STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

(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 253 SS=D	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, staff and resident interviews and record review the facility failed to keep a wheelchair, privacy curtain and walls clean for one of 20 residents. (Resident #12) The findings included: Observations on 8/2/2016 at 11:12 AM revealed Resident #12 was seated in her wheelchair in her room. Observations of the wheelchair revealed dried build-up of brown substance and dried food crumbs on the frame of the wheelchair. The dried build-up was observed on the front corners of the frame next to the seat and on the sides of the frame. Observations at this time included the wall behind the head of her bed and the privacy curtain. There were dried brown flecks on the wall the width of the headboard, and extending up to and including the ceiling. Brown dried substances were on the privacy curtain facing Resident #12 ' s bed. Observations on 8/3/2016 at 2:00 PM and 8/4/2016 at 9:00 AM revealed the wheelchair, wall, and privacy curtain had not been cleaned. Interview on 8/4/2016 at 9:00 AM with the Maintenance Director revealed he was also over housekeeping services. Rounds were made with the Maintenance Director in Resident #12 ' s room. Interview with the Maintenance Director revealed he was not aware the wall and privacy curtain needed cleaning. He further explained nursing was responsible for the cleaning of the	F 253	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: For Resident #12 the wheelchair and wall was cleaned. The privacy curtain was removed and another clean curtain was put back up on August 5, 2016. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Each resident's room was checked by the Administrative Staff to ensure that the wall's were clean as well as the privacy curtains. There were no other issues noted. All resident wheelchairs were	8/10/16

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

Electronically Signed | 08/26/2016

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F 253	Continued From page 1 wheelchair. That had been a duty of housekeeping, but in the last month nursing had taken over cleaning of the wheelchairs. Interview with the Director of Nursing (DON) on 8/4/2016 at 9:25 AM revealed a cleaning scheduled was in place to clean the wheelchairs on night shift by nursing. Interview with the DON on 8/4/16 at 11:05 AM revealed she had completed a QA (Quality Assurance) on wheelchair cleaning in July. Resident #12's wheelchair was checked by the DON on 7/22/16. A weekly "wipe down" was to be completed by the aides and the nurse was to sign a monitoring tool indicating the wheelchair was cleaned. Review of the weekly schedule revealed a nurse's initials for 8/1/16 the wheelchair had been "wiped down." That nurse was on vacation during the survey and was unable to be reached for interview. The DON observed Resident #12's wheelchair and stated "no, it's not clean". There was dried crumbs and dried, build-up food spills on the frame of the wheelchair. Interview on 8/4/2016 at 3:30 PM with the Administrator revealed a schedule had been prepared for Maintenance to keep up with the housekeeping tasks. She explained he had not had a system in place prior to 7/29/2016. The housekeeping check list had not been implemented prior to the survey.	F 253	checked by the Administrative Staff and if found to need cleaning was cleaned by the CNA's. The areas identified were checked by the Administrative Staff on August 5, 8, and 9, 2016 ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The responsibility for cleaning the wheelchairs/geri-chairs on a weekly basis has been assigned to the CNA's on third shift. The chairs will be assigned to CNA assigned to the resident on the scheduled cleaning day. The CNA's are responsible to complete a QA for wheelchairs/geri-chairs and turn it into the DON on a weekly basis. The DON will review the QA checklist for accuracy of all chairs being washed/cleaned for that week daily for one (1) month; bi-weekly for two (2) months and monthly for six (6) months. On a daily basis Monday through Friday the Administrative Staff are assigned to certain rooms as determined by a schedule made by the Administrator to check the resident rooms for the following in addition to the other areas already being reviewed: 1. Wheelchairs clean 2. Privacy curtains/walls 3. Side Rails being in place and not loose	

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F 253	Continued From page 2	F 253	4. Calls lights in place and in working order The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and put a corrective plan into place at that time. The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The DON will be responsible to bring the QA checklist of all chairs being washed/cleaned for that week for one (1) month; bi-weekly for two (2) months and monthly for six (6) months. The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and put a corrective plan into place at that time.	

