STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345411	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	516 WALL STREET WAYNESVILLE, NC 28786

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, resident and staff interviews, the facility failed to maintain dignity for 1 of 4 sampled residents by referring to a resident as a "feeder" (Resident #21). Findings included: 1. Resident #21 was admitted to the facility on 11/4/11 with diagnoses that included Alzheimer's disease and dysphasia (difficulty swallowing). The quarterly Minimum Data Set (MDS) dated 7/27/16 coded Resident #21 as severely, cognitively impaired and displayed no rejection of care. The MDS indicated Resident #21 required the assistance of 1 staff member with meals. On 10/25/16 at 5:35 PM, the Business Office Director (BOD) was asked if Resident #21 would be receiving a dinner tray. As she walked down the hallway, the BOD replied "she is a feeder. They should be in to feed her shortly." This statement was made in the presence of staff and other residents. During an interview on 10/26/16 at 2:01 PM the BOD stated she was aware she had made a mistake and should have not referred to Resident #21 as a "feeder." The BOD confirmed the term "feeder" should not be used when referring to residents who needed assistance with meals. During an interview on 10/27/16 at 2:15 PM, the Administrator, District Director of Clinical Services	F 241	F 241 Criteria #1 The Business Office Director was re-educated by the NHA on 11.2.2016 regarding treating residents with dignity and respect, with a focus on not using the word feeder when referring to Resident #21 or any other resident who needs assistance with meals. Criteria #2 All residents requiring assistance with meals have the potential to be affected by the alleged deficient practice. Facility Staff have been re-educated by the Staff Development Coordinator and the NHA regarding the aspects of dignity and respect for Residents. Criteria #3 Facility Staff have been re-educated by the Staff Development Coordinator on treating residents with dignity and respect, including no longer referring to residents that need assistance with meals as feeders. This education was completed by 11/24/16. The NHA or designee will make 5 random observations per week for 12 weeks during meal times to validate residents are treated with dignity and	11/24/16

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

Electronically Signed | 11/21/2016

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F 241	Continued From page 1 and Director of Nursing all confirmed it was their expectation that staff would not use the term "feeder" when referring to residents who needed assistance with meals.	F 241	respect. Opportunities will be corrected daily as identified. Criteria #4 NHA will report audit findings to the QAPI committee monthly for 3 months, then as determined by the QAPI committee.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and resident and staff interviews the facility failed to honor 2 out of 5 residents' (Resident #31 and Resident #71) choice of tub bath instead of shower. The findings included: 1. a. Resident #31 was admitted on 07/06/2016 with diagnoses which included generalized pain, anemia, hypertension, Dementia, and anxiety disorder. Resident #31's most recent Quarterly Minimum Data Set (MDS) dated 07/14/2016 indicated she had moderate cognition impairment. Further review of the MDS revealed Resident #31 was coded as not having rejected care and needing extensive assistance of one person with personal hygiene and bathing. A review of Resident #31's Care Area	F 242	F242 Criteria #1 The DON interviewed Residents #31 and #71 regarding bathing choices on 11/18/16. The care plans for Residents #31 and #71 were updated by the DON to reflect bathing choices on 11/18/16. The NHA has ordered a bariatric tub on 11.24.2016 with installation to be completed upon delivery. Criteria #2 All residents choosing to have a tub bath have the potential to be affected by the alleged deficient practice. The Interdisciplinary team including the DON and Nurse Managers will conduct interviews with current residents regarding bathing choices and update care plans	11/24/16

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F 242	Continued From page 2 Assessment (CAA) dated 07/14/2016 revealed she triggered for Activities of Daily Living (ADL) function and rehabilitation potential and ADL would be care planned. A review of Resident #31's care plan dated 07/19/2016 revealed that she was care planned for ADL functions with a goal of maintaining current level of function through the next review period. Her interventions included encouraging the resident to participate to her fullest capacity in her hygiene and bathing. An interview was conducted on 10/24/2016 at 9:41 am with Resident #31. She stated that she received two showers per week but she would like to have a soaking bath but there is no bath tub in the facility that worked. b. Resident #71 was admitted on 01/02/2015 with diagnoses which included hypertension, anxiety disorder, manic depression, psychotic disorder, Chronic Obstructive Pulmonary Disease (COPD) and respiratory failure with the use of continuous oxygen at 2 liters per minute. Resident #71's most recent Quarterly Minimum Data Set (MDS) dated 09/09/2016 indicated that she was cognitively intact. Further review of the MDS revealed Resident #71 was coded as not having rejected care and needing extensive assistance of one with personal hygiene and bathing. A review of Resident #71's Care Area Assessment 01/22/2016 revealed she triggered for ADL function and rehabilitation potential and ADL would be care planned. A review of Resident #71's care plan dated 01/05/2015 revealed she was care planned for ADL functions with a goal of maintaining current level of function through the next review period. Her interventions included encouraging participation to her fullest capacity in her hygiene	F 242	accordingly. These interviews and updates will be completed by 11/24/16. Criteria #3 All Licensed Nurses will be re-educated by the Staff Development Coordinator regarding the completion of resident interviews regarding bathing preferences during the admission process and update of the care plan. This education will be completed by 11/24/16. The DON and Nurse Managers will randomly audit 10 residents, including new admissions, weekly for 12 weeks to ensure bathing preferences are being honored. Opportunities will be corrected daily as identified. Tub was ordered 11.24.2016 with installation to be completed upon delivery. Criteria #4 The results of results of the audits and monitoring will be submitted to the QAPI Committee by the DON for review by IDT members each month for 3 months. The QAPI committee will evaluate the effectiveness and amend as needed.	

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F 242	Continued From page 3	F 242		

and bathing without causing problems with her breathing and maintaining her oxygenation.
An interview was conducted on 10/23/2016 at 6:16 pm with Resident #71. She stated that she received two showers per week but she would like to have a soaking bath but there was no working bath tub in the facility.
On 10/24/2016 at 10:00 am observed the shower room on North Hall. There was a large shower that was operational and a large tub that was dusty and had debris inside of it and the control for the water was broken off. On 10/24/2016 at 10:30 am observed the shower room on South Hall and there was a large shower with three shower benches inside it. There was a large bath tub with the controls broken and sitting inside the tub. The tub was dusty and had debris inside of it.
On 10/25/2016 at 4:50 pm went into the shower rooms on both North and South hall with the Maintenance Supervisor. He stated that the bath tubs had not worked in the six weeks that he had been employed with the facility. He stated that it was his understanding the plan was to tear out the tubs since they did not work anyway and put in gurney showers for the residents. He stated that he would like to put in a walk in tub but was not sure that would be possible financially due to the cost of the tub.
On 10/27/2016 at 5:15 pm an interview was conducted with the Administrator. The Administrator stated that the tubs had not worked for a long time and she would like to get a walk in tub for the residents who want a bath to use. She stated that they had talked about pulling the tubs out since they do not work and putting in gurney showers but she would look into the possibility of putting in a walk in tub in one of the bathrooms. The Administrator stated that at the moment they

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F 242	Continued From page 4 did not have a solution for the residents who preferred a bath in a tub.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and resident and staff interviews the facility failed to accommodate the needs of 1 of 2 residents (Resident #83) by not providing a foot rest/pedal on the right side of his wheelchair to rest his foot while not propelling himself in his wheelchair. The findings included: Resident # 83 was admitted to the facility on 05/27/2016 with diagnoses that included anxiety disorder, chronic atrial fibrillation, edema, muscle weakness, dementia without behaviors, cerebral stroke syndrome, pain in his limbs, and type II diabetes mellitus (DM). Review of the most recent Quarterly Minimum Data Set (MDS) dated 09/16/2016 revealed that Resident #83 had moderately impaired cognition but understands and was understood and able to make his needs known. It also revealed that he required extensive assistance of one staff member for hygiene, bathing and set up for eating. He required extensive assistance of two staff members with transfers to his wheelchair but	F 246	F246 Criteria #1 The Rehab Director applied a right footrest/pedal to Resident # 83□s wheelchair on 11/18/16. The DON updated the care plan for Resident #83 to reflect his preference for using a right footrest/pedal on the wheelchair on 11/18/16. #2 All residents preferring or needing to use a footrest/pedal with their wheelchair have the potential to be affected by the alleged deficient practice. The Rehab Director and Rehab Staff will conduct an audit of residents that use wheelchairs to evaluate the resident□s preference or need for foot rest/pedals and apply the footrest/pedal accordingly. The DON and Nurse Managers will update the resident□s care plan to reflect the need or preference of footrest/pedal. These audits and care	11/24/16

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F 246	Continued From page 5 once in his wheelchair was able to propel himself. Review of the most recent Care Area Assessment (CAA) dated 06/03/2016 revealed that Resident #83 triggered for Activities of Daily Living (ADL) function and rehabilitation potential, cognition, activities, falls, vision, and pain. His CAA for ADL function stated that he would be care planned. Review of his care plan dated 06/12/2016 revealed that he was care planned for ADL function with appropriate goals and interventions. An update to his care plan on 08/23/2016 revealed that he was care planned for exhibition of behavioral symptoms of neediness due to individual preferences. On 10/25/2016 at 12:00 pm Resident #83 was observed in his wheelchair out in the hallway close to his room. He was complaining of foot pain and his feet were red, shiny and swollen. He had his left foot up resting on the foot pedal of his wheelchair but his right foot was sitting on the floor. He stated that his feet were swollen but he could only elevate one on the footrest and he needed a foot pedal on the right side of his wheelchair. He stated in front of staff and residents that his foot rest had been taken off by staff for someone who needed worse than he did. He also stated that he had told staff that he needed it back but they did not pay attention to what he said. Interview on 10/25/2016 at 12:10 pm with the North hall Unit Manager revealed that she did not know who had taken his foot pedal off and that usually that is done by physical therapy. She stated that she would contact therapy to see if they could put his foot pedal back so he could elevate his foot on it while sitting in his wheelchair and not propelling. She stated that it was her expectation that if he needed the pedal that it would be provided for him on his wheelchair.	F 246	plan updates will be completed by 11/24/16. #3 Rehab and Nursing Staff have been re-educated by the Staff Development Coordinator regarding the resident□s preference and need of footrest/pedal when a wheelchair is in use. This re-education was completed by 11/24/16. The DON / designee will randomly observe 5 residents in wheelchairs weekly for 12 weeks to ensure foot rest/pedals are on the wheelchair as needed and preferred. Opportunities will be corrected daily as identified. #4 The results of this audit and monitoring will be submitted to the QAPI Committee by the DON for review by IDT members each month for three months. The QAPI committee will evaluate the effectiveness and amend as needed.	

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F 246	Continued From page 6 Observation on 10/25/2016 at 1:30 pm Resident #83 was sitting in his wheelchair out in the hallway and had 2 foot pedals on his wheelchair and had his feet elevated up on the pedals. Observation on 10/25/2016 at 2:45 pm Resident #83 was sitting in his wheelchair in the hallway with his feet up on the foot pedals of his wheelchair. He stated that his feet felt better and again stated that he had told staff that he needed his pedal back but was told that someone else needed it worse than he did. Interview on 10/27/2016 at 4:30 pm with the Director of Nursing revealed that her expectation was that all residents' needs be accommodated if possible. She would expect a resident with edema to have foot pedals on his wheelchair. Interview on 10/27/2016 at 5:15 pm with the Administrator revealed that her expectation was for the resident to have foot pedals on his wheelchair to rest his feet when not propelling.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, and resident and staff interviews the facility failed to maintain: sinks in the resident's rooms that do not drain in 5 of 19 rooms on the North hall, hot water in the bathrooms in 4 of 19 resident rooms on the North hall, paint on the walls in resident rooms in 6 of 46 rooms and in 1 of 2 hallways on the North hall, doors and door frames in 46 of 46 resident rooms	F 253	F253 Criteria #1 The following repairs have been completed by the Maintenance Director by 11/24/16: 1. The sinks in resident rooms 1-5 on the North Hall have been repaired and are now draining.	11/24/16

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F 253	Continued From page 7 and 2 of 2 clean linen rooms and 6 of 6 employee office areas and kitchen doors on the South hall, floors in 5 of 46 resident rooms and bathrooms and 1 of 2 shower rooms on the North hall, and clean resident equipment on 2 of 2 hallways. The findings included: 1. Sinks in the residents' rooms: a. On 10/23/2016 at 3:00 pm and 10/24/2016 at 9:18 am while testing the water in Rooms 1, 2, 3, 4 and 5 on the North hall, the sinks in these rooms did not drain and the water was almost overflowing. 2. Lack of hot water in the resident's bathrooms a. On 10/23/2016 at 5:06 pm while testing the water in Room 3 on the North hall, the water ran for over 2 minutes and was still cool. b. On 10/24/2016 at 9:10 am while testing the water in Room 2 on the North hall, the water ran for over 2 minutes and was still cool. c. On 10/24/2016 at 9:40 am while testing the water in Room 5 on the North hall, the water ran for over 2 minutes and was still cool. d. On 10/24/2016 at 11:20 am while testing the water in Room 1 on the North hall, the water ran for over 2 minutes and was still cool. On 10/23/2016 at 5:06 pm Resident #17 and Resident #71 who were alert and oriented and resided together in Room 3 on the North hall revealed that they did not have hot water in their bathrooms and had not had hot water in their bathrooms for some time (could not remember exact date). They stated that they had complained about the cold water and that maintenance had been in and checked it but it had not been fixed (could not remember when this was). They stated that it took so long for the water to even get warm that they had just given up and accepted that they did not have hot water in the bathroom. The residents stated that the	F 253	2. The hot water sensor and mixing valve were repaired. The hot water faucets in resident bathrooms # 1-5 on the North Hall are now reaching the target temperature range of 105-115 degrees within two minutes seconds of engaging the faucet. 3. Paint on the walls / hallways a. Room 2 North Hall □ the wall in the bathroom has been repaired and painted b. Room 3 North Hall □ the patched areas have been painted c. Room 8 North Hall □ the bathroom wall has been repaired and painted d. Room 38/39 Shared bathroom on South Hall □ the chipped paint has been repaired e. Room 38 South Hall □ the wall patch has been repaired and the holes behind the headboard have been repaired and painted. f. Room 37 South Hall □ Gashes in the plaster have been patched and painted g. Wall behind Fire door beside the shower room on the North Hall□ has been repainted h. North Hall water fountain □ wall underneath the water fountain has been painted i. North Hall water fountain □ white area above the water fountain has been painted 4. Doors and frames a. North Hall □ 19 resident room door frames have been repaired and repainted South □ 27 resident room door frames have been repainted and repainted b. Shared bathroom between Room 38-39 South Hall □ Bathroom door has been	

