STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

(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 242 SS=E	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 resident and staff interviews, and record review, the facility failed to offer a choice of a tub bath to 2 of 3 sampled residents (Residents #51 and #210). The finding included: 1. Resident #51 was admitted to the facility on 02/15/15 with diagnoses which included cerebral vascular accident with left hemiparesis. Review of Resident #51's admission Minimum Data Set (MDS) dated 01/12/16 revealed an assessment of moderately impaired cognition. The MDS indicated it was very important to Resident #51 to choose between a shower and tub bath. Review of Resident #51's quarterly MDS dated 09/30/16 revealed an assessment of intact cognition. The MDS indicated Resident #51 required the assistance of one person with bathing. Interview with Resident #51 on 10/31/16 at 10:00 AM revealed a tub bath would be preferred but	F 242	Resident #51 and #210 were offered a tub bath on 11/23/2016 and their choice was to have a shower. Interviewing of all the residents were started by the ADON and QI Nurse for their preference of a tub bath vs bed bath vs shower on 11/23/2016. The interviews will be completed by 11/30/2016. All staff retraining was initiated on 11/23/2016 to ask residents if they want a tub bath vs bed bath vs shower by the Staff Facilitator and will be completed by 11/30/2016. All newly hired staff will be trained on asking residents if they want a tub bath vs bed bath vs shower when getting bathed during orientation. 20% of the residents will be audited for their preferred type of bath using the Audit tool Dignity/Choices Tub Baths. The audits will be completed 5x week x4 weeks, then weekly x 8 weeks then monthly x 3 months. The results of the completed audit tools	12/1/16

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

Electronically Signed | 11/24/2016

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F 242	Continued From page 1 the facility did not offer a choice of a tub bath. Interview with Nurse Aide (NA) #2 on 11/02/16 at 8:05 AM revealed Resident #51 received assistance with showers twice weekly. NA #2 explained the facility's tub did not work and had not been used "for years." NA #2 reported she was not aware Resident #51 preferred a tub bath. Interview with Nurse #2 on 11/02/16 at 10:13 AM revealed all residents received showers. Nurse #2 explained the tub on the unit did not work. Interview with the Assistant Director of Nursing (ADON) on 11/02/16 at 10:32 AM revealed residents were asked their preference of shower frequency but not offered a choice of a tub bath. The ADON explained she was not certain in the tub baths in the facility worked. Interview with the Administrator on 11/02/16 at 10:58 AM revealed the bath tubs in the facility were not used by residents. The Administrator explained she would ask the maintenance director to check and determine if the bath tubs could be used. A second interview with the Administrator on 11/02/16 at 11:59 AM revealed the bath tub in the facility's secured unit worked and residents should be offered a choice of shower or tub bath. 2. Resident #210 was admitted to the facility on 06/10/16 with diagnoses which included cerebral vascular accident and traumatic brain injury. Review of Resident #210's admission Minimum Data Set (MDS) dated 06/21/16 revealed and assessment of short and long term memory loss	F 242	will be reviewed weekly by the Administrator and/or the Director of Nursing. The QI Committee will review the results of the audits monthly x 6 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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F 242	Continued From page 2	F 242		

with severely impaired decision making skills. The MDS indicated Resident #210's family or significant other was not included in an interview regarding preferences. The MDS indicated Resident #210 required total assistance of one person with bathing.

Telephone interview with Resident #210's responsible person on 10/31/16 at 3:00 PM revealed Resident #210 preferred tub baths. Resident #210's responsible person reported a choice of bath type was not offered during the admission interview.

Interview with Nurse Aide (NA) #2 on 11/02/16 at 8:05 AM revealed Resident #210 received assistance with showers. NA #2 explained the facility's tub did not work and had not been used "for years." NA #2 reported she was not aware Resident #210 preferred a tub bath.

Interview with Nurse #2 on 11/02/16 at 10:13 AM revealed all residents received showers. Nurse #2 explained the tub on the unit did not work.

Interview with the Assistant Director of Nursing (ADON) on 11/02/16 at 10:32 AM revealed residents were asked their preference of shower frequency but not offered a choice of a tub bath. The ADON explained she was not certain in the tub baths in the facility worked.

Interview with the Administrator on 11/02/16 at 10:58 AM revealed the bath tubs in the facility were not used by residents. The Administrator explained she would ask the maintenance director to check and determine if the bath tubs could be used.

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F 242	Continued From page 3 A second interview with the Administrator on 11/02/16 at 11:59 AM revealed the bath tub in the facility's secured unit worked and residents should be offered a choice of shower or tub bath.	F 242		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to resolve a strong urine odor in the bathroom shared by 4 residents in 2 rooms (Rooms 401 and 403) on a secured unit (Residents #84, #81, # 93, and #154). The findings included: On 11/01/16 at 09:29 AM, there was a strong smell of feces noted in the resident's rooms and shared bathroom (between rooms 401 and 403) on the secured unit. On 11/01/16 at 10:50 AM, an unpleasant odor of urine was noted when entering the secured unit. Upon observation of the bathroom used by the residents in rooms 401 and 403, a strong urine odor was noted. On 11/02/16 at 9:43 AM, an observation was performed of the bathroom used by the residents in rooms 401 and 403. A strong urine odor was again noted. An interview was conducted with the Maintenance Director on 11/02/16 at 9:53 AM. He stated he	F 253	Bathroom floor between 401 and 403 was pulled up, the concrete treated with Urine Be Gone, retiled and the toilet caulked on November 2, 2016. All bathrooms were audited for need of repair and/or stripping and waxing due to odors on November 2, 2016. Maintenance and Housekeeping staff were retained on 11/21/2016 that the bathrooms must be stripped and waxed or tile replaced when there is a problem with odor. A hall will be audited for need of stripping and waxing or tile replacement 5x week x 4 weeks, weekly x8 weeks and then monthly x3 months. The results of the completed audit tool will be reviewed weekly by the Administrator and/or Director of Nursing. The QI Committee will review the audits monthly x 3 months to determine the continued need for and frequency of monitoring.	12/1/16