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F 253	Continued From page 3	F 253	The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. The VP of Operations will be responsible to conduct a Quality Assurance Round on a monthly basis for six (6) months to evaluate the system and ensure the facility is sustaining the corrective plan put into place. The results of the QA check by the VP of Operations will also be reported to the Quality Assurance Committee for six (6) months. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274		8/12/16

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F 274	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change assessment for one of twenty residents (Resident #24). The findings included: Res #24 was admitted to the facility on 4/11/16 with diagnoses of Alzheimer's disease and arthritis at multiple sites. The Admission Minimum Data Set (MDS) assessment dated4/16/16 indicated Resident #24 had long and short term memory impairment, behaviors of rejection of care, required extensive assistance of two staff for bed mobility and transfers, supervision of one person to walk in the room and hallway, extensive assistance of one person for toileting, and personal hygiene. This MDS indicated the resident was always incontinent of bowel and frequently incontinent of bladder. Resident #24 had two falls since admission, one with injury. Review of the Care Area Assessment dated 4/16/16 for fall, indicated she had a history of falls, had 2 falls since admission. A personal body alarm (PBA) was in place when she was in bed. There were no referrals made, and a decision was made to proceed to care plan to monitor for fall related injuries. Review of a nurse ' s note dated 5/8/16 at 6:00 PM revealed Resident #24 was in a wheelchair near the nurse ' s station. She stood up, and the wheelchair moved due to not locking the brakes. Resident #24 twisted to the left, fell up against the	F 274	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The resident has been assessed by the MDS Nurse and the Interdisciplinary Team and the Care Plan reflects the resident's changes and needs. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents were evaluated to determine if a significant change was necessary and no other residents met the criteria for a significant change. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: When a resident is admitted or re-admitted the facility will have a Post Admission Meeting seventy-two hours after admission or readmission with the Interdisciplinary Team to discuss the each disciplines assessment to determine if there has been a decline or improvement in the resident. The MDS Nurse will use the information gleaned from this meeting to assist them in the determination that a	

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F 274	Continued From page 5 wall and landed on her bottom. Resident #24 put her left hand down to catch herself. She complained of pain in her left wrist, left lower leg and upper thigh. She was sent out to hospital, had sustained a fracture of the wrist, fracture of the femoral neck of left hip with total hip replacement arthroplasty. A cast was placed on the left wrist. She was discharged back to the facility on 5/16/16. Review of the nurse ' s notes dated 5/23/16 revealed Resident #24 " dependent on staff for all ADL ' s, incontinence care, feeding, repositioning in bed, bathing/grooming. On bed rest @ (at) present time as ordered, using log roll and lift sheet for positioning ... " A significant change MDS was not completed after Resident #24 returned to the facility from the hospital. Interview with the Director of Nursing (DON) on 8/4/16 at 12:50 PM indicated Resident #24 returned to the facility with fractures, use of a cast, and a surgical wound. The DON explained she would expect those areas to be on the care plan after her readmission. She further explained she did not know why a significant change MDS had not been completed upon readmission. Interview with the MDS nurse via phone on 8/4/16 at 1:30 PM indicated she was new in the position, still learning and missed the significant change MDS.	F 274	significant change is warranted. The MDS Nurse will initiate a signature sheet to reflect the disciplines present as well as document the areas discussed on a log and what the decision is and the justification for completing or not completing a significant change assessment. The MDS Nurse will also utilize the RUG Analysis Worksheet that is generated from our computer system that reflects the current MDS coding and the previous MDS coding. This is a second check to assist in determining if the resident has met the criteria for a significant change. The MDS Nurse will present this log to the DON after the meeting and the DON will sign the form to indicate agreement with the IDC decision. The MDS Nurse will complete the Significant Change QA Log weekly for one (1) month; bi-weekly for two (2) months; monthly for six (6) months. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The MDS Nurse will initiate a signature	

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F 274	Continued From page 6	F 274	sheet to reflect the disciplines present as well as document the areas discussed on a log and what the decision is and the justification for completing or not completing a significant change assessment. The MDS Nurse will present this log to the DON after the meeting and the DON will sign the form to indicate agreement with the IDC decision. The MDS Nurse will complete the Significant Change QA Log weekly for one (1) month; bi-weekly for two (2) months; monthly for six (6) months. This log will be presented to the Quality Assurance Committee on a quarterly basis. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Resident #40 was admitted on 6/8/2016 with diagnoses of Anemia, renal disease, diabetes, arthritis and a history of stroke. A review of the Minimum Data Set (MDS) admission assessment revealed that Resident #40 was rarely understood and had short term	F 282	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	8/15/16