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F 253	Continued From page 8 sinks had not drained properly for a long time (could not recall exact dates) and that had been reported but had not been fixed either. The residents also stated that there had not been a working tub in the facility since their admission (over a year ago). On 10/24/2016 at 9:10 am Resident #83 who was alert and oriented and resided in Room 2 on the North hall revealed that he had not had hot water in his bathroom and had not had hot water in his bathroom for some time (could not remember how long it had been). The resident stated that the sinks had not drained properly for a long time (could not recall exact dates) and that had been reported but had not been fixed either. On 10/24/2016 at 9:40 am Resident #31 who was alert and oriented and resided in Room 5 on the North hall revealed that she had not had hot water in her bathroom and had not had hot water in her bathroom for some time now (could not remember how long it had been). The resident stated that the sinks had not drained properly for a long time (could not recall exact dates) and that had been reported but had not been fixed either. The residents also stated that there had not been a working tub in the facility since their admission. 3. Paint on the walls in resident rooms and the hallways: a. On 10/24/2016 at 9:02 am observed area on the bathroom wall in Room 2 on the North hall that was torn with no patching or paint on the wall. b. On 10/24/2016 at 9:02 am observed areas on the wall in Room 3 where patching was done and was not painted. c. On 10/25/2016 at 8:42 am observed in Room 8 on the North hall a 12 inch x 12 inch hole in the wall of the bathroom that had not been patched or painted.	F 253	repaired and painted c. Resident Room 2 North Hall □ Bathroom door has been repaired. d. Resident Room 3 North Hall □ Interior Door has been replaced. 5. Floors a. Resident Room 2 North Hall □ floor leading into bathroom has been repaired and a transition strip placed. b. Resident Room 8 North Hall □ bathroom missing tiles have been replaced c. North shower tiles have been repaired d. North hallway □ holes in tile have been repaired e. Resident Room 45 South Hall □ transition strip has been placed between bedroom and bathroom to proved ease of access using lift equipment. f. Resident Room 42 South Hall □ broken tiles on the edge of bathroom floor have been repaired g. Resident Room 40 South Hall □ broken/missing shower tile has been replaced. 6. Clean Resident care equipment a. North □ Sit-to-stand lift has been cleaned b. South □ Sit-to-stand lift has been cleaned c. North scales □ have been cleaned and matting replaced Criteria #2 #2 All residents have the potential to be affected by this alleged deficient practice. Detailed maintenance rounds have been conducted by the NHA and Maintenance Director and a prioritized list of repairs had been developed for ongoing repairs and	

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F 253	Continued From page 9 d. On 10/24/2016 at 9:30 am observed in Room 38 and 39 on South hall shared bathroom with one door facing with a 3 foot section of chipped and missing paint revealing different colors of paint. e. On 10/25/2016 at 2:06 pm observed in Room 38 on South hall patched holes in the wall and holes in the wall behind the headboard that were not patched and not painted. f. On 10/25/2016 at 2:00 pm observed in Room 37 on South hall several gashed places in the plaster of the bathroom with no patching and not painted. g. On 10/26/2016 at 9:34 am observed large area of peeled paint behind the Fire door beside the shower room on the North hall. h. On 10/26/2016 at 9:34 am observed large unpainted area under the water fountain next to the nurse's desk. i. On 10/26/2016 at 9:34 am observed an area on the wall next to the water fountain with white paint on top of the burgundy paint. 4. Doors and door frames: a. On the initial tour on 10/23/2016 at 3:00 pm the door frames on the North hallway leading into 19 out of 19 resident rooms were all scraped and damaged. The door frames on the South hallway leading into 27 out of 27 resident rooms were all scraped and damaged. b. On 10/24/2016 at 2:06 pm Rooms 38 and 39 on the South hall shared a bathroom and one of the bathroom doors had a gash four inches above the bottom of the door across the entire width of the door. c. On 10/24/2016 at 9:02 am Room 2 on the North hall had chunks missing out of the bathroom door. d. On 10/24/2016 at 9:15 am Room 3 on the North hall had chunks missing out of the interior	F 253	maintenance by 11/24/16. Criteria #3 Facility Staff will be re-educated by the Staff Development Coordinator on the process for completion of the Maintenance Request Form for notification to the Maintenance Department for needed facility repairs. This re-education was completed by 11/24/16. The NHA or designee and Maintenance Director will conduct facility rounds weekly for 12 weeks to validate completion of needed repairs and maintenance as outlined on the prioritized maintenance list Criteria #4 The results of these audits and monitoring will be submitted to the QAPI Committee by the Maintenance Director for review by IDT members each month for three months. The QAPI committee will evaluate the effectiveness and amend as needed.	

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BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	516 WALL STREET WAYNESVILLE, NC 28786

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door.
5. Floors in the resident rooms and bathrooms:
a. On 10/24/2016 at 9:02 am Room 2 on the North hall had chunks missing out of the floor in the room leading into the bathroom.
b. On 10/24/2016 at 11:02 am Room 8 on the North hall had missing tiles in the bathroom under the sink and some of the other tiles were loose.
c. On 10/25/2016 at 9:00 am the Shower room on the North hall had broken tiles in the shower used by the residents.
d. On 10/26/2016 at 9:30 am observed holes in the floor tiles throughout the North hallway.
e. On 10/24/2016 2:30 pm Room 45 on the South hall had a groove in the floor from the room to the bathroom making it difficult to maneuver a wheelchair across into the bathroom.
f. On 10/24/2016 at 2:20 pm Room 42 on the South hall was observed with broken tiles on the edge of the bathroom floor leading into the resident room.
g. On 10/24/2016 at 2:15 pm Room 40 on the South hall had broken tile at the bottom corner of the shower in the bathroom.
6. Clean resident care equipment:
a. On 10/24/2016 at 2:15 pm, 10/25/2016 at 2:30 pm, and 10/26/2016 at 3:03 pm observed a Sit to Stand (a piece of equipment that allows residents who are sitting to pull themselves up and stand) in the hallway on the South hall that had a dirty platform, handles and frame.
b. On 10/24/2016 10:00 am, 10/25/2016 at 9:00 am and 10/26/2016 at 9:30 am observed a Sit to Stand (a piece of equipment that allows residents who are sitting to pull themselves up and stand) and a lift on North hall that was dirty. The Sit to Stand had a dirty platform, handles and frame. The lift had a dirty frame and handles.
c. On 10/24/2016 at 10:00 am and 10/25/2016

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F 253	Continued From page 11 at 9:00 am the scales outside room 19 on the North hall had visible dirt and debris on the platform and torn areas on the platform. On 10/25/2016 at 08:45 am observed housekeeper cleaning baseboards on the South hall and stated he was from another facility and stated he was not sure how often they are cleaned at this facility. Observed another housekeeper cleaning baseboards on the North hall and stated she was from another facility and was not sure how often baseboards were cleaned at this facility. On 10/25/2016 at 4:25 pm interview with the Maintenance Supervisor revealed that he had been employed with the facility for 6 weeks and had inherited a lot of issues from the previous supervisor. He stated that he had a plan for taking care of some of the issues throughout the building but it would take time. He stated that he knew the doors were in bad shape and he had a plan for replacing them. He stated that there were repairs and painting to be done but these projects take time. He stated that he was aware of the rooms with sinks that were not draining and he had a plumber coming out tomorrow to check the line. He stated that he knew there were rooms on the North hall that did not have hot water in their bathrooms and that he had planned to put a Boost (a mechanism that would make the hot water travel faster to the rooms furthest away from the hot water heater) on the water line to make the hot water travel faster to their rooms but he had not done this yet. He stated that it took a long time to get the water to even be warm in rooms 1-8 and when checking his temperatures of the water he had to run the water in these rooms for some time before it would even be warm. He stated he was aware of the	F 253		

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tubs not working but was told they were going to be removed and turned into gurney showers.
On 10/26/2016 at 5:05 pm interview with the Housekeeping Supervisor revealed that the housekeepers are responsible for 5-step and 7-step cleaning of rooms on a daily basis, deep cleaning rooms as scheduled, cleaning handrails daily, baseboards monthly and wheelchairs every 3 months. In addition, they are also responsible for cleaning the shower rooms. The Housekeeping Supervisor stated that she had 3 vacant positions one for laundry and 2 housekeeping positions. She stated that it had been hard to find good employees to fill the open positions. She stated that she expected the clean linen shelves to be clean and free of dust. She stated that she expected the housekeepers to keep the resident rooms and bathrooms clean and the hallways clean of dirt and debris. She stated that she expected the housekeepers to clean the resident equipment at least weekly and more often if needed. She stated that she expected the rooms and bathrooms of the residents to be free of dirt and debris on the floor. She stated that she expected the housekeepers to notify her if for some reason a room did not get cleaned daily.
On 10/27/2016 at 5:15 pm an interview with the Administrator revealed that she was aware of the problem with the water in the resident's bathrooms and she had asked the new Maintenance Supervisor to work on the problem. She stated that she expected the resident rooms and hallways to be clean of dirt and debris. She stated that she expected them to have hot water at safe temperatures in their bathrooms and sinks that drain. She stated that the paint, doors and flooring were a work in progress and there were plans for renovating the hallways and floors but

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F 253	Continued From page 13 there was no written plan for the renovations. She stated that she did not have a solution for the bath tubs that were not working but any other equipment not being used by the residents should be taken out of the shower rooms.	F 253		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observations, and resident and staff interviews the facility failed to provide comfortable temperatures in 2 of 48 rooms in the facility. The findings included: 1. Room 26 on South hallway a. On 10/26/2016 at 07:25 am, Resident #47 was observed to turn on the heat with the thermostat set at 78 degrees and the unit was blowing out cold air instead of heat. The thermostat was increased to 80 degrees by the staff and the unit was still blowing out cold air. b. The resident stated that the unit had not been working for about a month and that the staff was aware of it not working. 2. Room 3 on North hallway a. On 10/24/2016 at 08:45 am Resident #17 and Resident #71 stated that the thermostat does not work and the unit blows out whatever air it wants to. b. Residents #17 and #71 stated that the previous maintenance man had checked it and worked on it a couple of times but it still did not	F 257	F 257 Criteria #1 The heating unit was repaired in Resident Room 26 for Resident #47 and in Resident Room 3 for Residents # 17 and 71. These repairs were completed by the Maintenance Director by 10/28/16. Criteria #2 All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director conducted an audit of all resident rooms to ensure the heating units were functioning properly and opportunities identified were corrected. This audit was completed by 11/24/16. Criteria #3 Facility Staff will be re-educated by the Staff Development Coordinator on the process for completion of the Maintenance Request Form for notification to the Maintenance	11/24/16

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F 257	Continued From page 14 work consistently. On 10/26/2016 at 8:30 am two maintenance men were observed in room 26 on South hall replacing the heating and cooling unit for Resident #47. On 10/26/2016 at 1:30 pm interview with the Unit Manager for South hall revealed that she was not aware that the heating and cooling unit was not working in room 26. She stated that a work order had been filled out earlier today but she was not aware of the resident complaining about the unit prior to today. She stated that work orders are completed by the nursing staff. On 10/26/2016 at 4:50 pm interview with the Maintenance Supervisor revealed that he had been employed with the facility for 6 weeks and had inherited a lot of issues from the previous supervisor. He stated that he had replaced the heating and cooling unit in room 26 on the South hall because the old one could not be repaired. He stated prior to today he had not received a work order about the unit not working. He also stated that he had checked the heating and cooling unit in room 3 on the North hall and that it was working well at this time. On 10/27/2016 at 5:15 pm interview with the Administrator revealed that she expected the resident rooms to have functioning heating and cooling units that could be adjusted by the residents for their comfort.	F 257	Department for needed facility repairs. This re-education was completed by 11/24/16. The NHA or designee and Maintenance Director will conduct facility rounds weekly for 12 weeks to validate completion of needed repairs and maintenance as outlined on the prioritized maintenance list. The Maintenance Director will randomly audit 10 Resident Rooms weekly for 12 weeks to ensure the heating unit is working properly. Opportunities will be corrected daily as identified. Criteria #4 The results of these audits and monitoring will be submitted to the QAPI Committee by the Maintenance Director for review by IDT members each month for three months. The QAPI committee will evaluate the effectiveness and amend as needed.	
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.	F 278		11/24/16

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F 278	Continued From page 15 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the resident's bladder appliance status for 1 out of 36 sampled resident (Resident #46). Findings included: Resident #46 was admitted to the facility on 7/7/16 with diagnosis of end stage renal disease. The admission MDS dated 7/17/16 revealed Resident #46 was cognitively intact, had an indwelling catheter and was occasionally incontinent of bladder. The Care Area Assessment (CAA) indicated the resident had problems with urinating and was able to do in and	F 278	F278 Criteria 1 The MDS for Resident #46 with ARD 7/17/16 was corrected to reflect no use of a bladder appliance by the RCMD on 11/27/2016. Criteria 2 Residents with a bladder appliance have the potential to be affected by this alleged deficient practice. The Resident Care	

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F 278	Continued From page 16 out catherization herself. A care plan dated 7/17/16 indicated Resident #46 had episodes of frequent bladder incontinence. The goal was to have bladder incontinence decreased to no more than 0 episodes per day through next review. Care plan interventions included to observe elimination habits to determine pattern, establish a planned toileting program, and to assist with toileting upon rising, before and after meals and before bed. Medical record review for Resident #46 revealed admission orders dated 7/7/16 for straight catheter (an intermittent catheter that is not left in the bladder) every day (QD) for urinary retention. The medical record also revealed a medication administration record (MAR) dated 7/7/16 which indicated straight catheter performed on Resident #46 on 11PM-7AM shift from 7/8/16 to 7/15/16. Review of Resident #46's medical record revealed a nursing admission intake form dated 7/7/16 to indicate "straight cath QD". Further review of the medical record revealed "foley" written in by Nurse #2 under the genitourinary section of the nursing daily skilled summary notes dated 7/11/16, 7/12/16, 7/14/6, and 7/16/16. During an interview on 10/26/16 at 2:59 PM Nurse #2 stated from what she could recall the resident had an indwelling cath. The nurse stated she didn't remember who admitted the resident but she did take care of Resident #46. Nurse #2 went on to say that she could not remember all the details of the resident's care because that was many months ago. On 10/26/2016 at 3:17 PM an Interview with the Director of Nursing (DON) was conducted. She stated the resident never had an indwelling catheter and the daily skilled summary note by Nurse #2 was not correct. The DON indicated her expectations were for the documentation for each	F 278	Management Director conducted an audit of all MDSs completed during the last 30 days to validate accurate coding of bladder appliances. This audit was completed by 11/24/16. Criteria 3 The District Director of Care Management re-educated the Resident Care Management Director regarding accurate completion of the MDS related to the assessment of bladder appliances and documentation and coding of the MDS. This education was completed by 11/24/16. The Resident Care Management Director will randomly audit 5 completed MDSs per week to validate accurate coding of bladder appliances weekly for 12 weeks. Opportunities will be corrected as identified. Criteria 4 The Resident Care Management Director will report the results of these audits and monitoring to the QAPI committee monthly for three months and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed.	