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F 253	Continued From page 4 had not received any complaints regarding odors. On 11/02/16 at 1:32 PM, an interview was conducted with Nurse #4. She stated she had been aware of the strong urine odor coming from the bathroom between rooms 401 and 403. She stated multiple things had been tried to control the odor and stated housekeeping had tried to take care of the problem, but the problem kept returning. Nurse #4 stated she had not received any complaints from the residents or their family members concerning the odors in the secured unit. On 11/02/16 at 2:43 PM observation of the bathrooms for rooms 401 and 403 on the secured unit revealed a strong odor of urine. Grout around the base of the toilet was noted to be dark brown in color. The tile directly in front of the toilet was darker in color than the rest of the tile in the bathroom. On 11/02/16 at 3:00 PM observation of the bathroom shared with rooms 401 and 403 were conducted with a housekeeping staff #1. He stated the tile was stained with urine and he felt as if the urine smell was coming from urine underneath the tile or grout. On 11/02/16 at 3:15 PM, an observation was conducted in the bathroom between rooms 401 and 403 with the Maintenance Supervisor. He stated he was going to remove the tile and grout around the toilet in the bathroom. An interview on 11/02/16 at 3:15 PM conducted with the facility Administrator revealed maintenance staff was removing the tile and grout around the toilet in the bathroom (used by the	F 253	Any recommended changes will be discussed and carried out as agreed upon at that time.	

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F 253	Continued From page 5 residents in room 401 and 403) in an effort to remove the source of the urine smell. An interview was conducted with Nurse #4 on 11/03/16 at 1:01 PM. The nurse stated she had not received any complaints regarding urine on the floor of any resident's room and advised that if a resident had an accident with urine spillage, she or her staff (whomever noticed the urine on the floor) would use a towel to dry the floor. They would then call housekeeping and have them clean and sanitize the floor. For safety purposes, she stated a wet floor sign would be placed in the area until the floor had dried. On 11/03/16 at 1:18 PM an interview with a 1st shift (and occasionally 2nd shift) NA #7 revealed that occasionally a resident may have an accident and urine would "end up on the floor". She stated if urine got on the floor, she cleaned it up with towels and then called housekeeping to mop the floor.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272		12/1/16

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F 272	Continued From page 6 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to contractures for 2 of 4 sampled residents with contractures (Resident #51) and for 1 of 2 sampled residents with an indwelling urinary catheter (Resident #92). The findings included: 1. Resident #51 was admitted to the facility on	F 272	On 11/24/2016 the MDS nurse completed a detailed general care plan progress note for residents #51 and #92. The documentation for resident #51 is detailed related to the Activities of Daily Living Care Area Assessment (CAA). The documentation includes a description of the left hand contracture including causes, contributing factors, and risk factors. The documentation includes an analysis of the findings supporting the decision to proceed to care plan. The documentation	

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F 272	Continued From page 7 02/15/15 with diagnoses which included cerebral vascular accident with left hemiparesis. Review of Resident #51's annual Minimum Data Set (MDS) dated 01/12/16 revealed an assessment of moderately impaired cognition. The MDS indicated limitation of functional range of motion on one side of upper and lower extremities. Review of Resident #51's Activity of Daily Living Care Area Assessment (CAA) dated 01/26/16 revealed no documentation of findings with a description of the problem, causes, contributing factors and risk factors related to ADLs. There was no description of Resident #51's left hand contracture. There was no documentation of input from Resident #51. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Observation on 10/31/16 at 10:34 AM revealed Resident #51's left hand was contracted. Interview with Resident #51 on 10/31/16 at 10:35 AM revealed she experienced no pain and received range of motion exercises. Interview on 11/02/16 at 2:15 PM with the Rehabilitation Manager revealed Resident #51 was admitted with a hand contracture. Interview with the MDS nurse on 11/02/16 at 3:42 PM revealed Resident #51's ADL Care Area Assessment should include a description of contractures and impact on ADL function. The MDS nurse explained the CAA was written by a nurse who no longer worked in the facility.	F 272	for resident #92 is detailed related to urinary incontinence and indwelling catheter care. The documentation includes the description of the problem, causes, contributing factors, and risk factors related to an indwelling urinary catheter. On 11/24/2016 the Administrator began auditing each resident with a contracture to ensure the Activities of Daily Living CAA was completed accurately. On 11/24/2016, the Administrator began auditing each resident with an indwelling catheter to ensure the urinary incontinence and indwelling catheter care CAA was completed accurately. A detailed general care plan progress note was completed for each resident where a concern was noted. The audit will be completed on 11/30/2016. On 11/23/2016 the MDS Corporate Consultant completed an in-service with the MDS Coordinator and MDS nurses related to accurately completing the Activities of Daily Living and Urinary Incontinence and Catheter Care CAA's per the RAI manual. On 11/23/2016 the Administrator began auditing the Activities of Daily Living and Urinary Incontinence and Catheter Care CAA's using the Comprehensive Assessment Audit tool. This audit will be completed weekly x 4 weeks then biweekly x 8 weeks then monthly x 3 months by the Administrator and/or MDS nurses.	

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F 272	Continued From page 8 Interview with the Administrator on 11/03/16 at 9:19 AM revealed she expected staff to document a comprehensive assessment with an analysis of findings. 2. Resident #92 was admitted to the facility on 12/10/10 with diagnoses which included dementia and hydro-nephrosis. Review of Resident #92's August 2016 monthly physician's orders revealed Resident #92 received a daily prophylactic antibiotic for urinary tract infections and indwelling urinary catheter irrigations every shift. Review of Resident #92's annual Minimum Data Set (MDS) dated 08/25/16 revealed an assessment of severely impaired cognition and presence of an indwelling urinary catheter. Review of Resident #92's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 09/15/16 revealed no documentation of findings with a description of the problem, causes, contributing factors and risk factors related to an indwelling urinary catheter. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with the MDS nurse on 11/02/16 at 3:37 PM revealed there was no documentation of description and analysis of Resident #92's indwelling urinary catheter. Interview with the Administrator on 11/03/16 at 9:19 AM revealed she expected staff to document a comprehensive assessment with an analysis of	F 272	The monthly QI Committee will review the results of the Comprehensive Assessment Audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI Committee to the quarterly Executive QA committee for further recommendations and oversight.	