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F 282	Continued From page 7 and long term memory problems. It also indicated that Resident #40 needed extensive assistance with activities of daily living, including bathing and hygiene. The care plan dated 6/27/2016 indicated that staff was to bathe, groom and dress Resident #40 and encourage resident to participate as she is able. The care plan also directed staff to provide nail care including keeping nails clean, trimmed and rough edges filed. On 8/2/2016 at 9:20 am Resident #40 was observed to have a black substance under her all her fingernails on both hands. On 8/3/2016 at 4:29 pm Resident #40 was observed again to have a black substance under her nails. On 8/4/2016 at 9:29 am Nurse Aide #2 was observed providing care for Resident #40. She provided the proper assistance with bathing, toileting and denture care. Nurse aide #2 did not provide nail care. On 8/4/2016 at 10:01 am Nurse Aide #2 was interviewed. She acknowledged that she didn ' t complete nail care. She also indicated that she was aware that she was supposed to provide nail care daily. On 8/4/2016 at 11:10 am the Director of Nursing was interviewed. She explained that she expected the nurse aide to assess and clean her nails daily.	F 282	The resident's fingernails were cleaned on August 4, 2016.. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident's fingernails were checked by the Administrative staff on August 5, 8 and 9, 2016 and documented on the daily Quality Assurance Checklist and no other unclean nails were identified . ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: An In-service by the Administrator with the CNA's was conducted on August 15, 2016 concerning resident's personal care needs being met according to their Individualized Care Plan. During this In-service emphasis was placed on the importance of personal grooming and as a CNA the requirements to provide care basis on their training. CNA's will provide hand hygiene on a daily basis with the resident's ADL care and document the care or refusal of care by the resident on the Fingernail QA Sheet which indicates the following: 1. Name of resident refusing nail care; 2. Name of resident receiving nail care; 3. Fingernails soaked in warm water prior to being trimmed;	

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F 282	Continued From page 8	F 282	4. Fingernails trimmed and filed; 5. Interventions used to encourage resident to allow nail care. The form will reviewed by the DON on a weekly basis. Activities staff will provide Pretty Nail Salon on a weekly basis for any resident requesting their nails be done. The Activity Director will document the request on the Activity QA Record. The Administrative staff will conduct a QA of the residents daily Monday-Friday to ensure that nail care is being provided. The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and put a corrective plan into place at that time including re-education, disciplinary action or if required termination for not performing duties of their job description. The DON will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months that residents are receiving appropriate nail care. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE	

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F 282	Continued From page 9	F 282	ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: CNA's will provide hand hygiene on a daily basis with the resident's ADL care and document the care or refusal of care by the resident on the Fingernail QA Sheet which indicates the following: 1. Name of resident refusing nail care; 2. Name of resident receiving nail care; 3. Fingernails soaked in warm water prior to being trimmed; 4. Fingernails trimmed and filed; 5. Interventions used to encourage resident to allow nail care. The form will reviewed by the DON on a weekly basis The Activity Director will document the request on the Activity QA Record. The Administrative staff will conduct a QA of the residents daily Monday-Friday to ensure that nail care is being provided. The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and put a corrective plan into place at that time including re-education, disciplinary action or if required termination for not performing duties of their job description. The DON will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported	

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F 282	Continued From page 10	F 282	to the Quality Assurance Committee for nine (9) months that residents are receiving appropriate nail care. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Resident #40 was admitted on 6/8/2016 with diagnoses of Anemia, renal disease, diabetes, arthritis and a history of a stroke. A review of the Minimum Data Set (MDS) admission assessment revealed that Resident #40 was rarely understood and had short term and long term memory problems. It also indicated that Resident #40 needed extensive assistance with activities of daily living, including bathing and hygiene. The care plan dated 6/27/2016 indicated that staff was to bathe, groom and dress Resident #40 and encourage resident to participate as she is able. The care plan also directed staff to provide nail care including keeping nails clean, trimmed and rough edges filed. On 8/2/2016 at 9:20 am Resident #40 was observed to have a black substance under her all	F 312	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The resident's fingernails were cleaned on August 4, 2016. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident's fingernails were checked by the Administrative staff on August 5, 8 and 9, 2016 and documented on the daily Quality Assurance Checklist and no other	8/15/16

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F 312	Continued From page 11 her fingernails on both hands. On 8/3/2016 at 4:29 pm Resident #40 was observed again to have a black substance under her nails. On 8/4/2016 at 9:29 am Nurse Aide #2 was observed providing care for Resident #40. She assisted her to the bathroom, provided toileting assistance. She then washed the resident ' s hands with a wash cloth. She bathed her using the proper technique. She dressed her. She avoided washing her feet, but she did change her socks. Legs and feet were noted to have edema with even the toes being swollen. The nurse aide brushed Resident #40 ' s dentures and brushed her hair. Nurse Aide #2 was interviewed after morning care on 8/4/2016 at 9:48 am. She explained that she had been here two weeks. She indicated that nail care was to be done every day. She admitted that she did not provide nail care for Resident #40. She also indicated that she did not bathe the resident ' s feet due to the swelling and pain in her legs. She indicated that the physician was coming today to check her. On 8/4/2016 at 10:01 am Nurse Aide #2 returned to the room to provide nail care for Resident #40. She washed her hands and used an orange stick to remove a large amount of black material from underneath the nails on one hand, but the resident pulled back her hands and refused to let the Nurse Aide #?? Finish the nail care. Nurse Aide #2 stopped cleaning the nails and asked if she could trim and file them. The resident agreed and the nurse aide began trimming and filling the nails. She explained that she would return later that day to finish cleaning them. On 8/4/2016 at 11:10 am the Director of Nursing was interviewed. She explained that she expected the nurse aide to assess and clean her	F 312	unclean nails were identified. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: An In-service with the CNA's was conducted the Administrator on August 15, 2016 concerning resident's personal care needs being met according to their Individualized Care Plan. During this In-service emphasis was placed on the importance of personal grooming and as a CNA the requirements to provide care basis on their training. CNA's will provide hand hygiene on a daily basis with the resident's ADL care and document the care or refusal of care by the resident on the Fingernail QA Sheet which indicates the following: 1. Name of resident refusing nail care; 2. Name of resident receiving nail care; 3. Fingernails soaked in warm water prior to being trimmed; 4. Fingernails trimmed and filed; 5. Interventions used to encourage resident to allow nail care. The form will reviewed by the DON on a weekly basis. Activities staff will provide Pretty Nail Salon on a weekly basis for any resident requesting their nails be done. The Activity Director will document the request on the Activity QA Record. The Administrative staff will conduct a QA	

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F 312	Continued From page 12 nails daily.	F 312	of the residents daily Monday-Friday to ensure that nail care is being provided. The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and put a corrective plan into place at that time including re-education, disciplinary action or if required termination for not performing duties of their job description. The DON will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months that residents are receiving appropriate nail care. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: CNA's will provide hand hygiene on a daily basis with the resident's ADL care and document the care or refusal of care by the resident on the Fingernail QA Sheet which indicates the following: 1. Name of resident refusing nail care; 2. Name of resident receiving nail care; 3. Fingernails soaked in warm water	

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F 312	Continued From page 13	F 312	prior to being trimmed; 4. Fingernails trimmed and filed; 5. Interventions used to encourage resident to allow nail care. The form will reviewed by the DON on a weekly basis The Activity Director will document the request on the Activity QA Record. The Administrative staff will conduct a QA of the residents daily Monday-Friday to ensure that nail care is being provided. The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and put a corrective plan into place at that time including re-education, disciplinary action or if required termination for not performing duties of their job description. The DON will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months that residents are receiving appropriate nail care. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		8/10/16

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F 323	Continued From page 14 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, staff interviews and record review the facility failed to secure a side rail to the bed frame for one of twenty residents. (Resident #17). The findings included: Resident #17 admitted to the facility on 8/20/2014 with diagnosis of congestive heart failure dementia and type 2 diabetes. Review of the quarterly Minimum Data Set (MDS) dated 4/29/16 revealed Resident #17 had moderate impairment with long and short term memory, required limited assistance of one staff for bed mobility and transfers and had sustained a fall with no injury, since the prior MDS assessment A side rail assessment dated 4/29/16 indicated half side rails on both sides of the bed were used by the resident to assist with independence in positioning when in bed. A fall risk assessment dated 4/29/16 indicated Resident #17 was a high risk for falls. The most recent fall occurred on 7/20/16 at 12:00 PM. Resident #17 had attempted to self- transfer from his wheelchair into the bed. He indicated he had slipped out of the wheelchair and was on the floor	F 323	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The rail for the resident #17 was secured to the bed frame on August 4, 2016. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident's side rails were checked by the Administrative staff on August 8, 9 and 10, 2016 and documented on the daily Quality Assurance Checklist and no other loose rails were identified. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: On a daily basis Monday through Friday the Administrative Staff are assigned to certain rooms as determined by a schedule made by the Administrator to	