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F 278	Continued From page 17 resident to be correct. On 10/26/2016 at 3:31 PM an interview with the MDS Coordinator revealed Resident #46 did not have an indwelling catheter during the assessment period of the admission MDS. She further stated the resident had an in and out catheter which was noted in her urinary CAA. The MDS coordinator stated the MDS should have been coded intermittent catheterization instead of indwelling cath. The MDS coordinator also stated the nursing daily skilled summary notes from 7/11/16 to 7/16/16 indicated foley catheter so she must have looked at those notes when completing her MDS which were inaccurate. On 10/26/2016 at 3:41 PM an interview with the Administrator indicated her expectations were for the MDS coding to be accurate.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		11/24/16

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F 279	Continued From page 18 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to provide care plans with measurable goals and individualized interventions for 3 of 36 residents reviewed (Residents #10, #16, and #47). The findings included: 1. Resident #10 was admitted to the facility 05/20/15 with diagnoses which included dementia without behavioral disturbance, diabetes mellitus, and Parkinson's disease. An annual Minimum Data Set (MDS) dated 04/04/16 indicated Resident #10's cognition was severely impaired. The MDS specified the resident required extensive staff assistance for most activities of daily living and had demonstrated no behaviors. The MDS further specified the resident could usually be understood and usually understands others. A review of Resident #10's medical record revealed a Situation, Background, Assessment and Request (SBAR) form dated 06/30/16. The form noted a resident to resident altercation between Resident #10 and Resident #73 that was unwitnessed by facility staff. The 2 residents were roommates at the time. A facility incident report dated 06/30/16 specified Resident #73 stated he was going to the bathroom and Resident #10 hit him and he fell backwards. Resident #10 denied he hit his roommate. Resident #73 received a 2 centimeter (cm) by 0.5 cm open area to his right eyebrow. The cause of this incident was undetermined and designated an isolated incident. Resident #10 was moved to	F 279	F 279 Criteria 1 The care plans for Residents #10, #16 and #47 were reviewed by the Interdisciplinary Team including Nursing, Therapy, Social Services, Dietary and Activities and updated to include measurable goals and individualized interventions, with a focus on Behaviors for Resident #10, Anticoagulants for resident #16 and ADLs for Resident #47. These care plan revisions were completed by 11/24/16. Criteria 2 All residents have the potential to be affected by this alleged deficient practice. An audit of all current resident care plans was completed by the Interdisciplinary Team Nursing, Therapy, Social Services, Dietary and Activities and care plans were updated to include measurable goals and individualized interventions with a focus on Behaviors, Anticoagulants and ADLs. These audits and revisions were completed by 11/24/16. Criteria 3 The Interdisciplinary team, to include the Resident Care Management Director, will be re-educated by the District Care	

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F 279	Continued From page 19 another room and a psych referral was made. A care plan related to behavior symptoms and dated 06/30/16 described behavior exhibited by Resident #10 as physical abuse and was described as hitting, threatening, and aggression as related to a diagnosis of dementia. The care plan goal was Resident #10 would have no behaviors through the next review period ending 09/20/16. Approaches included ignore verbal outburst, modify environment, situations, and/or treatment to minimize external stressors, psych referral, and a room change. Approaches did not include monitoring, documenting, or reporting of behaviors. The behavior symptom care plan was updated 07/01/16 and described Resident #10 as quick to anger if he feels like others poke fun at him. The goal was to decrease episodes of identified behaviors to no more than 1 time per day/week through the review period ending 10/2016. The approaches included ignore verbal outburst. There was no approach to monitor, report, or document behaviors or outburst. Review of the Psychotherapy Treatment Plan dated 07/13/16 specified Resident #10 manifested additional diagnoses that included moderate major depressive disorder, unspecified anxiety and dementia with behavioral disturbance. The long term goal for the psychotherapy was to resolve or decrease depression and anger including intensity and frequency of verbal and physical outbursts which were designated as symptoms of depression. The goal further specified this would be evidenced by staff report, patient report, and clinical assessment. This document was electronically signed by the treating Psychologist. Continued medical record review revealed an SBAR dated 08/09/16 that described an incident	F 279	Management Director and the Staff Development Coordinator related to the development of comprehensive care plans to include measurable goals and individualized interventions. Care Plans will be updated during Clinical Start Up daily and during High Risk Meetings accordingly. This education was completed by 11/24/16. The Director of Nursing and/or Unit Managers will randomly audit 10 resident care plans weekly for 12 weeks to ensure goals are measurable and interventions are individualized. Opportunities will be corrected as identified. Criteria 4. The DON or Unit Managers will report the results of these audits and monitoring to the QAPI committee monthly for three months and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed.	

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involving Resident #10 and Resident #15.
Resident #15 was found with a 5 centimeter (cm) circular shaped skin tear on her upper left arm. A facility incident report and follow up investigation dated 08/09/16 specified Resident #15 received an unwitnessed injury on this date at approximately 8:00 PM. The report described a bruised area to the outer corner of the resident ' s left eye near her glasses frame. Also a 5 cm circular shaped skin tear to the left upper arm was noted. The resident was unaware of what happened. The area on the upper arm had thumb-shaped bruising next to the skin tear. The summary of the investigation specified another resident (Resident #10) was guarding the door to the outside smoking area. It was probable that Resident #10 grabbed Resident #15's arm causing the skin tear and bruise. The report further specified Resident #10 denied grabbing Resident #15's arm.
An update to the behavior symptom care plan dated 08/09/16 described Resident #10's behavior as aggressive toward others. An additional approach of redirect resident from guarding door as able. The care plan still contained the approach to ignore verbal outbursts and had no interventions to monitor, document, or report behaviors.
Additional medical record review revealed a SBAR dated 10/25/16 at 9:00 PM. This document specified Resident #10 and Resident #47 were roommates. Resident #10 hit Resident #47 with a trash can causing injuries to the roommate. At this time Resident #10 was sent to the hospital for a psych evaluation.
An interview was conducted with Certified Medication Aide (CMA) #1 on 10/26/16 at 2:50 PM. CMA #1 stated she had observed incidences in the past of Resident #10 getting

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angry with staff because he was out of cigarettes. CMA #1 did not provide dates this occurred but described incidences of Resident #10 being at the nurses station ranting and cursing with staff related to not having cigarettes. When asked if this behavior was documented or reported to the nurse on duty, CMA #1 stated "everyone at the desk" would observe this behavior.

An interview was conducted with Nursing Assistant (NA) #5 on 10/26/16 at 3:12 PM. NA #5 stated he had observed Resident #10 get angry regarding cigarette issues. No dates were provided. NA #5 stated during the 3 months he had worked in the facility, he had observed Resident #10 bickering with this roommate identified as Resident #73. NA #5 stated he had reported the observed behavior to the nurse.

An interview was conducted with the Social Worker (SW) on 10/27/16 at 11:13 AM. The SW stated Resident #10 lived in an assisted living facility (ALF) before admission to the present facility. He got in a fight with another resident at the ALF and sustained a fractured hip. The SW stated Resident #10 did exhibit poor coping mechanisms. The SW further explained Resident #10 will deny the things he does. She stated she had not observed any behavior from Resident #10 that she felt endangered other residents until the incident of 10/25/16.

An interview was conducted with the Director of Nursing (DON) and the District Clinical Services Manager (DCSM) on 10/27/16 at 1:51 PM. The DCSM explained the care plan forms were from a computer system. The DON indicated her expectation was for the care plan to reflect the individual resident needs. The DON and DCSM indicated outbursts of anger should not be ignored. Staff should be reporting and documents behaviors anytime the behavior

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occurred and the care plan approaches should reflect this.

2. Resident #16 was readmitted to the facility 09/20/16 with diagnoses which included recent cerebral vascular accident (stroke), atrial fibrillation, and dementia.
A review of Resident #16 ' s medical record revealed a physician's order dated 09/22/16. The order specified Coumadin (an anticoagulant medication) was to be held for 2 days per admission orders. A blood test to check Coumadin effectiveness was to be obtained 09/22/16.
A significant change Minimum Data Set (MDS) dated 10/05/16 indicated Resident #16 demonstrated long and short term memory loss and severely impaired cognition. The MDS further specified the resident required limited staff assistance with activities of daily living and an anticoagulant medication had been administered the past 7 days.
A review of care plans for Resident #16 revealed no plan of care regarding monitoring for side effects related to an anticoagulant medication. There were no measured goals or individualized interventions planned to monitor bleeding or other side effects of anticoagulant medication.
A review was conducted of the Resident Care Specialist Sheet (a care guide for nursing assistants that contained individualized approaches for each residents' care) dated 10/25/16. The sheet did not contain instructions to direct nursing assistants to watch for and report any signs of bleeding.
An interview was conducted with the MDS Coordinator on 10/26/16 at 4:24 PM. The MDS Coordinator stated residents on Coumadin should have a care plan related to anticoagulant therapy.

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It was important to alert Unit Managers who filled out the Resident Care Specialist Sheet to place instructions for nursing assistants to watch for signs of bleeding. The MDS Coordinator stated she always initiated a new care plan when a significant change MDS was required. She explained she was not sure why this care plan was not in Resident #16's medical record. It was her intent to have initiated a care plan for Resident #16 regarding Coumadin.
An interview was conducted with the Director of Nursing (DON) on 10/27/16 at 2:07 PM. The DON stated any resident on an anticoagulant medication should have a care plan that directed nursing staff to monitor for bleeding.
During an interview on 10/27/16 at 9:53 AM, Unit Manger #1 stated she was unaware the Resident Care Specialist Sheet should direct nursing assistants to observe for bleeding. She stated she had not been putting that information on the sheet.

3. Resident #47 was admitted to the facility on 8/1/14 with diagnoses that included cerebrovascular accident (stroke), left-sided hemiplegia (paralysis on one side of the body) and muscle weakness.

The annual Minimum Data Set (MDS) dated 8/5/16 coded Resident #47 as having mild cognitive impairment and displayed no rejection of care. The MDS indicated Resident #47 required extensive assistance of 1 staff person for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS indicated Resident #47 had functional limitation in range of motion due to impairment of upper and lower extremities

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on one side.

Review of Resident #47 s care plans dated 8/5/16, with a recent review date of 10/17/16, revealed an active plan in place for activities of daily living (ADL). The ADL care plan included goals that addressed his need for staff assistance while maintaining the highest level of independent functioning possible. Interventions included for Resident #47 to have adequate time to complete tasks and refer to therapy as indicated.

Review of Resident #47's care specialist assignment sheet (CNA guide for resident care) revealed no instructions for staff to provide range of motion exercises to joints at risk for contracture when providing care.

An observation on 10/23/16 at 5:02 PM revealed Resident #47 in his room sitting in the wheelchair. Resident #47's left hand was resting on his lap with his hand shaped into a fist and his fingers folded into the palm of his hand.

An observation and interview was conducted with Resident #47 on 10/24/16 at 8:58 AM. Resident #47 was sitting in his wheelchair, eating breakfast in his room. Resident #47's left hand was resting on his lap with his hand shaped into a fist and his fingers folded into the palm of his hand. Resident #47 stated he would like to be able to move his left hand and had noticed improvement when he had received therapy. Resident #47 stated he had not received any range of motion exercises since therapy services had ended.

During an interview on 10/24/16 at 9:32 AM Nurse #2 confirmed Resident #47 had a contracture of the left hand. Nurse #2 added

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F 279	Continued From page 25 Resident #47 did not currently receive range of motion (ROM) exercises. During an interview on 10/27/16 at 8:47 AM the Occupational Therapist (OT) confirmed Resident #47 had received therapy services in September of 2016 but had requested to be removed from the therapy caseload. The OT stated when a resident was ready to be released from therapy, they would develop a restorative care plan for maintenance but due to staffing issues, there was currently no restorative program. The OT stated Resident #47 would benefit from ROM to prevent skin breakdown and further worsening of the contracture. During an interview on 10/27/16 at 1:36 PM Nurse Aide (NA) #2 stated ROM exercises, such as arm stretches to loosen the muscles, were performed on Resident #47 when providing assistance with dressing. NA #2 stated there was no ROM exercises performed to stretch out the fingers of his left hand. An interview was conducted with the Director of Nursing (DON) and District Director of Clinical Services on 10/27/16 at 6:55 PM. The DON stated she had started working at the facility in April of 2016 and since that time, there had been no restorative program. The DON stated she expected residents to have no decline in ADL or skin breakdown related to prevention of contractures.	F 279		
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	F 309		11/24/16

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F 309	Continued From page 26 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 interviews the facility failed to monitor/assess a resident's outbursts of anger following demonstrations of physical or verbal behaviors toward other residents and staff for 1 of 2 residents reviewed for provision of well being (Resident #10). The findings included: Resident #10 was admitted to the facility 05/20/15 with diagnoses which included dementia without behavioral disturbance, diabetes mellitus, and Parkinson's disease. An annual Minimum Data Set (MDS) dated 04/04/16 indicated Resident #10's cognition was severely impaired. The MDS specified the resident required extensive staff assistance for most activities of daily living and had demonstrated no behaviors. The MDS further specified the resident could usually be understood and usually understands others, and requires supervision of wheelchair use for locomotion. A review of Resident #10's medical record revealed a Situation, Background, Assessment and Request (SBAR) form dated 06/30/16. The form noted a resident to resident altercation between Resident #10 and Resident #73 that was unwitnessed by facility staff. The 2 residents were roommates at the time. A facility incident report dated 06/30/16 specified Resident #73 stated he was going to the bathroom and	F 309	F 309 Criteria 1 A new Targeted Behavior Monitoring Tool was developed for Resident #10 to reflect past behaviors of being angry, a danger to others, fighting, striking out or hitting and threatening others. These new monitoring tools were developed by the DON and implemented by 11/24/16. Criteria 2 Residents with behaviors have the potential to be affected by this alleged deficient practice. The DON and Nurse Managers completed an audit of residents with behaviors to assess current behaviors and implement new Targeted Behavior Monitoring Tools to reflect these behaviors. These audits were completed and these tools were implemented by 11/24/16. Criteria 3 Licensed Nurses were re-educated by the Staff Development Coordinator regarding the assessment and monitoring of resident behaviors and the completion of the Targeted Behavior Monitoring Tool, including the addition of new behaviors as assessed or identified. This re-education was completed by 11/24/16. The DON	