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F 272	Continued From page 9 findings.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to accurately code the Minimum Data Set assessment for a contracture	F 278	Resident #210 MDS Assessment was modified to include the Contracture on 11/8/2016.	12/1/16

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F 278	Continued From page 10 for 1 of 3 sampled residents with contractures (Resident #210). The findings included: Resident #210 was admitted to the facility on 06/10/16 with diagnoses which included cerebral vascular accident and traumatic brain injury. Review of an occupational therapy plan of care dated 06/20/16 revealed Resident #210's right elbow contracture tolerated an extension splint for 15 minutes daily. Review of Resident #210's admission Minimum Data Set (MDS) dated 06/21/16 revealed and assessment of short and long term memory loss with severely impaired decision making skills. The MDS indicated no impairment of Resident #210's functional range of motion on both upper and lower extremities. Review of Resident #210's quarterly MDS dated 09/07/16 revealed functional impairment on one side of both the upper and lower extremities. Observation of Resident #210 on 10/31/16 at 2:36 PM revealed a right arm contracture. Interview with Resident #210's occupational therapist on 11/01/16 at 5:21 PM revealed Resident #210 was admitted with a left arm contracture. The occupational therapist explained Resident #210's right arm could not straighten to 180 degrees. Interview with the Assistant Director of Nursing (ADON) on 11/02/16 at 3:49 PM revealed she completed the admission MDS for Resident #210.	F 278	A 100% audit was completed for all resident's MDS Assessment with Contractures to ensure that their contractures are captured. Any negative assessments were modified to include contractures. The MDS nurses were reeducated by the MDS Corporate Consultant on 11/23/2016 to ensure that Contractures are coded on the MDS accurately and addressed on the Care Plan. The DON or licensed nurse designee will complete a 10% sample audit of the MDS and Care Plans to ensure the falls and wearing Ted hose were coded on the MDS and updated on the Care Plan bi-monthly for three months. The Administrator will review the completed audits with the QI Committee monthly for 6 months for follow up and recommendations or continuation as indicated.	

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F 278	Continued From page 11 The ADON reported Resident #210 was admitted with a contracture. The ADON explained the admission MDS was not accurate regarding functional range of motion. Interview with the Administrator on 11/02/16 at 4:05 PM revealed she expected the MDS to be accurately completed.	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 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to develop a care plan to prevent falls for 1 of 3	F 279	A Care Plan was developed for Resident #55 for risk of falls on 11/23/2016 and for Resident #142 for extremity swelling on	12/1/16

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F 279	Continued From page 12 sampled residents at risk for falls (Resident #55) and failed to develop a care plan for extremity swelling for 1 of 4 sampled residents for care and services to maintain well-being (Resident #142). The findings included: 1. Resident #55 was admitted to the facility on 08/23/16 with diagnoses which included seizures. Review of Resident #55's admission Minimum Data Set (MDS) dated 08/30/16 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #55 required the limited assistance of one person with transfers and inability to determine Resident #55's fall history. Review of Resident #55's Fall Care Area Assessment (CAA) dated 09/16/16 revealed an analysis of Resident #55's balance, psychoactive medication use and need for physical assistance with mobility. The CAA indicated a decision to proceed to care plan for fall prevention. Review of a nursing note dated 09/18/16 revealed Resident #55 fell out of the wheel chair during an attempt to take off a sock. Review of Resident #55's care plan revised 9/26/16 revealed no documentation regarding a fall risk or interventions to prevent falls. Review of a nursing note dated 10/23/16 revealed Resident #55 fell in the bathroom during a seizure. Observation on 11/03/16 at 9:06 AM revealed Resident #55 transferred with the assistance of	F 279	11/17/2016. A 100% audit was completed for all residents who have a fall within the last 90 days and residents with extremity swelling on 11/29/2016. Each resident identified with the potential for a fall or extremity swelling will have a Care Plan developed with interventions included to prevent falls and development of extremity swelling. The MDS nurses were in-serviced by the MDS Corporate Consultant on 11/23/2016 to ensure that all residents with the risk for falls or extremity swelling will have a care plan completed to address these areas. The DON or licensed nurse designee will complete a 10% sample audit of the Care Plans for risk of falls and extremity swelling to ensure there is a Care Plan bi-monthly for three months. The Administrator will review the completed audits with the QI Committee monthly for 6 months for follow up and recommendations or continuation as indicated.	

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Nurse Aide (NA) #3 into a wheel chair.

Interview with Nurse Aide (NA) #3 on 11/03/16 at 10:17 AM revealed Resident #55 usually transferred independently. NA #3 reported Resident #55 used her call light occasionally but required frequent reminders to ask for staff assistance to prevent falls.

Interview with the MDS nurse on 11/03/16 at 10:19 AM revealed Resident #55's fall prevention measures should be on the care plan. The MDS nurse explained the omission was an error.

2. Resident #142 was admitted to the facility on 12/19/13 with diagnoses which included bipolar mood disorder and anxiety.

Review of Resident #142's monthly physician's orders dated 10/06/16 revealed direction for Thrombo-Embolic Deterrent (TED) hose application in the morning with removal at bedtime.

Review of Resident #142's annual Minimum Data Set (MDS) dated 10/10/16 revealed an assessment of intact cognition. The MDS indicated Resident #142 required the extensive assistance of one person with dressing.

Review of Resident #142's care plan revised 10/16/16 revealed no documentation of interventions related to TED application and lower extremity swelling.

Review of Resident #142's Resident Care Guide revealed Resident #142 should wear wear non-skid footwear. There was no direction for TED hose application.

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Observation on 10/31/16 at 10:38 AM revealed Resident #142 wore white ankle socks and shoes. Resident #142's right ankle was slightly swollen.

Observations on 10/31/16 at 11:17 AM and 2:21 PM revealed Resident #142 wore white ankle socks and shoes. Resident #142's right ankle was slightly swollen.

Observation on 11/01/16 at 8:28 AM and 10:40 AM revealed Resident #142 wore white ankle socks and shoes. Resident #142's right ankle was slightly swollen.

Interview with Resident #142 on 11/01/16 at 10:41 AM revealed she relied on staff to put on socks and shoes. Resident #142 reported her ankles did not hurt and did not know if TED hose should be used.

Observation on 11/01/16 at 1:09 PM and at 4:09 PM revealed Resident #142 wore white ankle socks and shoes. The right ankle was slightly swollen.

Observation on 11/02/16 at 8:02 AM revealed Resident #142 wore white ankle socks and shoes.

Interview with Nurse Aide (NA) #2 on 11/02/16 at 8:03 AM revealed Resident #142 did not use TED hose. NA #2 explained Resident #142 "used to wear the hose" but thought the TED hose was discontinued since Resident #142 received a diuretic.

Interview with the MDS nurse on 11/02/16 at 3:28

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F 279	Continued From page 15 PM revealed interventions such as TED hose should be documented on Resident #142's care plan. The MDS nurse explained the Resident Care Guide used by nurse aides for direction of Resident #142's care did not contain the TED hose due to the care plan's omission.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and interviews the facility failed to update a care plan for 1 of 3 residents reviewed for falls (Resident #155). The findings included:	F 280	Resident #155 died on 11/16/2016. A 100% audit of all resident's care plans was completed on 11/30/2016 to ensure that they have been updated to include	12/1/16

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F 280	Continued From page 16 Resident #155 was admitted to the facility on 09/26/14 with diagnoses which included history of falls, muscle weakness, dementia with behavioral disturbance, kidney failure. A physician order dated 08/16/16 indicated while Resident #155 was in bed a fall mat should be at the bedside at all times. A significant change in condition Minimum Data Set (MDS) dated 08/19/16 indicated Resident #155 had severe cognitive impairment and was understood rarely to never. The MDS revealed Resident #155 required extensive assistance with bed mobility and transfers and was totally dependent on staff for eating, dressing, toileting, personal hygiene, and bathing. Further review of the MDS under Section J indicated the resident had a fall which resulted in major injury. A care plan dated 09/04/16 revealed Resident #155 was at risk for falls related to a history of falls and injury in regards to poor safety awareness, unaware of safety needs, impaired balance, and impaired cognition. The care plan revealed a goal for the resident was to be free of falls through the next review date and an intervention for a fall mat on the floor when the resident was in bed. Further review of this care plan did not indicate the fall mat was to be discontinued. Review of the nurse's notes indicated the following entries: · Dated 10/01/16-resident was observed on the floor in his room next to his wheelchair · Dated 10/30/16-on 10/29/16 resident was found on the floor in his room between the chair and bed · Dated 11/01/16-resident was found on the floor in his room Further review of Resident #155's medical record did not indicate an update in the care plan with	F 280	areas of intervention for each problem area. The MDS nurses were in-serviced by the MDS Corporate Consultant on 11/23/2016 to ensure that Care Plans are updated to reflect the resident and they are accurate. The DON or licensed nurse designee will complete a 10% sample audit of the Care Plans to ensure they are updated bi-monthly for 6 months. The Administrator will review the completed audits and the results of the audits will be reviewed with the QI Committee monthly x 6 months for follow up and recommendations or continuation as indicated.	

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the most accurate fall interventions since 09/04/16.
An interview was conducted with Nurse Aide (NA) #7 on 11/03/16 at 1:12 PM. NA #7 stated she was unaware a fall mat was to be placed in the floor at the resident's bedside. The NA #7 further stated if he was to have a fall mat it was be listed on the resident's care guide, inside the closet door. There was no care guide on the inside of Resident #155's closet door in order for NA #7 to verify whether or not a fall mat was to be used for Resident #155.
An interview was conducted with Nurse #5 on 11/03/16 at 1:20 PM. Nurse #5 stated Resident #155 had not had a fall mat at bedside since he had returned from the hospital due to a fall.
An interview was conducted with the Assistant Director of Nursing (ADON) on 11/03/16 at 1:30 PM. The ADON stated she would have expected the care plan to have been updated with the current information. She further stated the care guide should have been on the inside of the resident's closet door and was to be used by the NAs as a guidance tool which would indicate Resident #155's current fall interventions and care needs.
An interview was conducted with the Director of Nursing (DON) on 11/03/16 at 2:15 PM. The DON stated she would have expected the care guide and the care plan to have been updated to reflect the accurate fall interventions for Resident #155.
An interview was conducted with Care Plan Coordinator (CPC) on 11/03/16 at 2:28 PM. The CPC stated the care plan should have been updated and accurate according to the resident's current fall interventions. She also stated the care guide should have been in place on the inside door of the resident's closet to guide the NAs on what fall interventions were to be utilized for

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F 280	Continued From page 18 Resident #155.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, physician interviews and medical record review, the facility failed to obtain daily weights as ordered by the physician to assess a resident at risk for increased fluid volume (Resident #61) and failed to apply compression stockings as ordered by the physician to a resident at risk for lower extremity swelling (Resident #142) for 2 of 4 sampled residents reviewed for well-being. The findings included: Resident #61 was admitted to the facility on 10/25/14. Diagnoses included end stage renal disease with hemodialysis, heart failure, chronic kidney disease and oxygen dependent. Medical record review revealed a physician's order dated 04/21/16 which recorded to check Resident #61's weight each morning related to end stage renal disease, chronic kidney disease and heart failure.	F 309	The Assistant Director of Nursing reviewed Resident #142 to ensure they had Ted hose on and Resident #61 to ensure a daily weight was obtained per the physician's order. 100% audit of residents with orders for Ted hose or to be weighed daily was completed on 11/21/2016 by the ADON and QI Nurse. The audits checked by the following: 1)were the resident's Ted hose put on in the morning and taken off in the evening and actually observing the resident to see if the Ted hose are on as ordered. 2) Were the residents weighed daily and the weight documented? Immediate correction of missing documentation was completed upon identification by the RNs completing the audits. No other issues were identified during this audit. Beginning 11/23/2016 the RN Staff	12/1/16

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F 309	Continued From page 19 An annual Minimum Data Set dated 09/01/16 assessed Resident #61 with intact cognition and able to be understood/understand and used oxygen daily. A Care Area Assessment and Care Plan (CP) of 09/01/16 indicated Resident #61 was at risk for complications with end stage renal disease and actual ineffective breathing due to dialysis, oxygen dependency and congestive heart failure. The goal of the CP was that Resident #61 would not experience complications from dialysis treatment without appropriate intervention thru next review to include monitoring of his weights. Medical record review of the Medication Administration Record (MAR) and the electronic record (e-record) for vital signs (VS) revealed daily weight data was not available for the following: · 10 days in October 2016 · 10 days in September 2016 · 11 days in August 2016 · 16 days in July 2016 · 6 days in June 2016 · 21 days in May 2016 · 1 day in April 2016 During an interview on 10/31/16 at 1:31 PM, Resident #61 stated that he did not get weighed daily as he should. He stated the Physician wrote an order for staff to check his weight each morning, but it was not being done. Staff either expressed that they could not find the weight chair or that it was locked up and they did not have the key. He further stated that he continued to request to have his weight checked. During an interview on 11/03/2016 at 1:42 PM,	F 309	Facilitator began educating the Licensed Nurses on the application of Ted hose in the AM and the removal of the Ted hose in the PM and weighing residents daily who have a physician's order for a daily weight. All newly hired staff will be trained on applying Ted hose in the AM and the removal of the Ted hose in the PM and weighing resident's daily who have a physician's order for a daily weight and documentation of the weight in Orientation. The DON and ADON will review the MAR of the residents with Ted hose and observe the resident wearing the Ted hose and Daily Weights 5x a week x 4 weeks then, weekly x 3 weeks, then bi monthly x 3 months to ensure Physician's orders are being followed as it pertains to Ted hose and Daily weights. The Administrator will review the results of the audits weekly and present the results to the QI Committee for follow up and/or recommendations or continuation as indicated.	

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the Administrator stated that she was not aware of a resident who currently required daily weight checks. The Administrator stated that when daily weights were required for a resident, it was usually obtained by nursing staff on the 11 PM - 7 AM shift if the weight was ordered to be obtained before meals. The Administrator further stated that the results were recorded on the MAR and in the VS section of the e-record. The Administrator also stated that Nurse Aide (NA) #1 obtained weekly/monthly weights and at times also obtained daily weights as needed. She stated that the Certified Dietary Manager (CDM) kept a list of residents who required daily weights.

During an interview on 11/03/2016 at 1:48 PM NA #1 stated that she was routinely responsible for obtaining weekly/monthly weights and daily weights at times. NA #1 stated the results were recorded in the e-record and that she had no problems getting access to the weight scales. NA #1 stated when she obtained weight data, she compared the current weight to the previous weight and if the data reflected weight loss, she communicated it to the nurse and Registered Dietitian (RD). NA #1 also stated that she had obtained daily weights for Resident #61 in the past using the chair scale.

An observation occurred on 11/03/2016 at 2:25 PM of NA #1 using a chair scale to obtain Resident #61's weight. A lift scale was also observed available for use in the hallway.

An interview with the CDM on 11/03/16 2:34 PM revealed she was not aware of a current resident who required daily weights.

An interview on 11/03/16 at 2:35 PM with Nurse

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#1 revealed she routinely worked with Resident #61 on the 7 AM - 3PM shift and that she did not obtain daily weights for residents on her shift. Nurse #1 stated daily weights were obtained by nursing staff on the 11 PM - 7 AM shift, recorded on the MAR and that she was not aware of a problem with the accessibility of the weight scales. Nurse #1 stated that she did not typically review the weight data for Resident #61, but knew that his weight was being recorded on the MAR.

A telephone interview with the Registered Dietitian (RD) on 11/03/2016 at 3:25 PM revealed she was not aware that Resident #61 had a physician's order for daily weights, but stated that if the physician wrote the order, the order should be followed. The RD stated Resident #61 received hemodialysis due to end stage renal disease and had congestive heart failure so the order for daily weights was for monitoring to ensure he did not have excessive weight gain due to fluid volume. The RD stated that Resident #61 also had his weight checked while at the hemodialysis center and that she expected significant weight changes to be brought to her attention.

During a telephone interview on 11/03/16 at 04:13 PM, the Physician for Resident #61 stated that Resident #61 routinely received hemodialysis and had his weight monitored at the dialysis center. The Physician further stated that clinically Resident #61 was doing well, but that he expected all physician orders to be followed or clarified to see if changes were needed.

An interview with the Director of Nursing (DON) occurred on 11/03/16 at 4:29 PM and revealed that she was not aware that Resident #61's

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weight was not being obtained daily, but that she expected physician orders to be followed for daily weights. She further stated that Resident #61 received hemodialysis services and his weight was monitored there, but she had not reviewed that weight data. The DON further stated that she expected the regularly assigned nurse for Resident #61 on the 11 PM - 7 AM shift to obtain daily weights as ordered by the physician and to monitor these weights for significant changes.

A telephone interview on 11/03/16 at 4:53 PM with Nurse #3 who routinely worked the 11 P - 7A shift, revealed that sometimes Resident #61 did not get his weight checked daily because either the chair scale was locked up and she could not get to it or because at times he refused, especially if he was going to dialysis. Nurse #3 further stated that she usually instructed the NA to obtain daily weights and then she documented the results on the MAR and in the computer, but that she did not review the data. Nurse #3 also stated that if daily weights could not be obtained on her shift, sometimes she asked the oncoming nurse to see if weights could be obtained.

2. Resident #142 was admitted to the facility on 12/19/13 with diagnoses which included bipolar mood disorder and anxiety.

Review of Resident #142's monthly physician's orders dated 10/06/16 revealed direction for Thrombo-Embolic Deterrent (TED) hose application in the morning with removal at bedtime.

Review of Resident #142's annual Minimum Data Set (MDS) dated 10/10/16 revealed an assessment of intact cognition. The MDS

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indicated Resident #142 required the extensive assistance of one person with dressing.

Review of Resident #142's Medication Administration Record (MAR) revealed documentation of TED hose application during the day shift (7 - 3) with removal during the evening shift (3 - 11). The MAR indicated Resident #142 wore TED hose on 10/31/16, 11/01/16 and 11/02/16.

Observation on 10/31/16 at 10:38 AM revealed Resident #142 wore white ankle socks and shoes. Resident #142's right ankle was slightly swollen.

Observations on 10/31/16 at 11:17 AM and 2:21 PM revealed Resident #142 wore white ankle socks and shoes. Resident #142's right ankle was slightly swollen.

Observation on 11/01/16 at 8:28 AM and 10:40 AM revealed Resident #142 wore white ankle socks and shoes. Resident #142's right ankle was slightly swollen.

Interview with Resident #142 on 11/01/16 at 10:41 AM revealed she relied on staff to put on socks and shoes. Resident #142 reported her ankles did not hurt and did not know if TED hose should be used.

Observation on 11/01/16 at 1:09 PM and at 4:09 PM revealed Resident #142 wore white ankle socks and shoes. The right ankle was slightly swollen.

Observation on 11/02/16 at 8:02 AM revealed Resident #142 wore white ankle socks and

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F 309	Continued From page 24 shoes. Interview with Nurse Aide (NA) #2 on 11/02/16 at 8:03 AM revealed Resident #142 did not use TED hose. NA #2 explained Resident #142 "used to wear the hose" but thought the TED hose was discontinued since Resident #142 received a diuretic. Interview with Resident #142's physician on 11/02/16 at 10:15 AM revealed Resident #142 required a diuretic and TED hose for dependent edema. The physician explained he expected physician orders to be followed although the TED hose would not eliminate the positional edema. Interview with Nurse #2 on 11/02/16 at 10:24 AM revealed she initialed Resident #142's TED hose as applied on 10/31/16, 11/01/16, and 11/02/16. Nurse #2 reported she relied on the nurse aide to apply the TED hose and did not realize Resident #142 did not have the TED hose applied. Interview with the Assistant Director of Nursing (ADON) on 11/02/16 at 10:31 AM revealed she expected nurses to follow physician ' s orders. The ADON reported Resident #142 should wear TED hose daily as ordered.	F 309		
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	F 431		12/1/16

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F 431	Continued From page 25 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 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to remove from use expired pain medication from 1 of 7 medications carts. Findings included: Resident #75 was admitted 03/10/2009 with diagnosis that included osteoarthritis. The Minimum Data Set (MDS) dated 09/22/2016 assessed the resident as able to make her needs known.	F 431	The Ultram that was noted expired was returned to the Pharmacy by the Assistant Director of Nursing on 11/2/2016. A 100% audit was completed on 11/2/2016 by the Assistant Director of Nursing to ensure all medications to include Ultram are within the expiration date. All identified areas of concern were immediately corrected.	

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F 431	Continued From page 26 Review of Resident #75's Medication Administration Record (MAR) dated 08/01/16 through 08/31/16 revealed physician instructions to administer Tramadol 50 milligrams (mg) every 8 hours as needed for pain. Further MAR review revealed the resident received Tramadol 50 mg on 08/23/2016 and 10/30/2016. An observation conducted 11/02/2016 at 2:50 PM revealed the 800 hall medication cart contained a Tramadol 50 mg bubble card with 9 remaining pills ready for use. The pharmacy label on the card revealed the medication expired 08/18/2016. On 11/02/2016 at 2:50 PM Nurse #6 stated the procedure for expired narcotics was to complete a pharmacy narcotic return form, fax it to the pharmacy, wrap the medication to be returned with the form and lock it in the narcotics box for pick up in the evening by the pharmacy courier. She stated all nurses remove expired medications from the medication carts. On 11/03/2016 at 8:50 AM the Director of Nursing (DON) stated that any nurse can pull expired narcotics or medications. There was a controlled substance sheet to be filled out, faxed to the pharmacy and the expired narcotic was locked in the narcotic box on the medication cart until the pharmacy picked it up at night. The nurse and the pharmacy courier both sign that medication was being returned and it was locked in a secured tote and returned to the pharmacy. It is my expectation that all medications on the carts and in storage have not expired. On 11/03/2016 at 3:26 PM the Medical Director stated that he did not believe there would be adverse consequences to the resident receiving the Tramadol that was expired.	F 431	An in-service was initiated with 100% of all licensed nurses to include Nurse #1 regarding checking all medication for expiration dates and discarding when expired by the Staff Facilitator on 11/23/2016. The in-service will be complete on 11/30/2016. All newly hired Licensed Nurses will be oriented regarding checking all medication for expiration dates and discarding when expired during new employee orientation. The Director of Nursing, Assistant Director of Nursing, Unit Manager, QI Nurse or RN Supervisor will check all medication carts and medication rooms weekly x 4 weeks then every two weeks x 8 weeks, then monthly x 3 months to ensure all expired medications for expiration dates and discard any that are expired before using via an audit tool. All identified areas of concern will be immediately corrected. The monthly QI Committee will review the results of the expired medication audit tool monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or Director of Nursing will present the findings and recommendations of the monthly QI Committee to the quarterly Executive QA committee for further recommendations and oversight.	

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F 490	Continued From page 27	F 490		
F 490 SS=F	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: Based on observations, interviews with residents, family and staff, and review of medical and facility records, the facility's administration failed to sustain an effective Quality Assessment Program through implemented procedures and monitoring of these interventions that the committee put into place during 3 federal surveys of record for 8 repeat deficiencies in the areas of choices, housekeeping and maintenance services, comprehensive assessment, accuracy of assessments, well-being, medication storage, effective administration and Quality Assessment and Assurance. Findings included: This tag is cross referred to: F 520 Quality Assessment and Assurance: Based on observations, resident, family and staff interviews, and review of medical records and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March 2016. This was for 7 recited deficiencies that were originally cited in February	F 490	On 11/16/16 the facility QI Committee held a meeting. The Medical Director, Administrator, DON, ADON, QI Nurse, MDS Nurse, Treatment Nurse, Maintenance Supervisor and Housekeeping Supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 11/23/2016 the Facility Consultant in-serviced the Facility Administrator, DON, MDS Nurse, Treatment Nurse, Maintenance Supervisor, Housekeeping Supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identified issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified concerns, to include F242 Right to Make Choices, F431 Pharmacy, F253 Maintenance and Housekeeping, F272 Comprehensive Assessment, F278 Accuracy of Assessments, F309 Services for Highest Well Being, F490 Effective	12/1/16

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F 490	Continued From page 28 2016 on a Recertification/Complaint survey and subsequently recited on the facility's current Recertification/Complaint survey. The deficiencies were in the areas of choices, housekeeping and maintenance services, comprehensive assessment, accuracy of assessments, medication storage, effective administration and QAA. The facility's QAA committee also failed to maintain implemented procedures and monitor these interventions that the committee put into place in June of 2016. This was for a recited deficiency that was originally cited in May of 2016 on a Complaint survey and subsequently recited on the facility's current Recertification/Complaint survey. The deficiency was in the area of well-being. The continued failure of the facility during 3 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. During 3 federal surveys of record, February 2016 Recertification/Complaint survey, May 2016 Complaint survey, and the facility's current Recertification/Complaint of November 2016, the facility's Administrator failed to sustain an effective Quality Assurance Program due to repeat deficiencies in the areas of choices, housekeeping and maintenance services, comprehensive assessment, accuracy of assessments, medication storage, effective administration and QAA. The Administrator was interviewed on 11/03/16 at 3:45 PM and stated that the facility's QAA would discuss the results of weekly/monthly rounds for all areas of repeat deficiencies until the concerns were resolved. The Administrator further stated that she monitored the rounds conducted by her	F 490	Administration, and F520 Quality Assessment and Assurance Committee. The Facility QI Committee will meet a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F242 Right to Make Choices, F431 Pharmacy, F253 Maintenance and Housekeeping, F272 Comprehensive Assessment, F278 Accuracy of Assessments, F309 Services for Highest Well Being, F490 Effective Administration and F520 Quality Assessment and Assurance Committee. The Committee will continue to meet a minimum of monthly. The QI Committee including the Medical Director, will review monthly complied QI Report for information, review trends, and review corrective actions taken and the date's completion. The QI Committee will validate the facility's progress in correction of deficient practices or identified concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training and other interventions. The Administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	

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F 490	Continued From page 29 staff and going forward staff would discuss these results during daily stand up meetings rather than just monthly.	F 490		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews, and review of medical records and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to	F 520	On 11/15/2016 the facility QI Committee held a meeting. The Medical Director, Administrator, DON, QI Nurse, MDS Nurse, Treatment Nurse, Maintenance	12/1/16

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F 520	Continued From page 30 maintain implemented procedures and monitor these interventions that the committee put into place in March 2016. This was for 7 recited deficiencies that were originally cited in February 2016 on a Recertification/Complaint survey and subsequently recited on the facility's current Recertification/Complaint survey. The deficiencies were in the areas of choices, housekeeping and maintenance services, comprehensive assessment, accuracy of assessments, medication storage, effective administration and QAA. The facility's QAA committee also failed to maintain implemented procedures and monitor these interventions that the committee put into place in June of 2016. This was for a recited deficiency that was originally cited in May of 2016 on a Complaint survey and subsequently recited on the facility's current Recertification/Complaint survey. The deficiency was in the area of well-being. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1 a. F 242 Right to Make Choices: Based on resident and staff interviews, and record review, the facility failed to offer a choice of a tub bath to 2 of 3 sampled residents (Residents #51 and #210). During a Recertification/Complaint survey of February 04, 2016 the facility was cited for failure to honor resident preferences for wake up times and use of a cellular phone. On the current	F 520	Supervisor, Housekeeping Supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 11/23/2016 the Facility Consultant in-serviced the Facility Administrator, DON, MDS Nurse, Treatment Nurse, Maintenance Supervisor, Housekeeping Supervisor relate to the appropriate functioning of the QI Committee and the purpose of the committee to include developing and implementing appropriate plans of action for identified facility concerns, to include F 242 Right to Make Choices, F431 Pharmacy, F253 Maintenance and Housekeeping, F272 Comprehensive Assessment, F278 Accuracy of Assessments, F309 Services for Highest Well Being, F490 Effective Administration and F520 Quality Assessment and Assurance Committee. As of 11/23/2016, after the Facility Consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review work orders, review Point Click Care (Electronic Medial Record), Resident Council Minutes, Resident Concern Logs, Pharmacy Reports, and Regional Facility Consultant Recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans	

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F 520	Continued From page 31 Recertification/Complaint survey of November 03, 2016, the facility failed to offer a resident a choice of a tub bath. 1 b. F 253 Housekeeping and Maintenance Services: Based on observations and staff interviews, the facility failed to resolve a strong urine odor in the bathroom shared by 4 residents in 2 rooms (Rooms 401 and 403) on a secured unit (Residents #84, #81, # 93, and #154). During a Recertification/Complaint survey of February 04, 2016 the facility was cited for failure to maintain walls and furniture clean and in good repair. On the current Recertification/Complaint survey of November 03, 2016, the facility failed to maintain the secured unit free of urine odors. 1 c. F 272 Comprehensive Assessment: Based on resident and staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to contractures for 2 of 4 sampled residents with contractures (Resident #51) and for 1 of 2 sampled residents with an indwelling urinary catheter (Resident #92). During a Recertification/Complaint survey of February 04, 2016 the facility was cited for failure to conduct comprehensive assessments related to psychoactive medications, falls and activities of daily living. On the current Recertification/Complaint survey of November 03, 2016, the facility failed to conduct a comprehensive assessment related to contractures and urinary catheters. 1 d. F 278 Assessment Accuracy: Based on observation, staff interview and record review, the	F 520	of action for identified facility concerns. Corrective action has been taken for the identified concerns relate to F242 Right to Make Choices, F431 Pharmacy, F253 Maintenance and Housekeeping, F272 Comprehensive Assessment, F278 Accuracy of Assessments, F309 Services for Highest Well Being,F490 Effective Administration and F520 Quality Assessment and Assurance Committee. The Committee will continue to meet a minimum of monthly. The QI Committee, including the Medical Director, will review monthly complied QI Report information, review trends, and review corrective actions taken and the date's completion. The QI Committee will validate the facility's progress in correction of deficient practices or identified concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training and other interventions. The Administrator or her designee will report back to the Executive QI Committee at the next meeting.	

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facility failed to accurately code the Minimum Data Set assessment for a contracture for 1 of 3 sampled residents with contractures (Resident #210).

During a Recertification/Complaint survey of February 04, 2016 and a Complaint survey of May 24, 2016, the facility failed to complete assessments accurately related to contractures and cognition. On the current Recertification/Complaint survey of November 03, 2016, the facility failed to complete an assessment accurately related to contractures.

1 e. F 309 Care to Maintain Well-Being: Based on observations, staff interviews, physician interviews and medical record review, the facility failed to obtain daily weights as ordered by the physician to assess a resident at risk for increased fluid volume (Resident #61) and failed to apply compression stockings as ordered by the physician to a resident at risk for lower extremity swelling (Resident #142) for 2 of 4 sampled residents reviewed for well-being.

During a Complaint survey of May 24, 2016, the facility failed to schedule an orthopedic appointment in response to knee pain. On the current Recertification/Complaint survey of November 03, 2016, the facility failed to obtain weights daily and apply compression stockings.

1 f. F 431 Medication Storage: Based on observations, staff interviews and record review the facility failed to remove from use expired pain medication from 1 of 7 medications carts. During a Recertification/Complaint survey of February 04, 2016, the facility failed to remove expired insulin and date opened bottles of a blood

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thinner. During the current Recertification/Complaint survey of November 03, 2016, the facility failed to remove expired narcotics.

1 g. F 490 Effective Administration: Based on observations, interviews with residents, family and staff, and review of medical and facility records, the facility's administration failed to sustain an effective Quality Assessment Program through implemented procedures and monitoring of these interventions that the committee put into place during 3 federal surveys of record for 8 repeat deficiencies in the areas of choices, housekeeping and maintenance services, comprehensive assessment, accuracy of assessments, well-being, medication storage, effective administration and Quality Assessment and Assurance.

During a Recertification/Complaint survey of February 04, 2016, the facility's administration failed to maintain an effective QAA program during 4 federal surveys of record which resulted in 3 repeat deficienceis in the areas of dignity, choices, and QAA. During the current Recertification/Complaint survey of November 03, 2016, the administrator failed to maintain an effective QAA program during 3 federal surveys of record which resulted in 8 repeat deficiencies in the areas of choices, housekeeping and maintenance services, comprehensive assessments, assessment accuracy, well-being, medication storage, effective administration and QAA.

1 h. F 520 Quality Assessment and Assurance Committee: Based on observations, resident,

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family and staff interviews, and review of medical records and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March 2016. This was for 7 recited deficiencies that were originally cited in February 2016 on a Recertification/Complaint survey and subsequently recited on the facility's current Recertification/Complaint survey. The deficiencies were in the areas of choices, housekeeping and maintenance services, comprehensive assessment, accuracy of assessments, medication storage, effective administration and QAA. The facility's QAA committee also failed to maintain implemented procedures and monitor these interventions that the committee put into place in June of 2016. This was for a recited deficiency that was originally cited in May of 2016 on a Complaint survey and subsequently recited on the facility's current Recertification/Complaint survey. The deficiency was in the area of well-being. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.

During a Recertification/Complaint survey of February 04, 2016 and a Complaint survey of May 24, 2016, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions related to choices, housekeeping and maintenance services, comprehensive assessments, assessment accuracy, well-being, medication storage, effective administration and QAA. On the current Recertification/Complaint survey of November 03,

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F 520	Continued From page 35 2016, the facility failed to maintain implemented procedures and monitor these interventions related to repeat deficiencies in the areas of choices, housekeeping and maintenance services, comprehensive assessments, assessment accuracy, well-being, medication storage, effective administration and QAA. The Administrator was interviewed on 11/03/16 at 3:45 PM and stated that the facility would conduct weekly/monthly rounds for all areas of repeat deficiencies until the concerns were resolved. The Administrator stated that to correct the concerns with resident assessments, the facility would involve other administrative nurses. The Administrator also stated that the facility identified the urine odor on the secured unit, but did not realize the odor was in the floor and would require more monitoring of residents on this unit who urinated on the floor. The Administrator further stated that she attributed repeat deficiencies in the areas of well-being and medication storage to staff having a focus that was too narrow. She stated that staff were monitoring medication rooms, but did not expand their focus to medication carts.	F 520		