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F 323	Continued From page 15 in front of the wheelchair. No injuries were noted at that time. Observations on 8/2/16 at 2:29 PM revealed the resident ' s right side rail was not secured to the bedframe. Resident #17 was able to push the side rail away from his side about a foot, by pushing on the top of the rail. Observations of the side rail with the Maintenance Director on 8/4/16 at 9:30 AM revealed the side rail remained loose. The Maintenance Director explained he checked the side rails every week. He had checked this side rail last week and it was not loose. He further indicated he had not received a maintenance request to fix the side rail. The system in place to notify him of maintenance issues included filling out a work order, which were kept at the nurse ' s station. Interview with aide #1 on 8/4/16 at 9:31 AM revealed she was aware the side rail was loose. She had made out a work order and thought the side rail had been loose for a couple of weeks.	F 323	check the resident rooms for the following in addition to the other areas already being reviewed: 1. Wheelchairs clean 2. Privacy curtains/walls 3. Side Rails being in place and not loose 4. Calls lights in place and in working order The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and if side rails are noted to be loose a Maintenance Request Form is completed at that time and given to the Maintenance Supervisor who attends the meeting. Once he has completed the repair he returns the Maintenance Request Form to the Administrator who signs off that the area identified has been corrected. The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS	

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F 323	Continued From page 16	F 323	EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and if side rails are noted to be loose a Maintenance Request Form is completed at that time and given to the Maintenance Supervisor who attends the meeting. Once he has completed the repair he returns the Maintenance Request Form to the Administrator who signs off that the area identified has been corrected. The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		8/31/16

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F 329	Continued From page 17 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews the facility failed to obtain lab work to monitor interactions between medications for one of five sampled residents (Resident #12). The findings included: Resident #24 was re-admitted to the facility on 5/16/16 with diagnoses including fracture hip, femur and radius on the left side, Alzheimer's disease, and history of falls. A pharmacy consult report dated 7/19/16 included recommendations to obtain a complete blood count (CBC). The physician responded on 7/21/16 and agreed to obtain the CBC. Review of the medical record revealed no CBC results were in the chart.	F 329	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The lab was obtained for Resident #24 on August 5, 2016. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: A review of all of the resident's orders and labs was completed on August 31, 2016	

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F 329	Continued From page 18 Interview with the Director of Nursing on 8/3/16 at 12:21 PM revealed a CBC was not done between the dates of 7/19/16 and 8/3/16. Interview with nurse #1on 8/3/16 at 3:43 PM revealed the process to ensure lab work was obtained included the following: she gets physician orders from the supervisor that have been entered into the computer. If the order is on pharmacy recommendation, the unit manager would be responsible for those orders. It would then be the same process, the supervisor would call the lab, and the lab comes out to draw the lab work. Interview with the unit manager on 8/3/16 at 3:47 PM revealed she reviewed the pharmacy recommendations after the physician signed that he/she reviewed them. She continued to explain she would take the pharmacy recommendation, write the order, and the contract lab would draw the lab work. The lab came to the facility three times a week. Any " STAT " labs would be drawn by her or the floor nurse. The unit manager continued to explain she would process the order by placing a lab requisition in a number tabbed folder. The folder was kept on east hall and the lab person checked the folder for labs to be drawn. A carbon copy was kept by the unit manager. She would check for results by the carbon copy when the results came to the facility. A book was also kept with the names of residents and the lab work to be obtained. The list was checked and Resident #24 was not listed for a CBC to be drawn. Follow-up interview with the unit manager on 8/3/16 at 4:00 PM revealed the pharmacy	F 329	by the DON and Nurses Managers. If any orders or labs were not completed the attending physician will be notified and facility will take corrective action based on the attending physician's recommendations. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The Nurse Managers' will review the Pharmacy Consultant Report and complete the follow-up recommendations as appropriate for each resident once the Physician has written the order. Once these are completed both Nurse Managers or DON in absence of one of the nurse managers, will sign the form indicating they have checked behind the other to ensure that all orders to include labs have been initiated and completed. The Nurse Managers are responsible to complete a Lab QA Report monthly to indicate any lab recommendations and the labs have been obtained. The DON will review the Lab QA monthly for six (6) months after the Nurse Manager has completed the report and all recommendations have been signed by the physician. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING	

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F 329	Continued From page 19 recommendations were signed by the physician and should be put in a basket for her to review. It was put on the chart, and not in her basket. The lab work was not drawn. Interview with the consultant pharmacist on 8/4/16 at 1:19 PM revealed the CBC was ordered due to possible interactions between Coumadin (blood thinner) and an NSAID (Mobic) the resident was receiving.	F 329	THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Nurse Managers' will review the Pharmacy Consultant Report and complete the follow-up recommendations as appropriate for each resident once the Physician has written the order. Once these are completed both Nurse Managers or DON in absence of one of the nurse managers, will sign the form indicating they have checked behind the other to ensure that all orders to include labs have been initiated and completed. The Nurse Managers are responsible to complete a Lab QA Report monthly to indicate any lab recommendations and the labs have been obtained. The DON will review the Lab QA monthly for six (6) months after the Nurse Manager has completed the report and all recommendations have been signed by the physician. The DON will take the Lab QA to the Quality Assurance Committee meeting on a quarterly basis. The Quality Assurance Committee will review this for nine (9) months. If no other issues are determined during this time period then it will be reviewed as needed. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to	

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F 329	Continued From page 20	F 329	ensure that solutions are achieved and sustained.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep one of twenty call lights in working order for Resident #5. The findings included: Resident #5 was admitted to the facility on with diagnoses including Alzheimer ' s dementia. Review of the quarterly Minimum Data Set dated ...indicated Resident #5 had cognitive impairment and was not interviewable. Observations on 08/01/2016 at 12:00 PM revealed the call light for Resident #5 did not activate outside the door, did not light up at the call light outlet in the room and did not ring at the desk. Observations on 08/02/2016 at 3:30 PM revealed the call light was not in working order. Observations on 08/04/2016 at 9:12 AM on rounds with the Maintenance Director revealed the call light was not working. Interview at that time revealed the maintenance Director was not aware the call light had not been working. He further explained work orders were at the nurse ' s desk, and he had not received a work order.	F 463	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: For Resident #5 the call light was repaired on August 4, 2016 by the Maintenance Supervisor. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Each resident's call light was checked by the Maintenance Supervisor on August 4, 2016 to ensure that the call lights were in working order. No other call lights were noted to not be in full operation. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT	8/4/16

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F 463	Continued From page 21 Interview with Resident #5 ' s nurse (nurse #2), on 08/04/2016 at 9:12 AM, revealed she was not aware the resident ' s call light was not working. Interview with aide #1 on 08/04/2016 at 9:27 AM revealed she was not aware the call light did not work in Resident #5 ' s room.	F 463	THE DEFICIENT PRACTICE WILL NOT OCCUR: On a daily basis Monday through Friday the Administrative Staff are assigned to certain rooms as determined by a schedule made by the Administrator to check the resident rooms for the following in addition to the other areas already being reviewed: 1. Wheelchairs clean 2. Privacy curtains/walls 3. Side Rails being in place and not loose 4. Calls lights in place and in working order The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and if call lights are determined to not be working a Maintenance Request Form is completed at that time and given to the Maintenance Supervisor who attends the meeting. Once he has completed the repair he returns the Maintenance Request Form to the Administrator who signs off that the area identified has been corrected. The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE	

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F 463	Continued From page 22	F 463	SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discuss any identified areas of concern and put a corrective plan into place at that time. The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. The VP of Operations will be responsible to conduct a Quality Assurance Round on a monthly basis for six (6) months to evaluate the system and ensure the facility is sustaining the corrective plan put into place. The results of the QA check by the VP of Operations will also be reported to the Quality Assurance Committee for six (6) months. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		8/29/16

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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 520	Continued From page 23 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews 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 two recited deficiencies which were originally cited in August of 2015 on the annual recertification survey and on the current recertification survey. The deficiencies were in the areas of housekeeping/maintenance and	F 520	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: For Resident #12 the wheelchair and wall was cleaned. The privacy curtain was removed and another clean curtain was put back up on August 5, 2016.	

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	345140	A. BUILDING _____ B. WING _____	C 08/04/2016

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F 520	Continued From page 24 accidents/hazards. 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 Program. Findings included: This tag is cross referred to: 1a. F 253: Housekeeping/Maintenance: Based on observations, staff and residents interviews and record reviews the facility failed to keep a wheelchair, privacy curtain and walls clean for one of twenty residents (Resident #12). During the annual recertification survey August 14, 2015 the facility was cited for F-253 for failing to make repairs to walls and baseboards, repair constant dripping water faucet and replace cracked electrical outlet covers in twelve of thirty rooms. The facility ' s plan in September of 2015 indicated that the Quality Assurance committee would review the facility ' s progress monthly and quarterly for effectiveness and revise or develop new measures as necessary to ensure the system is sustained. b. F 323: Accident/Hazards: Based on observations, staff interviews and record reviews the facility failed to secure a side rail to the bed frame for one of twenty residents (Resident #17). During the annual recertification survey August 14, 2015 the facility was cited for F-323 for failing to secure bed rails for three of three sampled residents (Resident #4, #41 and #66) whose bed rails were not secured firmly to the bed. The facility ' s plan in September of 2015 indicated that the maintenance supervisor was responsible	F 520	The rail for the resident #17 was secured to the bed frame on August 4, 2016. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Each resident's room was checked by the Administrative Staff to ensure that the wall's were clean as well as the privacy curtains. There were no other issues noted. All resident wheelchairs were checked by the Administrative Staff and if found to need cleaning was cleaned by the CNA's. The areas identified were checked by the Administrative Staff on August 5, 8, and 9, 2016 All resident's side rails were checked by the Administrative staff on August 8, 9 and 10, 2016 and documented on the daily Quality Assurance Checklist and no other loose rails were identified. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The overall process of the quality assurance plans for the facility were reviewed to determine where the system failed that contributed to the deficiencies being recited. After review by the QAA Committee it was determined that the QA's were completed however they were not consistently reviewed or discussed after the time frame identified in the Plan	

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F 520	Continued From page 25 to do facility quality assurance rounds on a weekly basis to identify and repair any areas of concern, the plan also indicated the administrator would conduct QA rounds on a monthly basis for 3 months to ensure that all facility repairs are made and the facility maintain a sanitary, orderly and comfortable environment. If after 3 months the necessary corrections are being made then the administrator will do QA rounds on a quarterly basis. During an interview with the administrator on 8/4/16 at 11:45 AM revealed that a plan has been identified, the department managers have a form titled, " Quality Assurance Checklist " and the department managers are assigned a set of rooms to check daily, she explained that if a concern area is identified then it is reported to that department which is usually housekeeping and maintenance. The maintenance request form are to be filled out and maintenance checks the identified concern immediately.	F 520	of Correction. The facility has changed the way the Quality Assurance Checklist is completed and reviewed. The new procedure to prevent the failure of systems is as follows: 1. The Administrative staff bring their QA checks to the morning meeting. 2. At which time the Administrative Team will discuss any identified areas of concern and put a corrective plan into place at that time. 3. If it is a Maintenance issue a Maintenance Request form is completed in the meeting and given to the Maintenance Supervisor who attends the meetings. 4. The Maintenance Supervisor is responsible to correct or repair whatever is identified and return the form to the Administrator/Designee who will sign the form after the Administrator/Designee has visually looked at whatever was identified as being complete. 5. If it is another Department Manager the issue will be discussed and a plan put into place at that time. The Department Manager is responsible to report back to the Committee the next working day the results of the initiated plan. 6. The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months unless the QAA Committee recommends continuing the QA checks because of continuing issues. The QAA Committee will be	

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F 520	Continued From page 26	F 520	responsible to determine the time frame necessary to achieve compliance. 7. The VP of Operations will be responsible to conduct a Quality Assurance Round on a monthly basis for six (6) months to evaluate the system and ensure the facility is sustaining the corrective plan put into place. 8. The VP of Operations conducted a training for the Administrative Staff and completed a walking QA Round with each of the Administrative Staff member to train them on how to identify any area of concern and the process once it is identified on August 29, 2016. The results of the QA check by the VP of Operations will also be reported to the Quality Assurance Committee for six (6) months. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Administrator will complete a Quality Assurance Checklist weekly for one (1)	

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F 520	Continued From page 27	F 520	month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months unless the QAA Committee recommends continuing the QA checks because of continuing issues. The QAA Committee will be responsible to determine the time frame necessary to achieve compliance. The VP of Operations will be responsible to conduct a Quality Assurance Round on a monthly basis for six (6) months unless an extended period of time is identified to evaluate the system and ensure the facility is sustaining the corrective plan put into place. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	