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F 309	Continued From page 27 Resident #10 hit him and he fell backwards. Resident #10 denied he hit his roommate. Resident #73 received a 2 centimeter (cm) by 0.5 cm open area to his right eyebrow. The cause of this incident was undetermined and designated an isolated incident. Resident #10 was moved to another room and a psych referral was made. A MDS annual assessment dated 05/20/16 described Resident # 73 with mild cognitive impairment, required oversight with ambulation in his room, and utilized walker or wheelchair for locomotion. A care plan related to behavior symptoms and dated 06/30/16 described behavior exhibited by Resident #10 as physical abuse and was described as hitting, threatening, and aggression as related to a diagnosis of dementia. The care plan goal was Resident #10 would have no behaviors through the next review period ending 09/20/16. Approaches included ignore verbal outburst, modify environment, situations, and/or treatment to minimize external stressors, psych referral, and a room change. Approaches did not include monitoring, documenting, or reporting of behaviors. The behavior symptom care plan was updated 07/01/16 and described Resident #10 as quick to anger if he feels like others poke fun at him. The goal was to decrease episodes of identified behaviors to no more than 1 time per day/week through the review period ending 10/2016. The approaches included ignore verbal outburst. There was no approach to monitor, report, or document behaviors or outburst. Review of the Psychotherapy Treatment Plan dated 07/13/16 specified Resident #10 manifested additional diagnoses that included moderate major depressive disorder, unspecified anxiety and dementia with behavioral	F 309	and Nurse Managers will randomly audit 10 residents per week with behaviors to ensure accurate assessment and documentation of resident behaviors on the Targeted Behavior Monitoring Tool. This audit will continue for 12 weeks. Opportunities will be corrected as identified. Criteria 4 The Director of Nursing will report the results of these audits and monitoring to the QAPI committee for three months then as needed. The QAPI committee will evaluate the effectiveness and amend as needed.	

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disturbance. The long term goal for the psychotherapy was to resolve or decrease depression and anger including intensity and frequency of verbal and physical outbursts which were designated as symptoms of depression. The goal further specified this would be evidenced by staff report, patient report, and clinical assessment. This document was electronically signed by the treating Psychologist. A psychotherapy progress note dated 07/18/16 and electronically signed by the treating Psychologist specified Resident #10 was oriented to place and situation. The note further specified the resident could readily become irritable. Continued medical record review revealed an SBAR dated 08/09/16 that described an incident involving Resident #10 and Resident #15. Resident #15 was found with a 5 centimeter (cm) circular shaped skin tear on her upper left arm. A facility incident report and follow up investigation dated 08/09/16 specified Resident #15 received an unwitnessed injury on this date at approximately 8:00 PM. The report described a bruised area to the outer corner of the resident's left eye near her glasses frame. Also a 5 cm circular shaped skin tear to the left upper arm was noted. Resident #15 was unaware of what happened. The area on the upper arm had thumb-shaped bruising next to the skin tear. The summary of the investigation specified another resident (Resident #10) was guarding the door to the outside smoking area. It was probable that Resident #10 grabbed Resident #15's arm causing the skin tear and bruise. The report further specified Resident #10 denied grabbing Resident #15's arm. An annual MDS assessment dated 07/18/16 described Resident #15 with severely impaired cognition and wheelchair bound.

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An update to the Behavior Symptom care plan dated 08/09/16 described Resident #10's behavior as aggressive toward others. An additional approach specified redirect resident from guarding door as able. The care plan still contained the approach to ignore verbal outbursts and had no interventions to monitor, document, or report behaviors.
Additional review of psychotherapy progress notes revealed Resident #10 was seen by the Psychologist on 09/05/16 and 09/12/16. The last psychotherapy progress note was dated 09/13/16 and signed by the treating Psychologist. This note specified this would be the last visit for this Psychologist because the facility had cancelled the contract with this company. The note further specified Resident #10 stated he does feel a little depressed and agitated at times and had a short temper. An additional diagnosis of possible major vascular dementia was added. The note further specified Resident #10 should continue to be followed with psych therapy.
Continued medical record review revealed behavior monitoring since the incident of 06/30/16 through 10/25/16 consisted of observations of sadness and feelings of isolation. No behavioral assessments for anger or documentation of episodes involving anger could be found.
Further medical record review revealed a SBAR dated 10/25/16 at 9:00 PM. This document specified Resident #10 and Resident #47 were roommates. Resident #10 hit Resident #47 with a trash can causing a laceration to the left forehead and a skin tear to the left arm. At this time Resident #10 was sent to the hospital for a psych evaluation.
An interview was conducted with Resident #47 on 10/26/16 at 6:45 AM. Resident #47 was lying in his bed in his room. A bandage was observed on

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his right forehead. Resident #47 stated he was lying in his bed asleep last evening when Resident #10 started hitting him with the trash can. Resident #47 stated he tried to get out of bed and Resident #10 left the room. Resident #47 explained he moved into the semi-private room with Resident #47 about 2 to 3 months ago. Last evening Resident #10 had asked him to turn off his TV. Resident #47 would not turn off his TV and went to sleep. The resident stated he had not been physically attacked before, but Resident #10 had told him to turn off his TV on previous occasions. Resident #47 stated his roommate did not want him to watch TV. Resident #47 stated up until now he had not been afraid of his roommate. A quarterly MDS assessment dated 08/05/16 described Resident #47 with intact cognition, impairment of upper and lower extremities of left side, and used a wheelchair for locomotion.

An Interview was conducted with the Director of Nursing (DON) on 10/26/16 at 7:52 AM. The DON stated the staff had given Resident #10 the job of protecting the smoker's area and not letting residents go outside unattended. She added the resident took his job very seriously. The DON explained she felt Resident #10 was likely "protecting" Resident #15 from going outside by grabbing her arm and leaving a bruise. The DON stated no report was filed because they did not feel there was the intent of harm.

An interview was conducted with the Administrator on 10/26/16 at 8:45 AM. The Administrator stated she had been the Administrator at this facility since 05/02/16. Her interactions with Resident #10 have always been pleasant. She described Resident #10 as smiling and happy. The Administrator stated she was unaware of any other altercations with other

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residents. The Administrator added it was not until this morning she found out prior to admission Resident #10 had an incident with a resident while in another facility. She stated the DON notified her via phone around 8:30 PM last evening of the incident with Resident #47. The Administrator stated she instructed staff to move Resident #47 away from Resident #10 and to send Resident #10 to the hospital for a psych evaluation. The staff further reported to the Administrator Resident #10 was refusing to go to the hospital. The Administrator instructed staff to obtain involuntary commitment papers and have the police to escort Resident #10 to the hospital. The Administrator stated the nurse and the policeman communicating with Resident #10 reported to her the resident stated he did hit his roommate and "I would do it again". She stated again she was unaware of any violent history with any other resident nor had staff indicated this behavior had occurred in the past.

An interview was conducted with Nurse #2 on 10/26/16 at 1:03 PM. She stated she had not observed any aggressive behaviors demonstrated by Resident #10 since the incident involving Resident #73. Nurse #2 stated the incident between Resident #10 and Resident #15 happened on the 3:00 PM to 11:00 PM shift on 08/09/16. She explained on 08/09/16 she was leaving the facility at the end of her day shift and exited the building through the door to the smoker's area. Nurse #2 described Resident #10 was guarding the door to keep Resident #15 from exiting. She heard an exchange of words between the 2 residents. She described Resident #10 kept telling Resident #15 to back up. Resident #15 was telling Resident #10 he was not her boss. Nurse #2 stated she left the building. The following day she heard about the incident

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that occurred between the 2 residents.
A phone interview was conducted with the treating Psychologist on 10/26/16 at 2:33 PM. The Psychologist confirmed she did treat Resident #10 for a few months before the facility cancelled the contract with her company. She stated she could not speak for Resident #10's condition at present. When she last saw the resident, he was pleasant and nice but his was capable of erratic behavior. The Psychologist stated facility staff precipitated some of Resident #10's behavior by giving him the job of guarding the door. She added the resident took his job seriously. The Psychologist stated she had discussed her findings with the DON.
An interview was conducted with Certified Medication Aide (CMA) #1 on 10/26/16 at 2:50 PM. CMA #1 stated she had observed incidences in the past of Resident #10 getting angry with staff because he was out of cigarettes. CMA #1 did not provide dates this occurred but described incidences of Resident #10 being at the nurses station ranting and cursing with staff related to not having cigarettes. The CMA further stated she had observed Resident #10 going out to the smoking area and going through ashtrays getting cigarette butts to smoke. When asked if this behavior was documented or reported to the nurse on duty, CMA #1 stated "everyone at the desk" would observe this behavior.
An interview was conducted with Nursing Assistant (NA) #5 on 10/26/16 at 3:12 PM. NA #5 stated he had observed Resident #10 get angry regarding cigarette issues. NA #5 stated during the 3 months he had worked in the facility, he had observed Resident #10 bickering with this roommate identified as Resident #73. NA #5 stated he had reported the observed behavior to the nurse. Dates of these observations were not

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F 309	Continued From page 33 provided. An interview was conducted with Unit Manager (UM) #1 on 10/27/16 at 9:56 AM. UM #1 stated she had observed Resident #10 get sporadically frustrated on occasion. UM #1 added Resident #10 had several room changes over time which were due to not getting along with roommates. An interview was conducted with the Social Worker (SW) on 10/27/16 at 11:13 AM. The SW stated Resident #10 lived in an assisted living facility (ALF) before admission to the present facility. He got in a fight with another resident at the ALF and sustained a fractured hip. The SW stated Resident #10 did exhibit poor coping mechanisms. The SW further explained Resident #10 will deny the things he does. She stated she had not observed any behavior from Resident #10 that she felt endangered other residents until the incident of 10/25/16. An interview was conducted with the Administrator, DON, and Director of Clinical Services on 10/27/16 at 1:51 PM. All three confirmed there was no evidence of monitoring, assessing, or documenting Resident #10's outburst of anger since the episode of 06/30/16. The DON and Director of Clinical Services confirmed the nursing staff was monitoring episodes of sadness and feelings of isolation if they were observed. There was no documentation of the reported behaviors in the resident's medical record. The Administrator stated she never knew Resident #10 bickered with other residents or exhibited behaviors as the staff verbally reported. Resident #10's anger outburst and behaviors toward other residents should be monitored and assessed as they occurred.	F 309		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		11/24/16

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F 318 SS=D	Continued From page 34 IN RANGE OF MOTION 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, medical record review and staff interviews, the facility failed to provide range of motion exercises to 1 of 2 reviewed residents that were at risk for further decline and development of contractures (Resident #8). The findings included: Resident #8 was readmitted to the facility 09/02/16 with diagnoses which included depression, anxiety, and psychotic disorder. A quarterly Minimum Data Set (MDS) dated 09/09/16 indicated Resident #8's cognition was severely impaired. The MDS specified the resident was delusional, had psychomotor retardation and required extensive staff assistance to total dependence on staff for activities of daily living. The MDS further specified Resident #8 verbally responded to simple direct communication only. A care plan updated 09/09/16 described Resident #8 with contractures of both arms and foot drop of both feet. The care plan goal specified the staff would provide range of motion to both arms and feet daily thru the next 90 day review. Interventions included passive range of motion to all major joints during care, monitor of range of motion decline, and encourage to wear shoes	F 318	F318 Criteria 1 Resident #8 was evaluated by the Rehab Staff on 11.17.2016 and a treatment plan developed to include splinting, range of motion and development of a Restorative Nursing Program for ongoing management. Criteria 2 Residents with contractures have the potential to be affected by this alleged deficient practice. An audit of current residents with contractures was conducted by the Rehab Staff by 11/24/16. Based on the results of this audit, an individualized treatment plan was developed to include splinting and range of motion where clinically appropriate. Ongoing Restorative Nursing Programs will be developed and implemented as therapy treatment plans are completed. Criteria 3 Rehab and Licensed Nurses were re-educated by the Staff Development Coordinator regarding the assessment of	

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F 318	Continued From page 35 and left palm guard as ordered. A review of the resident care specialist assignment sheet dated 10/25/16 did not contain instructions to provide range of motion exercises to all major joints during care. An observation on 10/24/16 at 2:12 PM revealed Resident #8 was lying in a recliner. Both arms were bent at the elbow and hands were folded under her chin. Both hands were in the shape of a fist with fingers bent into the palms of her hand. The left hand had a palm guard present. An observation on 10/25/16 at 10:53 AM revealed Resident #8 was lying in bed mumbling inaudible words. Both hands were in a fist with fingers curled into the palms. A palm guard was observed in the resident's left hand. Both elbows were bent so that her arms folded over her chest. An observation was conducted on 10/25/16 at 12:43 PM with Nursing Assistant (NA) #6. Resident #8 was observed lying in bed with head of bed raised. The resident's arms were bent at the elbow with hands in fist under her chin. NA #6 was able to straighten the fingers on both of the resident's hands. She stated the left fingers were more difficult to straighten. NA #6 stated at times it appeared to hurt the resident when she attempted to straighten her left fingers. Both of the resident's arms remained bent at the elbow. An observation on 10/26/16 at 6:20 AM revealed Resident #8 was lying in bed chanting. Her hands were in a fist with fingers curled into the palms. Both elbows were bent so that her arms and hands were resting on her chest. During an interview on 10/27/16 at 10:24 AM NA #7 stated she has cared for Resident #8 for the past couple of months. The NA stated she straightened out her fingers to clean her hands but provided no other repetitive straighten of fingers or range of motion at the shoulders.	F 318	residents with decreased range of motion and contractures to include therapy referral for evaluation and ongoing treatment by Restorative Nursing. The re-education was completed by 11/24/16. The Rehab Director will randomly audit 5 residents weekly for 12 weeks with contractures to ensure range of motion and splinting is completed as clinically indicated. Opportunities will be corrected as identified. Criteria 4 The Rehab Director will report the results of these audits and monitoring to the QAPI committee monthly for three months, then as needed. The QAPI committee will evaluate the effectiveness and amend as needed.	

