STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(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 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		3/16/17

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment

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

Electronically Signed | 03/06/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and family interviews, the facility failed to notify the healthcare power of attorney (HCPOA) when a resident received occupational therapy (OT) with a hand splint (Resident #59) and a guardian of a resident's discharge (Resident #92) for 2 of 10 sampled residents reviewed for notification of changes. Findings included: 1. Resident #59 was admitted on 04/21/15 with the following diagnoses: Alzheimer's disease, depression and arthritis. Review of the most recent comprehensive minimum data set (MDS) assessment dated 08/30/16 revealed Resident #59 had severely impaired cognition and required extensive assistance with most activities of daily living. Functional limitation in range of motion (ROM) for the upper extremities was coded no impairment. Review of the (OT) plan of care dated 02/14/17 revealed staff to don/doff bilateral upper extremity resting hand splints to decrease further contractures.	F 157	Criteria 1 Resident #59 HCPOA was made aware on 2/16/17 that OT had started on 2/14/17 and wearing splints per resident interview. Resident #92 was discharged on 1/24/17. Criteria 2 Residents on therapy caseload have the potential to be affected. Therapy will complete an audit of all current residents on therapy to ensure proper notification had been completed by March 16, 2017. Residents pending discharge from the facility had the potential to be affected. Social Services Director and or Medical Records Coordinator will complete an audit on all current residents face sheets by March 16, 2017 to ensure proper identification of HCPOA or legal guardian was updated and identified to ensure proper notification of changes/discharge. Criteria 3	

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F 157	Continued From page 2 An observation on 02/14/17 at 3:30 PM revealed Resident #59 in the therapy room with a splint on her right hand. Review of physician's orders revealed an order dated 02/15/17 for orthotic management for bilateral hand contractures. An interview on 02/16/17 at 5:59 PM with the rehab department director revealed families are never notified when a resident started therapy. She further stated there was no policy about notifying the family and the therapy department was not educated that it was required. An interview with the occupational therapist on 02/16/17 at 6:08 PM revealed families are not notified when a resident starts therapy. The occupational therapist further stated it would have been a good idea to call the family. An interview on 02/16/17 at 6:15 PM with the interim director of nursing revealed she expected the therapy department to notify the family when a resident started therapy. An interview on 02/16/17 at 6:18 PM with Resident #59's HCPOA revealed the HCPOA was not notified OT had started on 2/14/17. The HCPOA further stated she did not want Resident #59 to wear splints because the splints caused Resident #59 more pain. 2. Review of the "letters of appointment guardian of the person" dated 01/14/17 revealed Resident #92 was incompetent and Resident #92's family member was his guardian. Resident #92 was admitted on 01/16/17 with	F 157	An in-service training by the Director of Rehabilitation was completed on 3/3/17. Therapy staff was reeducated and rein-serviced on therapy initiation and adaptive equipment implementation and notification. Face Sheets including updates to legal guardians/HCPOA status will be audited upon admission and at care conferences by the Social Worker and or Medical Records and updated face sheets will be placed on charts when changes occur or are noted. Criteria 4 The Director of Rehabilitation or designee will monitor all new admissions or referrals to therapy in clinical start up/stand up meeting daily to ensure compliance providing intervention, education and training and corrective action as needed. The Social Service Director or designee will report Findings of Face Sheet audits in QAPI monthly. The results of the Director of Rehab and Social Services or designee's monitoring will be reported to the QAPI committee monthly for three months, then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the	

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F 157	Continued From page 3	F 157		

diagnoses which included non-Alzheimer's dementia and anxiety disorder.

Review of the admission face sheet form dated 01/17/17 revealed Resident #92's significant other as the contact person.

Review of the most recent comprehensive MDS assessment dated 01/23/17 revealed Resident #92 had moderately impaired cognition and required limited assistance with transfers, dressing, and toileting. Resident #92 was independent with locomotion on and off unit.

Review of the psychosocial assessment dated 01/23/17 revealed Resident #92 had a legal guardian.

Resident #92 was discharged on 01/24/17.

An interview on 02/15/17 at 2:58 PM with the social worker revealed she did not notify the guardian when Resident #92 left because Resident #92 was with his significant other at the time of discharge.

An interview on 02/15/17 3:05 PM with the interim administrator revealed Resident #92's family member was his guardian. The guardian was not notified when Resident #92 left the facility. The interim administrator further stated the guardian should have been notified when Resident #92 left the facility. The interim administrator stated "We thought the significant other was his guardian". The interim administrator indicated she expected the social worker to notify the guardian when a resident left the facility.

An interview with the social worker on 02/16/17 at

minutes of the QAPI meeting.

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F 157	Continued From page 4 8:09 AM revealed she knew Resident #92 had a guardian. The guardian gave the social worker the guardianship form. An interview on 02/16/17 at 12:43 PM with the interim administrator revealed nurses, the MDS coordinator, social worker, and admissions coordinator can update the face sheet form. An interview on 02/16/17 at 3:41 PM with the social worker revealed she put the guardian information on the face sheet in the computer but did not reprint the face sheet and put it on the chart. It was the social worker's usual practice to notify the guardian about the discharge. The guardian could not be reached by phone.	F 157		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation	F 226		3/16/17

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F 226	Continued From page 5 requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of abuse investigations and personnel files, the facility failed to implement their abuse policy to report 2 of 3 allegations of abuse within 24 hours and the results of the investigations within 5 working days to the North Carolina Health Care Personnel Investigations (NCHCPI) (Residents #83 and #5), notify law enforcement of misappropriation of resident property (Resident #83) and obtain 2 references for 1 of 5 new employees prior to hire. The findings included: 1. The facility's policy entitled Investigations and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, Version #3, effective 11/18/16, recorded in part, Reporting: It is the responsibility of each individual employee to immediately report any reasonable suspicion of a crime...and or misappropriation of resident property to the	F 226	Criteria 1 Law enforcement was contacted and came to facility to discuss with resident #83 in private. Resident #5-five day follow up report dated 10/12/16 shows it was originally faxed at that time. The five day follow up was refaxed/sent to NCHPI on 3/3/17. Upon investigation facility found no harm or injury and resident is unchanged prior to or thereafter and allegation found to be unsubstantiated. The References were obtained for the Dietary Manager on the following dates 1/22/17 and 3/7/17. Criteria 2 Residents of the facility have the potential to be affected.	

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F 226	Continued From page 6 designated supervisor in charge at the time. The Executive Director shall notify the appropriate state agency/law enforcement, in accordance with state law regarding the alleged violation and findings. a. Resident #83 was admitted to the facility on 06/20/16. Diagnoses included a stroke with hemiplegia, among others. Review of a quarterly Minimum Data Set dated 12/13/16, assessed Resident #83 with intact cognition, clear speech and able to be understood and to understand. Review of the facility's abuse investigation and written statements by the Assistant Director of Nursing (ADON), a nurse and the social worker (SW) revealed Resident #83 reported to the ADON on 11/25/16 and to a nurse on 11/26/16 that he was missing $1000 that he kept in a drawer in his room. Resident #83 stated he did not see who took his money, but although he thought he knew who took it, he wanted a room change, but did not want to file a police report. The SW interviewed Resident #83 on 11/28/16 and he again stated he could not say who took his money, but he was satisfied with the room change. Review of the facility's investigation revealed the allegation of misappropriation of resident property was not reported to law enforcement, was not reported to the NCHCPI until 12/9/16 (14 days after the facility was notified) and the 5 Day Working Report was reported on 12/14/16 (19 days after the facility was notified). b. Resident #5 was admitted to the facility 2/22/02. Diagnoses included End Stage	F 226	An audit of the past 3 months of the noted facility reportable events were audited on 3/8/17 by the Executive Director. An audit of the past 3 months of the facility new hires reference checks will be completed by 03/16/17 by the Business Office Assistant and reviewed by the Business Office Manager and any reference checks if found to be incomplete will be obtained. Criteria 3 The Assistant Director of Nursing will re-educate and rein-service staff on investigation and reporting of alleged violations of federal and state laws involving mistreatment, neglect, abuse, injuries of unknown source and misappropriation of residents property, HCPR 24 hour initial report and 5 day follow up reporting requirements as well as the Elder Justice Act and reporting responsibilities. The Business Office Manager and or Business Office Assistant will ensure all documents related to the hiring process are in place prior to an employee beginning their onsite orientation. The Business Office Assistant and Business Office Manager were re-educated by the Executive Director and process was explained to department Managers on 3/9/17. Criteria 4	

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F 226	Continued From page 7 Alzheimer's disease, dementia, depression, and anxiety, among others. A quarterly Minimum Data Set assessment dated 01/18/17 assessed Resident #5 with severely impaired cognition, clear speech, usually understood/understands, no behaviors, totally dependent on staff for all activities of daily living (ADL), and a life expectancy of 6 months or less. Review of the facility's abuse investigations revealed that Adult Protective Services (APS) visited the facility on 10/11/16 to investigate an allegation of resident neglect regarding Resident #5. The investigation documented that APS stated that the family of Resident #5 reported she was not receiving staff assistance with ADL. There were no specific dates of neglect given. The investigation documented that the facility provided APS with written evidence to support Resident #5's assistance with ADL. Further review of the investigation revealed the facility documented NCHCPI was notified on 10/12/16 of the allegation of neglect, but there was no documentation to support when NCHCPI received a 5 Day Working Report. An interview with the facility's interim administrator occurred on 02/15/17 at 1:27 PM. During the interview she stated that she was not the facility's administrator in November 2016 when the allegation of misappropriation of resident property occurred, but when she came on board 12/1/16, the facility identified that this allegation had not been reported to the NCHCPI and so it was reported to NCHCPI, but not to law enforcement. She stated the ADON and prior DON no longer worked for the facility. The interim administrator also stated that she was not the	F 226	The Executive Director or Director of Nursing will review/monitor with department managers in the daily stand up meeting any concerns / grievances or reportable events for submission or follow up to ensure compliance and immediate corrective action regarding abuse investigations. The Business Office Manager will report in the daily stand up meeting the status of all new hire documents communicated to her by the Business Office Assistant that are pending and or completed to proceed to hire/in-house orientation process to ensure references are obtained. The Executive Director or Director of Nursing will be responsible for monitoring the process. The results of the monitoring will be reported to the QAPI committee monthly for three months, then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	

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administrator of the facility at the time the allegation of resident neglect was investigated, but that she contacted NCHCPI on 02/15/17 and that NCHCPI had no record of receiving notification of a 24 Hour or 5 Day Working Report regarding this allegation of resident neglect. The interim administrator further stated that she expected the facility's abuse policy to be followed regarding reporting any allegation of abuse.

A telephone interview was conducted on 02/15/17 at 4:05 PM with the facility's previous administrator. He stated he could not recall specifically why there was a delay in reporting the 11/25/16 allegation of misappropriation of resident property to the NCHCPI, but perhaps staff did not recognize this as a reportable incident and did not immediately notify administration of the allegation. He confirmed the allegation was not reported to law enforcement. He further stated he could not explain why there was no evidence that the 10/11/16 allegation of resident neglect was reported to the NCHCPI, but he felt certain it was reported. He further stated that once he faxed the 24 hour report, the NCHCPI usually contacted him if the 5 Day Working Report was not received. He stated he may have delegated the reporting to the DON and it just did not get done.

Attempts to interview the previous DON during the survey were unsuccessful.

2. The facility's policy entitled Investigations and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, Version #3, effective 11/18/16, recorded in part,

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F 226	Continued From page 9 Screening: All applicants for employment in the Company shall, at a minimum, have the following screening checks conducted: 1. Reference checks with the current and/or past employer. Review of the facility's documentation of employee prescreening for the dietary manager revealed he was hired to the facility on 02/06/17 and currently worked at the facility. Review of his employee personnel file revealed there was no documentation to support reference checks were obtained from either the current or past employer. An interview with the facility's business office manager (BOM) occurred on 02/16/17 at 11:46 AM. The BOM stated the reference checks for prescreening new employees was conducted by the corporate office Human Resources (HR) Department. An interview with the interim administrator was conducted on 02/16/17 at 3:38 PM and revealed she expected reference checks to be obtained on new employees prior to their date of hire. A telephone interview was conducted with the talent acquisition from the HR Department on 02/16/17 at 3:46 PM who stated she was having computer problems and could not confirm whether or not reference checks were completed for the facility's dietary manger prior to the date of hire.	F 226		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility.	F 244		3/16/17

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F 244	Continued From page 10 (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on 5 resident interviews (#36, #14, #24, #20 and #28), staff interviews and review of Resident Council Minutes the facility failed to resolve resident grievances voiced during Resident Council related to food palatability for 4 consecutive months (November 2016, December 2016, January 2017 and February 2017). The findings included: 1a. Resident #36 was admitted to the facility on 10/14/16. Diagnoses included hypertension, diabetes mellitus II, and hyperlipidemia, among others. A quarterly Minimum Data Set (MDS) assessment dated 01/17/17, assessed Resident #36 with clear speech, able to be understood/understand, intact cognition and independent with eating, requiring set up help only. During an interview on 02/15/17 at 3:21 PM, Resident #36 stated that the food was not good and had not improved. He stated "I have been	F 244	Criteria 1 Resident grievances voiced in resident council related to food palatability for previous months were addressed and communicated for resident #36, #14, #24, #20 and #28 on 3/2/17. Criteria 2 Residents of the facility receiving meal trays may have the potential to be affected. For residents who receive a meal tray, dietary staff were retrained and reeducated by the Dietary Manager on proper cooking of foods to include temperature, palatability, and following of recipes. