hand rolls daily to Resident #130's contracted hands.	F 318	supervisor will check that the CAA references the contracture. These quarterly assessments, and annual CAAs, will be audited for accuracy on a weekly basis by the RN supervisor. These audits will be submitted to the DON/ADON for review on a weekly and ongoing basis. D. The audits, as defined above, will be submitted and discussed in Quality Assurance meetings on a monthly basis X 6 months.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		9/8/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to air dry plastic glasses and service trays, stacking them while still wet, and failed to maintain the temperature of thickened liquids at or below 41 degrees Fahrenheit during operation of the tray line. Findings included: During review of the kitchen on 8/10/16 at 10:01 AM, Dietary Staff #1 was observed removing dishware from the dishwasher after the rinse cycle. Dietary Staff #1 pulled a dishwashing tray from the dishwasher and 22 of the 30 plastic glasses was standing upright and filled with rinse water. Dietary Staff #1 dumped the water out and immediately stacked the glasses, with 14 in one stack and 16 in the other stack. When asked why she was stacking them, Dietary Staff #1 indicated she was in a hurry and space was limited. At 10:11 AM on 8/10/16, Dietary Staff #2 took the stacks of glasses and set them out individually onto a tray in the upright position. He indicated they were put this way in preparation for the residents' lunch and would soon be filled with water and tea. Observation revealed 25 of the 30 glasses ready for use had standing rinse water in them. During an interview on 8/10116 at 11:33 AM, the Dietary Supervisor stated she trains new staff to rinse everything and then run it through the dishwasher. She said when the plates, cups and glasses come out of the dishwasher, they should be allowed to dry in the racks and glasses/cups should be upside-down until ready to use. She	F 371	F371 1. A. Compliance was accomplished through immediate correction, and adherence thereafter, to facility policy on ware washing and sanitation, effective immediately. Glassware at time of citation was sanitized via high temp dish machine, with final rinse temperatures of >185 degrees. All glassware was turned over and allowed to air dry completely in racks prior to refilling for next meal. Monitored on 8/10/2016 by Dietary manager. B. All residents will only be served glassware at meal times that has been completely air- dried after washing, and prior to refilling. Completed on an ongoing basis beginning 8/10/2016. A. Dietary Manager and/or designee will regularly observe dishroom and ware-washing activity. Observation will include ongoing education/re-education, and correction of improper techniques to ensure all staff are in compliance. Weekly audits will take place to ensure that facility policy is adhered to with regard to proper sanitation of glassware. Audits will include checking machine wash/rinse temperatures, proper removal of glassware from dishwasher, and ensuring that wet glassware is properly drained and allowed to air dry completely prior to	

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	345544	A. BUILDING _____ B. WING _____	C 08/11/2016

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F 371	Continued From page 13 also stated, "Only the silverware goes through the washing cycle twice." The Dietary Supervisor could not remember when Dietary Staff #1 and Dietary Staff #2 had been inserviced on dishwashing/drying protocol. During an interview on 8/10/16 at 12:22 PM, the Dietary Manager indicated it was her expectation that dishware be allowed to dry because when stacked wet there is increased risk of bacteria forming. 2. On 8/10/16 at 11:44 AM, Dietary Staff #2 was observed filling glasses in a tray with ice and thickened liquids. At 12:12PM on 8/10/16, the Dietary Manager (DM) calibrated a thermometer and began checking food temperatures on the third floor tray line. The temperature of the thickened sweet tea was 53 degrees Fahrenheit. On 8/10/16 at 12:22 PM, the DM took the temperature of the thickened tea and a thickened water on the second floor tray line and found them to be 68 degrees and 60 degrees Fahrenheit, respectively. She stated she was very surprised and she expected beverages to be less than 40 degrees when served.	F 371	service. The Dietary manager and/or designee will complete audits and monitor for compliance immediately and ongoing. B. The dishroom audit results will be discussed in monthly QA meetings X 6 months. 2. A. In order to ensure that these beverages are chilled at the time of service, an adequate supply of unopened containers of thickened water and tea will be chilled prior to pouring for service. This procedure was effective immediately on 8/10/2016. B. All thickened beverages will be chilled to <40 degrees prior to service, for all residents who require thickened liquids beginning 8/10/2016. Packages of thickened tea and water are properly kept in dry storage at room temperature, and are safe at room temperature for 8 hours after package opening, according to manufacturer's instructions. C. Weekly audits will take place to ensure that facility policy is adhered to with regard to beverage temperatures. Audits will involve checking temperatures of thickened beverages served at mealtimes in order to ensure they are served chilled. Ongoing education and re-education will be provided to ensure adherence to policy. The Dietary manager and/or designee will complete audits and monitor for compliance beginning 8/29/2016 and ongoing. D. The thickened beverage audit results will be discussed in monthly QA meetings	

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F 371	Continued From page 14	F 371	X 6 months.	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to reduce the chance of infestation by insects, rodents, and vermin by allowing the dumpster area to become cluttered with debris and by failing to keep the dumpster lid closed on 1 of 1 dumpster. Findings included. On 8/10/16 at 2:30 PM, a review of the dumpster area was conducted with the dietary manager. The observation revealed 2 paper cups, 8 plastic cup lids, approximately 12 blue latex gloves, plastic wrappers, a plastic bag, a 15 ounce tin can, 8 pieces of plastic silverware, and a soda can were in an area about 3 feet square, between the dumpsters and the grease trap container. The debris was mixed with old leaves in various stages of decay. The lid to the dumpster was also open and there were flies in the area. During an interview at 2:45 PM on 8/10/16, Dietary Manager stated that the facility had a service who emptied the dumpster and another service who monitored the grease trap container. She stated that she had never looked at the area between the two containers. The Dietary Manager stated it was her expectation that the area be free	F 372	F372 A. Garbage was removed by dietary staff. Leaves and debris were cleaned by the groundskeeping department. Complete on or before August 11th, 2016. B. All areas around dumpster will be kept free of garbage and leaves. Completed on ongoing basis. C. The area where garbage and leaves were found will be inspected regularly to ensure that garbage is not being disposed of by any individuals, either within or outside of the dietary department. The groundskeeping department will also monitor the area and perform removal of leaves and debris as needed. The specific area, located between the dumpster and the grease disposal bin, will be added to the regularly conducted monthly audits under the existing title Receiving areas, refuse disposal. The dietary manager or designee will complete the audits and monitor for compliance on an ongoing basis. D. The refuse disposal audit results will be discussed in monthly QA meetings X 6 months.	9/8/16

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F 372	Continued From page 15 of anything that would attract pests or vermin.	F 372		
F 500 SS=B	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to obtain a written agreement for services provided by an outside provider for 3 of 3 residents (Resident #158, Resident #197, and Resident #227) receiving dialysis services and the residents received dialysis without a contract in place. The findings included: The recertification survey was held on 08/08/16 through 08/11/16. On 08/08/16 the facility provided a list of 3 residents in the facility that	F 500	F500 A. Admissions Director immediately contacted to dialysis providers for residents #158, #197 and #227 and initiated the process to get a contract between Fresenius and DaVita Dialysis Providers and Asbury Care Center for the outside services they are providing. Contact with providers was made on 8/11/2016 and contracts were initiated by the Admissions Director. B. All resident□s charts that are currently receiving dialysis services were reviewed	8/22/16

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F 500	Continued From page 16 were receiving outside hemodialysis services. On 08/09/16 at 3:20 PM the Administrator and Director of Nursing (DON) were asked for the hemodialysis contract and stated that they had no contract because everyone went a different dialysis facility and their only responsibility was to arrange transportation for the residents. During an interview with the Administrator on 08/10/16 at 11:01 AM she confirmed that the facility had no dialysis contract in place because none of their long term members required dialysis. The Administrator further stated that the residents that were in the facility that required dialysis were short term and would be discharging fairly quickly and the facility did not advertise that they provided the dialysis services. The Administrator agreed that they should have an agreement in place like they did for hospice services and that she would work on obtaining a contract for dialysis.	F 500	to determine the location of dialysis. The Admissions Director reached out to each dialysis provider for a written contract. Contract obtained with current dialysis providers on or before 8/22/2016. Upon admitting any new resident receiving dialysis services, Admissions Director will ensure a contract is in place upon admission to Asbury Care Center. Completed on 8/11/2016 and ongoing. C. Director of Nursing and/or designee will audit dialysis patient□s charts on a monthly basis X 12 months to ensure a contract with their dialysis provider is in place. Completed immediately and on an ongoing basis. D. The Dialysis contract audit will be discussed at monthly QA meetings X 12 months.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		9/8/16

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F 514	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately document a resident's contractures in the medical record for 1 of 1 sampled resident (Resident #130) and documented on the wrong resident in a Care Are Assessment for 1 of 5 sampled residents (Resident # 197). The findings included: 1. Resident #130 was admitted to the facility on 01/19/15 with diagnoses that included muscle contractures of left and right hands, dementia and others. The most recent Minimum Data Set (MDS) dated 06/25/16 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making and had impaired functional limitation in range of motion on both sides of his upper extremities. A care plan updated on 07/07/16 identified the resident had an ADL deficit related to dementia and contractures. An assessment titled "Contracture Assessment" dated 07/07/16 completed by Nurse #1 specified Resident #130 had full extension of left and right fingers. On 08/09/16 at 2:06 PM Resident #130 was observed in bed. His hands were clinched. The resident was unable to open his hands. On 08/09/16 at 2:37 PM Nurse #1 was interviewed and reported that Resident #130 had bilateral hand contractures. She reviewed the contracture assessment dated 0707/16 and stated the assessment was inaccurate.	F 514	F514 1. A. The contracture assessment for resident #130 was corrected for errors and inaccuracies. Completed on or before 8/29/16 by the MDS Coordinator. B. All contracture assessments of current residents were assessed for accuracy. Completed on 8/11/16 by the MDS Coordinator. C. On a quarterly basis, the MDS coordinator will complete the contracture assessments for those residents that are due for the assessment. The RN supervisor will check the contracture assessment for accuracy. If the resident has a contracture and is due for an annual (or significant change assessment), the MDS coordinator will reference the contracture on the CAA. The RN supervisor will check that the CAA references the contracture. These quarterly assessments, and annual CAAs, will be audited for accuracy on a weekly basis by the RN supervisor. These audits will be submitted to the DON/ADON for review on a weekly and an ongoing basis. D. The audit, as defined above, will be submitted and discussed in Quality Assurance meetings on a monthly basis X 6 months. A. Resident #197□s CAA was modified to reflect accurate pronoun of he rather than she. Resident□s Care Area Assessment	

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F 514	Continued From page 18 2. Resident #197 was initially admitted to the facility on 06/02/16 discharged to the hospital on 06/21/16 and readmitted to the facility on 06/29/16. Review of the most recent comprehensive Minimum Data Set (MDS) dated 07/06/16 revealed that Resident #197 was cognitively intact and required extensive assistance of 2 staff members with bed mobility, transfers, toileting, and personal hygiene. Review of a physician order dated 07/01/16 read 1 liter fluid restriction. Review of the Care Area Assessment (CAA) dated 07/07/16 titled Dehydration/Fluid Maintenance read " Resident will not be dehydrated. He will consume adequate fluids. Her labs will be normal for her. She will not have skin breakdown, UTI, or constipation. She will be offered fluids on med pass, care rounds, meals, and snack rounds. She voices an understanding of the availability of food/fluids on the unit at all times. Will proceed to care plan. " Review of the Nutritional CAA dated 07/07/16 read in part that Resident #197 was on 1 liter fluid restrictions per day. Interview with Resident #197 on 08/09/16 at 3:47 PM revealed that he was on fluid restrictions because of his kidneys and the fact that he was on dialysis. Resident #197 stated that he received 8 ounces of fluids 3-4 times a day and that he only drank what was given to him. Resident #197 stated that they did not routinely offer him fluids because of the restrictions, and that if he became thirsty he would chew on ice but he rarely had to do that. Interview with Nurse #2 on 08/09/16 at 3:57 PM revealed that Resident #197 was on fluid	F 514	was also modified to reflect resident□s one-liter fluid restriction. Completed on 8/7/2016 by the MDS Coordinator nurse. B. All resident□s CAAs that are currently on fluid restrictions and/or dialysis were checked for accuracy. All resident care plans and resident care sheets that are currently on fluid restrictions and/or dialysis were checked for accuracy. Completed on or before September 5, 2016 by the RN Supervisors and MDS Coordinators. C. Ten percent of resident□s admission assessments will be audited for accuracy, which will include the resident□s dehydration assessment and initial care plan. Completed as an ongoing basis by the MDS Coordinator or designee. D. Admission assessment audits will be submitted to the Quality Assurance meetings on a monthly basis X 6 months.	

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F 514	Continued From page 19 restrictions and that on her shift he received 200 milliliter of fluids. Nurse #2 stated that they did not routinely offer Resident #197 fluids due to his restrictions and that rarely Resident #197 would chew on ice if he got thirsty. Interview with the MDS Nurse on 08/09/16 at 4:16 PM confirmed that she had wrote the Dehydration/Fluid Maintenance CAA for Resident #197 but stated after reading the CAA " that may have been wrote for someone else. " The MDS Nurse stated that Resident #197 was a male and was on fluid restrictions and in the CAA she had referred to the resident as a female and was offering fluids multiple times a day. The MDS nurse stated that clearly the CAA was incorrect and may have been intended for another resident and was a mistake on her part. Interview with the Director of Nursing (DON) on 08/10/16 at 3:23 PM revealed that her expectation was that all MDS's and CAA's were completely accurately for the correct resident.	F 514		