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F 318	Continued From page 36 An interview with the Physical Therapist (PT) on 10/26/16 at 4:48 PM revealed residents were referred to therapy by the nursing staff when they noticed contractures worsening. The PT stated Resident #8 was last treated by therapy in February of 2016. The therapy goal at that time was to strengthen the resident grasps to hold items. During an interview on 10/27/16 at 2:36 PM, the Occupational Therapist (OT) stated she had assessed Resident #8. The OT described the resident with tightness in the elbows. The OT also stated Resident #8 was at risk for skin breakdown and further contracture and could benefit from range of motion exercises. An interview was conducted with the Director of Nursing (DON) on 10/27/16 at 6:55 PM. The DON stated she had been working at this facility since April of 2016. She added the facility has not had a restorative program since she had been here. The DON stated she expected no decline in activities of daily living and prevention of contractures.	F 318		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		11/24/16

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F 353	Continued From page 37 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide restorative nursing services for 1 of 1 resident reviewed for range of motion due to insufficient staffing (Resident #8). Findings included: This tag is cross-referenced to: F 318: Based on observations, medical record review and staff interviews, the facility failed to provide range of motion exercises to 1 of 2 reviewed residents that were at risk for further decline and development of contractures (Resident #8). An interview was conducted with the Physical Therapist (PT) on 10/26/16 at 4:48 PM. The PT stated Resident #8 had been treated by the therapy department in February of 2016. The goal was to strengthen the resident's grasp so she could hold items in her hands. The PT stated there was no restorative nursing program in the facility to continue range of motion exercises. An interview was conducted with the Occupational Therapist (OT) on 10/27/16 at 2:36	F 353	F353 Criteria 1 A Restorative Nursing Program for range of motion and splinting has been developed by the Restorative Nursing Coordinator and implemented for Resident #8 on 11/15/16. Restorative Nursing staff were designated and trained on 11/11/16 by the Staff Development Coordinator. Criteria 2 Residents with contractures have the potential to be affected by this alleged deficient practice. Restorative Nursing staff were designated and trained on 11/11/16 by the Staff Development Coordinator. An audit of current residents with contractures was conducted by the Rehab Staff by 11/24/16. Based on the results of this audit, an individualized treatment plan was developed to include splinting and range of motion where clinically appropriate. Ongoing Restorative Nursing Programs will be developed and implemented as therapy treatment plans	

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F 353	Continued From page 38 PM. The OT stated the facility used to have a good restorative program. She explained the therapist would create a care plan that the restorative aides could follow after the resident was released from therapy. The OT stated range of motion exercises would be greatly benefit Resident #8. An interview was conducted with the Director of Nursing (DON) on 10/27/16 at 6:53 PM. The DON stated the facility had pulled the restorative aide to work as a nurse aide due to insufficient staffing. The DON could not remember the exact date the restorative program had ended but stated it had occurred prior to April of 2016. The DON added no restorative program had been in place since. An interview was conducted with the Administrator on 10/27/16 at 7:24 PM. The Administrator stated there had been so many variables in leadership, the facility had not gotten to that steady foundation for compliance.	F 353	are completed. Criteria 3 Nursing and Rehab staff were re-educated by the Staff Development Coordinator regarding the implementation of a Restorative Nursing Program, designated staff, specific training requirements and directions for making referrals. Rehab and Licensed Nurses were re-educated by the Staff Development Coordinator regarding the assessment of residents with decreased range of motion and contractures to include therapy referral for evaluation and ongoing treatment by Restorative Nursing. The re-education was completed by 11/24/16. The Rehab Director/designee will randomly audit 5 residents weekly for 12 weeks with contractures to ensure range of motion and splinting is completed as clinically indicated. Opportunities will be corrected as identified. Criteria 4 The Rehab Director will report the results of these audits and monitoring to the QAPI committee monthly for three months and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		11/24/16

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F 364	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow the recipes in order to conserve nutritive value and flavor of the food items for pureeing BBQ pork and cooked cabbage by adding water and thickening powder to thin the entrées without measuring and the facility failed to provide residents with palatable foods based on resident preference for warm food temperature for 1 of 1 observations of the tray line meal service, and a test tray. The findings included: Observations were made of the facility's kitchen, food preparation, and tray line meal service and a test tray was completed during the 5 days of the survey investigation from 10/23/16 to 1027/16. 1. On 10/26/16 at 3:50 PM the Food Service Director (FSD) and the District Food Service Director (DFSD) were present while Cook #1 proceeded to prepare puree BBQ pork, and cooked cabbage for the supper meal. Cook #1 was observed pureeing an unmeasured quantity of cut up pieces of cooked BBQ pork product into a food processor. Cook #1 poured approximately ½ of 2 quart pitcher of hot water without measuring into the BBQ pork mixture and re-processed the meat to a thinner consistency. Cook #1 added some more unmeasured amount of water into the meat product. The kitchen cook then added powdered thickener several more times without measuring and without looking at the instructions of the product before the pureed	F 364	F 364 Criteria #1 1. The preparation for the pureed meal in question was redone according to the correct diet extension used to breakdown portion size. The correct size measuring scoops were used to provide adequate nutrition. 2. A new thermometer was purchased and was used to monitor food temps. Criteria #2 1. All residents have the potential to be affected by the alleged deficient practice therefore, food services staff have been educated by the District HSG Food Service Director on the puree recipes and diet extension needed to breakdown portion size to provide the correct nutritive food value; they have received education regarding the portion sizes and the correct scoop to use for the portion. 2. All residents have the potential to be affected by the alleged deficient practice therefore, food temps are checked at the steam table prior to plating as well as a test tray which is prepared last and tested after the last Resident tray is served. Criteria #3 1. The correct use of diet extensions and provision of food with the adequate nutritive value will be monitored 3 times per day for four weeks and then once daily for four weeks. NHA and/or Food Services Director will be monitoring the pureed diets for consistency, temperature	

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F 364	Continued From page 40 BBQ pork resembled a smooth "mashed potato" consistency. During the observations, Cook #1 was interviewed and explained that she added water to the puree pork meat. She further explained she then added the thickening powder to the puree because it was too thin in order to get it to the right consistency similar to mashed potatoes. She further explained she did not measure because she just knew how much water and thickener to add to the meat. Cook #1 revealed the pork was a prepackaged BBQ product that was a frozen 2 lb. bag. The recipes for puree BBQ Pork and cabbage were observed on the table next to preparation area. Prior to serving the cook prepared a new batch of BBQ Pork and added chicken broth for thinning instead of water and thickening powder. Cook #1 was observed pouring an unmeasured quantity of cooked cabbage into the food processor. Cook #1 then poured an unmeasured quantity of water from a 2 quart pitcher of hot water without measuring into the cabbage slurry mixture and re-processed it to a thinner consistency. Cook #1 added some more unmeasured amount of water into the product. Cook #1 then added powdered thickener several more times without measuring and without looking at the instructions of the product before the pureed cabbage resembled a smooth puree consistency. During the observations, Cook #1 was interviewed and reported that she added water to the cabbage mixture to puree it. She explained she then added the thickening powder to the puree because it was too thin and to get to the right consistency similar to mashed potatoes. She further explained she did not measure because she just knew how much water and thickener to add to the cabbage to puree it.	F 364	and flavor three times daily for four weeks. The Food Services Director and/or lead cook will monitor the preparation of the pureed meals to ensuring the right size portion scoop is used by the prep staff. 2. The food temperatures will be tested daily by the Food Service Director or lead cook prior to plating the Resident meals. These temperatures will be monitored and recorded daily. The warming plates are being taken from the plate warmer in small batches in order to preserve the plate temperature. The test tray will continue to be monitored three times per day for two weeks; and then one time per day, random meals, three days per week for two months. Criteria #4 The NHA and/or Food Service Director will present the puree diet, temperature audits and taste review monthly x 3 months to the QAPI committee, then as determined by the QAPI committee.	

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Review of the facility's recipes revealed for BBQ pork quantities for 3 ounce portion sizes for 80 servings. The ingredients listed were 24 pounds (lbs.) pork, 1& 1/10 tablespoon seasoning, and 1&1/4 gallon BBQ sauce. Under notes for preparation the instructions indicated for pureed to measure out desired number (#) of servings into food processor, blend until smooth, follow directions on food thickener guidelines of the specific product used in your facility for liquid and thickener measurements. There were no notes indicating calculations were made for the number of servings being prepared for this meal on the recipe.

Review of the facility's recipes revealed for cooked cabbage quantities for ½ cup portion sizes for 80 servings. The ingredients listed were 16 & 2/3 lbs. cabbage, 1& 1/10 tablespoon seasoning pepper, ¾ cup margarine and 1 & 2/3 gallon water. Cook cabbage, drain well, and add margarine and pepper. Under notes for preparation the instructions indicated for pureed to measure out desired # of servings into food processor, blend until smooth, follow directions on food thickener guidelines of the specific product used in you facility for liquid and thickener measurements. There were no notes indicating calculations were made for the number of servings being prepared for this meal on the recipe.

An interview was conducted on 10/26/16 at 4:28 PM with Registered Dietitian (RD). The RD stated she did not think that the water was enough to deplete the nutritive value of the foods especially since they used larger scoop sizes of these items than portion sizes indicated. Cook #1 then pulled out a 2 ounce (oz.) scoop which should have

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been a 3 oz. scoop for mechanical soft meat and a 6 oz. scoop which should have been an 8 oz. scoop for puree meat as indicated for the portion sizes. Cook #1 stated she was not sure which size scoop to use. The RD and the DFSD both verified Cook #1 was unable to pull out the proper scoop size to serve for the residents and the scoops she was going to use were smaller than the portion sizes indicated for the meal. The RD and the DFSD both further verified it was obvious the kitchen staff required further education.

An interview was conducted on 10/27/16 at 5:16 PM with the Food Service Director (FSD). The FSD stated based on the observations of preparation of pureed foods and portion size scoops that the staff required education for correctly pureeing food, identifying proper portion sizes. The FSD further stated the kitchen staff required training on following standardized recipes more strictly, measuring foods and liquids when pureeing food and knowing what size scoops were required for portion sizes. The FSD explained the puree foods were prepared to serve for approximately 10 residents on puree diets. The FSD verified Cook #1 did not properly prepare the puree foods for the supper meal observed, did not measure ingredients, and did not know portion sizes of serving scoops. The FSD indicated the last in-service related to food quality and portion sizes was on 10/18/16 The FSD stated it was his expectation that his dietary staff know how to prepare foods, puree foods according to recipes and know proper scoop sizes for portions to be served.

An interview was conducted on 10/27/16 at 6:58 PM with the Administrator. The Administrator stated it was her expectation for dietary service

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staff to know how to prepare foods, puree foods according to recipes and know proper scoop sizes for portions to be served.

2. On 10/26/16 at 7:09 AM observed Cook #1 setup of foods on the steam table for breakfast meal, observed calibration of the thermometer, and temperatures were observed being taken of the food products on the steam table. The DFSD and FSD #2 were present at the time of the thermometer calibration and temping of steam table foods. Cook #1 was observed having difficulties calibrating the thermometer and temping the foods on the steam table. The DFSD then assisted Cook #1 to accomplish these tasks and reheating steam table foods while giving her instructions. The foods were then temped at the proper steam table holding temperature.

On 10/26/16 at 8:19 AM all tray carts for the breakfast meal were completed, pushed to the halls and no cart covers were observed except for the last cart. The last serving cart was covered with a clear plastic zip cover and a test tray was requested. At that time Dietary Aide #2 stated the facility only had one cart cover they were testing out.

On 10/26/16 at 8:23: AM the last cart was sent to the floor for serving. A nurse, nursing assistant, the Facility Maintenance director (FMD) and the Business Office Manager (BOM) were observed on 10/26/16 at 8:30 AM assisting to pass out meal trays. The FMD stated he sometimes assisted serving trays when he had time. The BOM stated she sometimes assists to serve trays and further stated this was the first time she saw a tray cart cover on the hall and she thought it was new.

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F 364	Continued From page 44 On 10/26/16 at 8:31 AM the last meal tray was served and the test tray was brought to the conference room with the FSD and the DFSD. The food was tested and determined the temperature by the surveyor and the FSD. The oatmeal, eggs and ground sausage were barely lukewarm. The FSD stated the food was not really hot enough. The FSD further stated there was a problem with their thermometer when temping the foods, they had 6 people today assisting with the steam table when they normally had only 3, and that cold food was still a concern. An interview was conducted on 10/27/16 at 5:16 PM with the Food Service Director (FSD). The FSD indicated the last in-service for food service regarding food temperatures was on 10/21/16. The FSD verified the facility had only one tray cart cover, and further verified it was not working well because there was still a problem with cold food. The FSD stated it was his expectation that all food served to residents was to be at the proper temperatures hot food should be hot, and cold foods should be cold. An interview was conducted on 10/27/16 at 6:58 PM with the Administrator. The Administrator stated it was her expectation that all food served to residents should be at the proper temperatures, hot food should be hot, and cold foods should be cold.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		11/24/16

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F 371	Continued From page 45 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to keep a clean and sanitary kitchen, provide proper food storage, and the facility failed to ensure staff completed hand washing and donning of gloves prior to touching food, food service plates and trays during meal service for 1 of 1 tray line observations. The findings included: 1. On 10/23/16 at 3:07 PM the following observations were made in the kitchen. a. One flour bin inside the dry storage room was observed with an open lid not closed and a plastic water pitcher on top of the bin with flour on it used as a scoop. On 10/26/16 at 6:59 AM the sugar bin was left wide open with grains of sugar on top of the lid. No staff were observed using it at the time. The FSD was unable to verify how long the flour and sugar bins were left open or who had last accessed them. b. Four bins containing white sugar, brown sugar, thickener, and cornmeal were observed outside of the dry storage room door. All lids on the 4 bins were closed but dirty with smeared finger prints and food particles and brown splashes were noted inside the white sugar bin.	F 371	F 371 Criteria #1 1.a. Dry storage bins were cleaned and items removed from the top. b. The four bins containing sugar, brown sugar, thickener and cornmeal were emptied of product, cleaned and sanitized. New product was placed into the cleaned bins. c. The reach-in milk cooler chest was cleaned and all non-dairy food items were removed. The cooler has since been removed from service. d. The stainless steel equipment and been cleaned and polished: double oven stove, steam craft machine, deep fryer and plate warmers. 2. Entr¿e lids were cleaned and sanitized; the steam table was cleaned and sanitized. e. The kitchen floors were cleaned and degreased with special attention to the debris and substance in front of the cooking equipment, steam table and three compartment sink. f. The white tile walls were cleaned of streaks and food particles. g. The stainless steel walls were cleaned and polished free of streaks and	

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F 371	Continued From page 46 c. The reach in milk cooler chest was observed with 40 milk cartons, a dinner plate with a chief salad wrapped in saran wrap not dated and partially open with salad falling into the bottom of the cooler, a bowl of cottage cheese was not dated or sealed, a juice container with approximately a tablespoon of cottage cheese on top of one of the juices, and the bottom of cooler was observed to have dried lettuce, and food particles under the racks on the bottom of the cooler. d. The following stainless steel kitchen equipment were observed to have smeared greasy streaks and food particles on all of the outside surfaces and the handles were sticky and greasy to the touch: · Garland double oven stove · Steam craft machine · Deep fryer · Stainless steel plate warmer machines (2) · 5 of 6 entrée lids with handles were streaked with grease and food particles on the steam table · The front and sides of the steam table and the glass look thru screen in front of steam table were streaked with grease and food particles. e. Observations of all the kitchen floors were dirty and sticky. Further observations of the floors revealed thick brownish-black greasy substance, food particles and debris in front of and around all the kitchen cooking equipment, around the steam table and also in the 3 sink dishwashing area. f. The white tile walls behind and around cooking equipment were streaked and dirty brownish stains and were noted to have brownish black substance running along the length of the tile	F 371	food particles h. The drawers of the prep table containing serving utensils have been cleaned and sanitized as well as the utensils in the drawers. 2. a. Any unlabeled and unsealed items were discarded b. Any items pre-poured, pre-plated and unlabeled i.e. cereal was discarded. c. Carton of undated and unsealed frozen fish was discarded. d. Unsealed open container of powdered sugar was discarded. e. Open cartons with open bags of frozen foods in the freezer, unsealed and containing frost were discarded. f. Bags of frozen food in the freezer which were open and not in their original container, resealed and not dated when opened were discarded. 3. All cooks and line prep staff wear gloves to maintain a sanitary food service environment. NOTE: The cleaning log has been updated and delineated as to position responsible and specific duties to include cleaning of outside of stove, ovens and deep fryer, steam table, plate warmers, coolers and other kitchen equipment. Mopping of all floors is listed as daily task and washing the walls is now assigned to the weekly cleaning schedule. Criteria #2 All residents have the potential to be affected by the alleged deficient practice therefore, the Regional and facility Food Service Directors are performing kitchen sanitation checks twice daily as well as	

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F 371	Continued From page 47 walls and up approximately ½ foot up from floor. g. The stainless steel walls in the kitchen were noted with streaks and food particles running down the walls. h. 1 of 3 drawers of the prep table containing slotted and strainer serving spoons had liquid and debris in the bottom of the drawer. 2. On 10/23/16 at 3:07 PM the stored foods in the dry storage and freezer were noted as follows: a. 2 bags of open Rice Crispy Cereal were not labeled when open and not sealed. b. 3 bowls of Raisin Bran Cereal and 2 bowls Corn Flake Cereal were not dated c. 1 carton of frozen fish was not dated and not sealed d. One unsealed opened 2 lb. bag of powdered sugar e. Open cartons with open bags of frozen foods in the freezer were not sealed and contained frost were as follows: · a carton containing a bag of frozen frosted hamburger patties · a carton containing a bag of frozen frosted corn · a carton containing a bag of frozen frosted peas · a carton containing a bag of frozen frosted hot dogs · a carton containing a bag of frozen frosted biscuits · a carton containing a bag of frozen frosted	F 371	clarifying the cleaning schedule, assigning duties by position and providing ongoing staff education regarding proper storage of food as well as cleaning and sanitizing the kitchen. In addition the line prep is inspected 3X per day to insure appropriate use of gloves and that staff are maintaining a sanitary kitchen environment. Criteria #3 The food storage areas will be inspected by the Food Services Director or designee 2 times daily for four weeks. Any foods found to be improperly stored, undated or unlabeled with be discarded immediately. The line prep will be inspected for sanitary food preparation 3X per day for four weeks. The ongoing standard will be food storage inspections daily and line prep /sanitation / cleaning inspections daily. Criteria #4 The NHA and/or Food Service Director will present the sanitation and food storage audits monthly x 3 months to the QAPI committee, then as determined by the QAPI committee.	

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chicken nuggets

f. Bags of frozen food tins in the freezer that were opened, not in their original labeled carton and resealed were not dated when opened were as follows:
- 2 bags frozen okra
- 2 bags frozen hash brown
- 1 frozen tater totes
- 2 bags frozen home fries
- 1 bag frozen waffles not dated and not sealed
- 1 bag frozen pancakes

Review of the weekly cleaning log binder revealed it was last completed in July 2016. Review of the current past 2 weeks daily cleaning calendar was posted on the kitchen bulletin board was dated 10/17/16 through 10/30/16. Review of the daily cleaning tasks revealed the following but not limited to:
- Not listed or specified for cleaning of the outside of all stoves, ovens, and deep fryer.
- Not listed for cleaning the steam table, plate warmers, coolers, and other kitchen equipment. The steamer was listed for de-limed on Fridays but not specified when it was to be cleaned.
- Mopping of all floors was listed one day of the week on Mondays.
- Washing kitchen walls was listed on Saturdays and was not signed off as completed.

During an interview on 10/23/16 at 3:07 PM Cook #2 denied using the flour bin and was unable to verify when the flour bin was last accessed and left open. Cook #2 verified they were supposed to close the food bins and the scoops should be washed after using them.

An interview was conducted on 10/23/16 at 4:02

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PM with the food service director (FSD#2) from another facility who was present at the time of the first day of the kitchen investigation. FSD#2 was unable to verify when the flour bin was last accessed and how long it had been left open. The FSD#2 further verified the kitchen was not clean, had dirty walls, floors, and appliances and was not up to her expectations. The FSD#2 explained all stored foods in the dry storage, refrigerators and freezers should be sealed labeled and dated. FSD #2 stated it was her expectations that the kitchen was to be clean including all food storage areas, food bin containers, all floors, walls, and the inside and outside of all kitchen equipment and prep areas. FSD#2 further stated it was also her expectation that all foods in the dry storage, refrigerators, coolers, and freezers were to be sealed, labeled, and dated and they were supposed to close the food bins and the scoops should be washed after using them.

On 10/26/16 at 6:59 AM Cook #1, and the FSD stated they were putting away stock and both denied having accessed the sugar bin. The FSD and Cook #1 were unable to identify when and who accessed the sugar bin. Both stated it was standard practice to close food bins after using them.

An interview was conducted on 10/27/16 at 5:15 PM with the facility Food Service Director (FSD). The FSD stated he had only started a weekly cleaning schedule in the past 3 weeks that was posted on the bulletin board and it did not clearly indicate who was responsible for all cleaning tasks. The FSD revealed the facility didn't have a thorough cleaning schedule that specified all kitchen cleaning tasks and that he would devise one that was more defined for specific tasks and

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assign the responsibilities to specific staff. The FSD verified the kitchen was not cleaned, the staff were not following the schedule, not signing off completed kitchen tasks and it was not acceptable. The FSD explained the kitchen staff were supposed to be cleaning the appliances and steam table after each shift or at least daily and further stated that clearly was not done. The FSD further explained it was his expectation that the kitchen was to be clean including all food storage areas, food bin containers, all floors, walls, and the inside and outside of all kitchen equipment and prep areas. He stated it was also his expectation that all foods in the dry storage, refrigerators, coolers, and freezers were to be sealed, labeled, and dated.

An interview was conducted on 10/27/16 at 6:58 PM with the Administrator. The Administrator stated it was her expectation that the kitchen was to be clean including all food storage areas, food bin containers, all floors, walls, and the inside and outside of all kitchen equipment and prep areas. She further stated it was also her expectation that all foods in the dry storage, refrigerators, coolers, and freezers were to be sealed, labeled, and dated.

3. On 10/26/16 at 7:09: AM Dietary Aide #1 was observed not wearing gloves, standing on the serving side of the steam table, folded her arms with hands under arm pit area, coughed into her hand, then wiped her forehead with her ungloved hands. Dietary Aide #3 was also observed on the tray service side of steam table not wearing gloves just prior to meal service setting up drinks and flatware. The dietary aides were starting tray service and touched food plates when they were stopped by the surveyor. The District Food

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F 371	Continued From page 51 Service Director (DFSD) was observing meal service and was asked of her expectations regarding infection control and cleanliness of food service. The DFSD stated her expectation was for dietary staff to have clean gloved hands prior to touching food or food service plates for residents. The DFSD instructed the two dietary aides to wash their hands and put on gloves, and the plates they touched were removed to the dishwashing area before restarting the meal service. An interview was conducted on 10/27/16 at 5:16 PM with the Food Service Director (FSD). The FSD indicated the last in-service for hand washing and tray line service was on 10/10/16. The FSD verified the aides needed to wash their hands and wear gloves prior to during the meal service. The FSD stated it was his expectation that all dietary staff to wash hands and wear gloves prior to touching food or performing meal service. An interview was conducted on 10/27/16 at 6:58 PM with the Administrator. The Administrator stated it was her expectation for dietary service staff to wash hands and don gloves prior to touching food or reforming meal service.	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the	F 406		11/24/16

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F 406	Continued From page 52 required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, the facility failed to communicate an order for physical therapy staff to evaluate and provide physical therapy services as ordered by the primary care provider for 1 of 1 sampled resident (Resident #57). Findings included: Resident #57 was admitted to facility on 2/15/16 with diagnoses that included chronic obstructive pulmonary disease, fibromyalgia, difficulty in walking and pain in joint. The annual Minimum Data Set (MDS) dated 8/26/16 indicated Resident #57 was cognitively intact, required supervision with activities of daily living (ADL), and used a walker and wheelchair for locomotion. The MDS also revealed the resident frequently had pain and received scheduled and as needed pain medication during the assessment period. A care plan dated 8/26/16 indicated Resident #57 required supervision to limited assistance with ADL. The goal was for the resident to have ADL needs met with staff assistance. The interventions included to encourage active participation in tasks and to refer to therapy services as indicated. Medical record review revealed an order by a geriatric nurse practitioner (GNP) dated 9/7/16 for therapy to evaluate left knee. A progress note by the GNP dated 9/7/16 indicated Resident #57 had left knee pain and physical debility. The GNP requested for therapy to evaluate for left knee	F 406	F406 Criteria 1 The DON notified the Physician on 10/26/16 of the delay in therapy evaluation for Resident #57 requested on 9/7/16 and 10/7/16. An order clarification for therapy evaluation and treatment was obtained by the DON on 10/26/16 and was initiated by therapy on 10/26/16. A treatment plan was developed and implemented by Physical Therapy and Speech Therapy on 10/26/16. Criteria 2 Residents with orders for therapy services have the potential to be affected by this alleged deficient practice. The DON and Nurse Managers conducted an audit of all resident records to validate all orders for therapy services have been communicated to the therapy department and implemented. This audit was completed by 11/24/16. Criteria 3 Licensed Nurses were re-educated on the process for entering physician□s orders for therapy evaluation into PCC by the Staff Development Coordinator. The DON, Nurse Managers, and Rehab Director were re-educated on reviewing the Order Listing report from PCC during the morning clinical meeting to ensure communication of new Physician□s	

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F 406	Continued From page 53 pain to provide heat/cold and exercise. An order by the GNP dated 10/7/16 indicated for physical therapy (PT) to evaluate and treat left knee pain. No physical therapy notes were noted in the chart. No communication to physical therapy form was noted on the chart. No documentation was in the chart regarding staff providing heat or cold packs to Resident #57's left knee. Interview with Resident #57 on 10/23/16 at 5:45 PM revealed she was supposed to have PT for a bad left knee and the staff hadn't talked to her about it. She stated she had been asking the staff about therapy for her knee for the past 2 months. Interview with PT #1 on 10/25/16 at 3:18 PM revealed she was familiar with resident #57. She stated the resident had not been referred to PT since May 2016. She further stated if there was a referral for therapy, an evaluation was supposed to be done and placed on the resident's chart. PT #1 stated a discontinued order was supposed to be written if a resident declined therapy. Then PT #1 asked, "Did we miss an order for therapy for her? I don't remember being notified of a therapy order for her." Interview with the Director of Nursing (DON) on 10/25/16 at 3:44 PM revealed when an order was written by the Geriatric Nurse Practitioner for therapy an in house communicator form was supposed to be completed by the nurse taking the order and given to therapy. The DON went on to say there were no in house communicator forms regarding therapy for Resident #57 for 9/7/16 or 10/7/16. The DON further stated that therapy would not have known to evaluate the resident if a communicator form had not been completed. The DON indicated her expectations	F 406	Orders with the therapy department. This Education was completed by the Staff Development Coordinator by 11/24/16. The DON or Nurse Manager will review the Order Listing report 3 times per week for 12 weeks to validate therapy orders have been communicated to the Rehab Director and implemented. Opportunities will be corrected as identified. Criteria 4 The Director of Nursing will report the results of these audits and monitoring to the QAPI committee monthly for three months and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed.	

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were for the nurses to complete the communicator forms for therapy when a therapy order was written by the Geriatric Nurse Practitioner.
Interview with Nurse #3 on 10/25/16 at 4:14 PM stated he filled out a communicator form to therapy on 9/7/16 and spoke with a therapist but could not remember which therapist. Nurse #3 stated he thought he remembered doing cold packs for the resident.
Interview with the Administrator on 10/25/16 at 4:25 PM stated her expectations were for nursing staff to complete the communication to therapy form and for therapy to complete the evaluation when an order was written.
Interview with the DON on 10/25/2016 at 4:25 PM stated there was a communication form to therapy completed on 10/7/16 that was crumpled in the bottom of the communication box that she had found. The DON stated that physical therapy would not have known to complete therapy for the resident on 10/7/16.
The Rehab Program Manager was interviewed via phone call on 10/25/2016 at 5:12 PM. She stated she didn't know of an actual PT order for Resident #57 on 9/7/16. She stated the resident had complained of knee pain. The Rehab Program Manager further stated she asked PT #1 to look into resident #57 ' s complaints of knee pain on 9/7/16. She also stated resident #57 had agreed to do ice and heat, but she refused a formal therapy evaluation. The rehab program manager went on to say there was no documentation for resident's refusal for evaluation on 9/7/16 or an order to discontinue therapy.
Interview with PT #1 on 10/25/2016 at 5:14 PM stated she did not remember during the earlier interview but on 9/7/16 when she talked with the

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F 406	Continued From page 55 resident, the resident wanted ice and heat so she referred her to nursing. PT #1 stated she did not document what was done or write a discharge order on 9/7/16. She further stated she had failed to complete the documentation on 9/7/16 for Resident #57.	F 406		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		11/24/16

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F 431	Continued From page 56 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to remove medication that was in use and past the manufacturer expiration date from 1 of 6 medication carts. The findings included: Observation on 10/27/16 at 3:26 PM of the South Wing Medication Cart #2 revealed one opened bottle of Zinc Sulfate (an over the counter mineral supplement) 220 milligrams, 100 count, that was approximately 75% full with a manufacturer's expiration date of June 2016. An interview on 10/27/16 at 3:47 PM with Nurse #6 regarding who was responsible for checking medication expiration dates revealed every nurse giving medications from the cart was expected to check expiration dates of medications. An interview on 10/27/16 at 3:50 PM with Unit Manager #1 regarding who was responsible for checking medication expiration dates revealed every nurse giving medications from the cart was expected to check expiration dates of medications. An interview on 10/27/16 at 7:02 PM with the Director of Nursing (DON) about the facility's system for monitoring for expired medication revealed the Medication Aides who are administering medication should be checking	F 431	F 431 Criteria 1 All expired drugs were discarded by the DON on 10/27/2016 following identification. Criteria 2 All residents have the potential to be affected by this alleged deficient practice. An audit of all medication storage rooms, refrigerators and medication carts was conducted on 11.18.16 by the DON and the nurse managers. All expired, opened and unlabeled items identified were discarded immediately. Criteria 3 The Staff Development Coordinator re-educated the Licensed Nurses regarding the policies for medication administration technique, resident rights, as well as the proper medication cart and medication storage. Addressed specifically was the policy regarding the removal of any discontinued and/or expired medications from the medication cart or medication storage areas immediately. This education was completed by 11.24.2016. The DON and Nurse Managers will audit all medication storage rooms, refrigerators and medication carts per the Monitoring audit tool for expired medications weekly for 12 weeks to verify medication storage per	

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F 431	Continued From page 57 expiration dates. The DON stated the Unit Managers do audits of the medication carts and check for expired medication and the nurses working the 11:00 PM to 7:00 AM are responsible for cleaning the medication carts and should also be checking for expired medications. The DON stated she expected expired medication to be removed from the medication carts. She further stated there should not be any expired medications on the medication carts.	F 431	policy. During the weekly audit, any medications found to be expiring within 7 days will be discarded immediately or returned to pharmacy. Opportunities will be corrected as identified. Criteria 4 The results of the audit will be reported monthly for three months in the QAPI meeting by the DON. The committee will evaluate and make further recommendations as indicated.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		11/24/16

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F 441	Continued From page 58 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, document reviews and staff interviews the facility failed to maintain infection control procedures by not washing resident clothing in water temperatures of 160 degrees or greater than 160 degrees. The findings included: During an environmental tour of the facility with the Housekeeping Supervisor on 10/26/2016 at 2:35 pm the laundry room on the South hall was observed to have one industrial size washer and dryer that was currently not washing and drying clothes. An observation of the laundry room on the North Hall was observed to have one industrial size washer and dryer and both were being utilized. The temperature gauge for the washer was observed to be at 148 degrees while washing clothes. The Assistant Housekeeping Supervisor was in the laundry room doing laundry at the time of the observation. An interview with the Housekeeping Supervisor and Assistant Supervisor revealed that the temperatures for the washers were maintained by the Maintenance Supervisor. An interview was conducted with the Maintenance	F 441	F 441 Criteria #1 The alleged deficient practice has been correct by the facility contracting with Ecolab chemicals to provide the addition of Advacare 120 for personal laundry items to the washing machines on both units, in lieu of the 160¿ temperature requirement, to provide sanitizing for the resident laundry. Criteria #2 All residents have the potential to be affected by the alleged deficient practice. Therefore, the sanitizing agent has been added to both North and South washing machines to provide sanitation for the resident personal laundry items. Criteria #3 The Advacare 120 will provide the necessary sanitation required. The addition of this agent will be monitored By Ecolab Industries 1X per week for four weeks. Criteria #4	

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F 441	Continued From page 59 Supervisor on 10/26/2016 at 4:05 pm. He stated that the temperatures for the washers were checked daily and logged and he could provide a log of the temperatures. A log of the temperatures for the washer in the North hall laundry room and the washer in the South hall laundry room were provided for 10/01/2016 through 10/26/2016 - the logs recorded the washer temperatures on both halls as 148 - 150 degrees. A request was made for additional temperature logs and these were never provided by the Maintenance Supervisor. An interview was conducted with the Administrator on 10/27/2016 at 5:15 pm. The Administrator was not aware that the washer temperatures were not 160 degrees or greater. She stated that the linens were washed and rinsed with a 125 parts per million bleach solution but the resident's clothing was not washed in the bleach solution. She stated that currently the resident's clothing was not being washed according to the Center for Disease Control (CDC) recommended water temperature for washing resident clothing and that she would contact the company who maintains their laundry equipment.	F 441	NHA and or the Maintenance Director will review the results of the audits with the QAPI committee members monthly x 3 months, then as determined by the QAPI committee.	
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490		11/24/16

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F 490	Continued From page 60 Based on observations and resident and staff interviews, the facility failed to maintain comfortable water temperatures in the resident's bathrooms for 5 of 19 rooms on the North Hall (Rooms 1,2,3, and 5) for an extended period of time. The findings included: The following observations were conducted: a. On 10/23/2016 at 5:06 pm while testing the water in Room 3 on the North hall, the water ran for over 2 minutes and was still cool. b. On 10/24/2016 at 9:10 am while testing the water in Room 2 on the North hall, the water ran for over 2 minutes and was still cool. c. On 10/24/2016 at 9:40 am while testing the water in Room 5 on the North hall, the water ran for over 2 minutes and was still cool. d. On 10/24/2016 at 11:20 am while testing the water in Room 1 on the North hall, the water ran for over 2 minutes and was still cool. On 10/23/2016 at 5:06 pm Resident #17 and Resident #71 who were alert and oriented and resided together in Room 3 on the North hall revealed that they did not have hot water in their bathrooms and had not had hot water in their bathrooms for some time (could not remember exact date). They stated that they had complained about the cold water and that maintenance had been in and checked it but it had not been fixed (could not remember when this was). They stated that it took so long for the water to even get warm that they had just given up and accepted that they did not have hot water in the bathroom. The residents stated that the sinks had not drained properly for a long time (could not recall exact dates) and that had been reported but had not been fixed either. The residents also stated that there had not been a working tub in the facility since their admission	F 490	F 490 Criteria #1 The hot water supply for rooms #1 through #5 and affecting Residents #17, #71, #83, #31 was restored and hot water temperature was within acceptable parameters within 2 minutes. Criteria #2 All residents have the potential to be affected by the alleged deficient practice therefore; the Maintenance Director checked all resident rooms for adequate and timely flow of hot water supply. Criteria #3 The Central Supply Clerk or designee will audit residents rooms #1-#5 and 5 other random rooms 5 times per week for 4 weeks, then resident rooms #1-#5 and 5 other random resident rooms every other week for 2 months to ensure hot water supply is adequate and temperature is within acceptable limits. Any issues with the hot water will be immediately corrected. Criteria #4 The Maintenance Director will review the audits monthly x 3 months with the QAPI committee, then as determined by the QAPI committee.	

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F 490	Continued From page 61 (over a year ago). On 10/24/2016 at 9:10 am Resident #83 who was alert and oriented and resided in Room 2 on the North hall revealed that he had not had hot water in his bathroom and had not had hot water in his bathroom for some time (could not remember how long it had been). The resident stated that the sinks had not drained properly for a long time (could not recall exact dates) and that had been reported but had not been fixed either. On 10/24/2016 at 9:40 am Resident #31 who was alert and oriented and resided in Room 5 on the North hall revealed that she had not had hot water in her bathroom and had not had hot water in her bathroom for some time now (could not remember how long it had been). The resident stated that the sinks had not drained properly for a long time (could not recall exact dates) and that had been reported but had not been fixed either. The residents also stated that there had not been a working tub in the facility since their admission. On 10/25/2016 at 4:25 pm interview with the Maintenance Supervisor revealed that he had been employed with the facility for 6 weeks and had inherited a lot of issues from the previous supervisor. He stated that he knew there were rooms on the North hall that did not have hot water in their bathrooms and that he had planned to put a Boost (a mechanism that would make the hot water travel faster to the rooms furthest away from the hot water heater) on the water line to make the hot water travel faster to their rooms but he had not done this yet. He stated that it took a long time to get the water to even be warm in rooms 1-5 and when checking his temperatures of the water he had to run the water in these rooms for some time before it would even be warm. On 10/27/2016 at 5:15 pm an interview with the	F 490		

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F 490	Continued From page 62 Administrator revealed that she was aware of the problem with the water in the resident's bathrooms and she had asked the new Maintenance Supervisor to work on the problem. An interview was conducted with the Administrator on 10/26/16 at 7:24 PM. The Administrator stated the owning company provided a template for administrators to follow while running a facility. She added over the course of the past several months there have been many variables in leadership at this facility. The Administrator stated they have not gotten to that steady foundation to maintain compliance.	F 490		
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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document a resident's behaviors following demonstrations of physical or verbal behaviors toward other residents and staff (Resident #10), write a verbal order received to	F 514	F514 Criteria 1 A new Targeted Behavior Monitoring Tool was developed for Resident #10 to reflect past behaviors of being angry, a danger to	11/24/16

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F 514	Continued From page 63 treat lacerations for a resident (Resident #47), and inaccurately document the urinary assessment for a resident resulting in an inaccurate Minimum Data Set documentation (Resident #46) for 3 of 36 residents' medical records reviewed for accuracy. The findings included: 1. Resident #10 was admitted to the facility 05/20/15 with diagnoses which included dementia without behavioral disturbance, diabetes mellitus, and Parkinson's disease. An annual Minimum Data Set (MDS) dated 04/04/16 indicated Resident #10's cognition was severely impaired. The MDS specified the resident required extensive staff assistance for most activities of daily living and had demonstrated no behaviors. The MDS further specified the resident could usually be understood, usually understands others, and requires supervision of wheelchair use for locomotion. A review of Resident #10's medical record revealed a Situation, Background, Assessment and Request (SBAR) form dated 06/30/16. The form noted a resident to resident altercation between Resident #10 and Resident #73 that was unwitnessed by facility staff. The 2 residents were roommates at the time. A facility incident report dated 06/30/16 specified Resident #73 stated he was going to the bathroom and Resident #10 hit him and he fell backwards. Resident #10 denied he hit his roommate. Resident #73 received a 2 centimeter (cm) by 0.5 cm open area to his right eyebrow. The cause of this incident was undetermined and designated an isolated incident. Resident #10 was moved to another room and a psych referral was made. A MDS annual assessment dated 05/20/16 described Resident # 73 with mild cognitive	F 514	others, fighting, striking out or hitting and threatening others. These new monitoring tools were developed by the DON and implemented by 11/24/16. The Charge Nurse documented the verbal Physician□s Order she received on 10/25/16 for treatment to Resident #47 skin tear. The DON clarified the inaccurate nursing documentation regarding a foley catheter for Resident #46 on 11/19/16. Criteria 2 All residents have the potential to be affected by this alleged deficient practice. The DON and Nurse Managers completed an audit of residents with behaviors to assess current behaviors and implement new Targeted Behavior Monitoring Tools to reflect these behaviors. The DON and Nurse Managers completed an audit of the Treatment Administration Records to ensure all treatments documented have current physician□s orders in place. The DON and Unit Managers completed an audit for residents with catheters to ensure correct coding on the nursing assessment and MDS. These audits were completed and these tools were implemented by 11/24/16. Criteria 3 Licensed Nurses were re-educated by the Staff Development Coordinator regarding the facility policy for accurate transcription of Physician□s Orders; documentation of assessments for residents with catheters to ensure MDS accuracy; and documentation and interventions to include the assessment and monitoring of	

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F 514	Continued From page 64 impairment, required oversight with ambulation in his room, and utilized walker or wheelchair for locomotion. Review of the Psychotherapy Treatment Plan dated 07/13/16 specified Resident #10 manifested additional diagnoses that included moderate major depressive disorder, unspecified anxiety and dementia with behavioral disturbance. The long term goal for the psychotherapy was to resolve or decrease depression and anger including intensity and frequency of verbal and physical outbursts which were designated as symptoms of depression. The goal further specified this would be evidenced by staff report, patient report, and clinical assessment. This document was electronically signed by the treating Psychologist. A psychotherapy progress note dated 07/18/16 and electronically signed by the treating Psychologist specified Resident #10 was oriented to place and situation. The note further specified the resident could readily become irritable. Continued medical record review revealed an SBAR dated 08/09/16 that described an incident involving Resident #10 and Resident #15. Resident #15 was found with a 5 centimeter (cm) circular shaped skin tear on her upper left arm. A facility incident report and follow up investigation dated 08/09/16 specified Resident #15 received an unwitnessed injury on this date at approximately 8:00 PM. The report described a bruised area to the outer corner of the resident's left eye near her glasses frame. Also a 5 cm circular shaped skin tear to the left upper arm was noted. The resident was unaware of what happened. The area on the upper arm had thumb-shaped bruising next to the skin tear. The summary of the investigation specified another resident (Resident #10) was guarding the door to	F 514	resident behaviors and the completion of the Targeted Behavior Monitoring Tool, including the addition of new behaviors as assessed or identified. This re-education was completed by 11/24/16. The DON and Nurse Managers will randomly audit 10 residents□ records per week for 12 weeks to ensure accurate documentation of Physician□s Orders, Targeted Behavior Monitoring Tools and nursing assessments /coding for catheters. Opportunities will be corrected as identified. Criteria 4 The Director of Nursing will report the results of these audits and monitoring to the QAPI committee monthly for three months, and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed.	

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the outside smoking area. It was probable that Resident #10 grabbed Resident #15's arm causing the skin tear and bruise. The report further specified Resident #10 denied grabbing Resident #15's arm. An annual MDS assessment dated 07/18/16 described Resident #15 with severely impaired cognition and wheelchair bound.

Additional review of a psychotherapy progress note dated 09/13/16 specified Resident #10 stated he does feel a little depressed and agitated at times and had a short temper. An additional diagnosis of possible major vascular dementia was added. The note further specified Resident #10 should continue to be followed with psych therapy.

Continued review of Resident #10's medical record revealed behavior monitoring since the incident of 06/30/16 through 10/25/16 consisted of a check sheet form. The form indicated sadness and feelings of isolation should be monitored. There was no instruction to monitor/document episodes of verbal or physical expressions of anger. No nurses' progress notes were found to indicate any behavioral or verbal expressions of anger.

Further medical record review revealed a SBAR dated 10/25/16 at 9:00 PM. This document specified Resident #10 and Resident #47 were roommates. Resident #10 hit Resident #47 with a trash can causing a laceration to the left forehead and a skin tear to the left arm. At this time Resident #10 was sent to the hospital for a psych evaluation.

An interview was conducted with Nurse #2 on 10/26/16 at 1:03 PM. She stated she had not observed aggressive behaviors demonstrated by Resident #10 since the incident involving Resident #73. Nurse #2 stated the incident

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between Resident #10 and Resident #15 happened on the 3:00 PM to 11:00 PM shift on 08/09/16. She explained on 08/09/16 she was leaving the facility after her day shift and exited the building through the door to the smoker's area. Nurse #2 described Resident #10 was guarding the door to keep Resident #15 from exiting. She heard an exchange of words between the 2 residents. She described Resident #10 kept telling Resident #15 to back up. Resident #15 was telling Resident #10 he was not her boss. Nurse #2 stated she left the building. The following day she heard about the incident between the 2 residents. Nurse #2 stated she did not document or provide information concerning the behavior she observed between Resident #10 and Resident #15 on 08/09/16.

An interview was conducted with Certified Medication Aide (CMA) #1 on 10/26/16 at 2:50 PM. CMA #1 stated she had observed incidences in the past of Resident #10 getting angry with staff because he was out of cigarettes. CMA #1 stated she had observed Resident #10 getting mad with the Social Worker because she would not buy him cigarettes. CMA #1 did not provide dates this occurred but described incidences of Resident #10 being at the nurses station ranting and cursing with staff related to not having cigarettes. The CMA further stated she had observed Resident #10 going out to the smoking area and going through ashtrays getting cigarette butts to smoke. When asked if this behavior was documented or reported to the nurse on duty, CMA #1 stated "everyone at the desk" would observe this behavior.

An interview was conducted with Nursing Assistant (NA) #5 on 10/26/16 at 3:12 PM. NA #5 stated he had observed Resident #10 get angry regarding cigarette issues. NA #5 stated during

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the 3 months he had worked in the facility, he had observed Resident #10 bickering with this roommate identified as Resident #73. NA #5 stated he had reported the observed behavior to the nurse. Dates of these observations were not provided.

An interview was conducted with Unit Manager (UM) #1 on 10/27/16 at 9:56 AM. UM #1 stated she had observed Resident #10 say a "few things". She stated the resident will get sporadically frustrated on occasion. UM #1 added Resident #10 had several room changes over time which were due to roommate problems. UM #1 explained she thought Resident #10 did not like to hear the alarm that would go off if Resident #15 tried to go out of the door to the outside smoking area. UM #1 stated physical or verbal outbursts of anger occurred, the incidence should be documented on a nurses' note and reported to the relieving shift. UM #1 stated the nursing staff had missed documenting Resident #10's anger outbursts.

An interview was conducted with the Social Worker (SW) on 10/27/16 at 11:13 AM. The SW stated Resident #10 lived in an assisted living facility (ALF) before admission to the present facility. He got in a fight with another resident at the ALF and sustained a fractured hip. The SW stated Resident #10 did exhibit poor coping mechanisms. The SW further explained Resident #10 will deny the things he does. She stated she had not observed any behavior from Resident #10 that she felt endangered other residents until the incident of 10/25/16. The SW explained she had no problem redirecting Resident #10 when he exhibited any behavior.

An interview was conducted 10/27/16 at 1:51 PM with the Director of Nursing, Administrator, and Director of Clinical Services. All participants

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F 514	Continued From page 68 confirmed there was no documentation of verbal or physical anger outbursts for Resident #10 in his medical record. The Administrator stated she was unaware of bickering between Resident #10 and his roommates. All participants agreed Resident #10's behaviors should be documented in his medical record anytime the behaviors occurred. 2. Resident #47 was admitted to the facility on 8/1/14 with diagnoses that included cerebrovascular accident (stroke), left-sided hemiplegia (paralysis on one side of the body) and muscle weakness. Review of the Situation Background Assessment Recommendation (SBAR) communication form dated 10/25/16 revealed an incident involving Resident #47 in which he had sustained a skin tear to his right forearm and laceration to his forehead. The SBAR indicated the facility Family Nurse Practitioner (FNP) was notified on 10/25/16 at 10:00 PM who instructed the nurse to "monitor resident, clean areas and apply dressings." Review of the Medication Record (MR) for Resident #47 dated 10/25/16 through 10/31/16 revealed the following treatment orders: 1. "Clean right forearm skin tear with wound cleaner, apply antibiotic ointment, cover with dry dressing, change daily." 2. "Clean laceration above eye with wound cleaner, apply antibiotic ointment, cover with dry dressing." Further review of the MR revealed Resident #47 had received treatment as ordered to both his forearm and forehead on 10/25/16, 10/26/16, and 10/27/16.	F 514		

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Review of the Physician's Telephone Orders (PTO) revealed no order for treatment.
During an interview on 10/27/16 at 5:17 PM Nurse #4 stated she had received the verbal order from the FNP to treat Resident #47's injuries. Nurse #4 confirmed Resident #47's MR had been updated but stated "it had been so hectic" she had forgotten to write the PTO.
During an interview on 10/27/16 at 5:25 PM, the Director of Nursing confirmed Nurse #4 had obtained verbal treatment orders for Resident #47 but had not written the PTO. The DON stated all verbal orders received from the Physician or FNP needed to be written as a telephone order, signed by the Physician or FNP and filed in the resident's medical record.

3. Resident #46 was admitted to the facility on 7/7/16 with a diagnosis of end stage renal disease. The admission Minimum data set (MDS) dated 7/17/16 revealed Resident #46 was cognitively intact and had an indwelling catheter. The Care Area Assessment (CAA) indicated the resident had problems with urinating and was able to do in and out catheterization herself.
Medical record review for Resident #46 revealed admission orders dated 7/7/16 for straight catheter (an intermittent catheter that is not left in the bladder) every day (QD) for urinary retention. The medical record also revealed a medication administration record (MAR) dated 7/7/16 which indicated straight catheter was performed on Resident #46 on 11PM-7AM shift from 7/8/16 to 7/15/16. Review of Resident #46's medical record revealed a nursing admission intake form dated 7/7/16 to indicate "straight catheter QD". Further review of the medical record revealed "foley" written in by Nurse #2 under the genitourinary

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F 514	Continued From page 70 section of the nursing daily skilled summary notes dated 7/11/16, 7/12/16, 7/14/16, and 7/16/16. During an interview on 10/26/16 at 2:59 PM, Nurse #2 stated from what she could recall the resident had an indwelling cath. Stated she didn't remember who admitted the resident but she did take care of Resident #46. Nurse #2 went on to say that she could not remember all the details of the resident's care because that was many months ago. On 10/26/2016 at 3:17 PM an interview with the Director of Nursing (DON) was conducted. The DON stated the resident never had an indwelling catheter and the daily skilled summary note by Nurse #2 was not correct. The DON indicated her expectations were for the documentation for each resident to be correct. On 10/26/2016 at 3:31 PM an interview with the MDS Coordinator revealed Resident #46 did not have an indwelling catheter during the assessment period of the admission MDS. She further stated the resident had an in and out catheter which was noted in her urinary CAA. The MDS Coordinator stated the MDS should have been coded intermittent catheterization instead of indwelling cath. The MDS Coordinator also stated the nursing daily skilled summary notes from 7/11/16 to 7/16/16 indicated foley catheter so she must have looked at those notes when completing her MDS which were inaccurate.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		11/24/16

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F 520	Continued From page 71 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 observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in January of 2016 and May of 2016. This was for six recited deficiencies that were cited on a recertification survey in December of 2015 and a complaint investigation in March 2016 and subsequently cited in October of 2016 on the current recertification survey. The repeated deficiencies were in the areas of dignity, maintenance and housekeeping, comprehensive care plans, drug labeling, and storage, complete and accurate medical records, and administration. The continued failure of the	F 520	F 520 Criteria #1 Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 11.11.2016 to discuss the outcomes of the annual survey and repeat citations of F241 Dignity, F253 Housekeeping and Maintenance, F279 Developing the Care Plan, F431 Storage of Medications, and F514 Inaccurate Medical Record. QAPI education was provided for the Administrator and Interdisciplinary Team by the Divisional Director of Clinical Services on 11.21.2016. The education	

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F 520	Continued From page 72 facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1. F 241: Dignity. Based on observations, medical record review, resident and staff interviews, the facility failed to maintain dignity for 1 of 4 sampled residents by referring to a resident as a "feeder" (Resident #21). During a previous recertification survey of December of 2015, the facility was cited F 241 for not serving the dinner meal at the same time to the residents sitting at the same table. On the current recertification survey the facility was cited F 241 for referring to a resident as a "feeder". F 253: Maintenance and Housekeeping. Based on observations, and resident and staff interviews the facility failed to maintain: sinks in the residents' rooms that drain in 5 of 19 rooms on the North hall, paint on the walls in resident rooms in 6 of 48 rooms and in 1 of 2 hallways on the North hall, doors and door frames in 48 of 48 resident rooms and 2 of 2 clean linen rooms and 6 of 6 employee office areas and kitchen doors on the South hall, floors in 5 of 48 resident rooms and bathrooms and 1 of 2 shower rooms on the North hall, and clean resident equipment on 2 of 2 hallways. During a previous recertification survey in December of 2015, the facility was cited F 253 for failing to maintain walls, doors, tile, bathroom light fixtures and mirrors in good repair. On the current recertification survey the facility was cited again for failing to maintain paint on walls in resident rooms, multiple door frames, sinks with free flowing drains, and clean resident equipment. F 279: Comprehensive Care Plans. Based on record review, and staff interviews, the facility	F 520	included the Sava QAPI program and the expectations associated with the program. The program enables the identification of opportunities for improvement, prioritization of those opportunities, root cause analysis, performance improvement plans and evaluation of the PIP through the plan, do, study, act philosophy to ensure sustainability. Criteria #2 F241 All residents requiring assistance with meals have the potential to be affected by the alleged deficient practice. F253 All residents have the potential to be affected by this alleged deficient practice. Detailed maintenance rounds have been conducted by the NHA and Maintenance Director and a prioritized list of repairs had been developed for ongoing repairs and maintenance by 11/24/16. F 279 All residents have the potential to be affected by this alleged deficient practice. An audit of all current resident care plans was completed by the Interdisciplinary Team Nursing, Therapy, Social Services, Dietary and Activities and care plans were updated to include measurable goals and individualized interventions with a focus on Behaviors, Anticoagulants and ADLs. These audits and revisions were completed by 11/24/16. F 431 All residents have the potential to be affected by this alleged deficient practice. An audit of all medication storage rooms, refrigerators and medication carts was conducted on 11.18.16 by the DON and the nurse managers. All expired, opened and	

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F 520	Continued From page 73 failed to provide care plans with measurable goals and individualized interventions for 2 of 36 residents reviewed (Residents #10 and #16). During a previous recertification survey of December of 2015, the facility failed to develop a comprehensive car plan addressing wandering behaviors for a resident. On the current recertification survey the facility continued to provide care plans with measurable goals and individualized interventions for a resident with behaviors and resident on an anticoagulant medication. F 431: Drug Labeling and Storage. Based on observations and staff interview the facility failed to remove medication that was in use and past the manufacturer expiration date from 1 of 6 medication carts. During the previous recertification survey of December 2015 the facility failed to remove expired stock medications from 1 medication storage room. Again on the current recertification survey the facility failed to remove an expired stock medication from 1 medication cart and continued to administer that expired medication. F 514: Complete and Accurate Medical Records. Based on record review and staff interviews the facility failed to document a resident's behaviors following demonstrations of physical or verbal behaviors toward other residents and staff (Resident #10), write a verbal order received to treat lacerations for a resident (Resident #47), and accurately document the urinary assessment for a resident resulting in an inaccurate Minimum Data Set documentation (Resident #46) for 3 of 36 residents' medical records reviewed for accuracy. During the previous recertification survey of December 2015 the facility failed to ensure medication orders were complete and accurate	F 520	unlabeled items identified were discarded immediately. F514 All residents have the potential to be affected by this alleged deficient practice. The DON and Nurse Managers completed an audit of residents with behaviors to assess current behaviors and implement new Targeted Behavior Monitoring Tools to reflect these behaviors. The DON and Nurse Managers completed an audit of the Treatment Administration Records to ensure all treatments documented have current physician□s orders in place. These audits were completed and these tools were implemented by 11.24.2016. Criteria #3 The Interdisciplinary Department Head Team were re-educated by the Director of Nursing and the Administrator regarding the regulatory requirement for F241 Dignity, F253 Housekeeping and Maintenance, F279 Developing the Care Plan, F431 Storage of Medications, and F514 Inaccurate Medical Record. This education was completed by 11.24.2016. The Administrator will hold a weekly Ad Hoc QAPI committee meetings for four weeks to review F241 Dignity, F253 Housekeeping and Maintenance, F279 Developing the Care Plan, F431 Storage of Medications, and F514 Inaccurate Medical Record to ensure all regulatory aspects are addressed and in compliance. The focus for each tag will be on the scope of the regulation in addition to the specific area of alleged deficient practice.	

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F 520	Continued From page 74 for 1 resident. Again on the complaint investigation of March 2016 the facility failed to maintain accurate and complete medical documentation in the medical record related to nursing monitoring and services provided for falls, illness and death. On the current recertification survey the facility failed to document a resident's behaviors of anger, write a verbal order received to treat lacerations for a resident, and in accurately document the urinary assessment for a resident resulting in an inaccurate Minimum Data Set documentation for 3 residents. F 490: Administration. Based on observations and resident and staff interviews, the facility failed to maintain comfortable water temperatures in the resident's bathrooms for 5 of 19 rooms on the North Hall (Rooms 1,2,3, and 5) for an extended period of time. During the complaint investigation of 03/24/16 the facility's Administration failed to follow abuse policies following an alleged staff to resident abuse. On the correct recertification survey the facility failed to provide warm water to resident rooms over an extended period of time. An interview was conducted with the Administrator on 10/26/16 at 7:24 PM. The Administrator stated the owning company provided a template for administrators to follow while running a facility. She added over the course of the past several months there have been many variables in leadership at this facility. The Administrator stated they have not gotten to that steady foundation to maintain compliance.	F 520	Opportunities will be corrected as identified. Criteria #4 The Administrator and Director of Nursing will analyze the data obtained and report any patterns and/or trends to the QAPI Committee monthly for 12 months. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional information based on the outcomes identified to ensure continued compliance.	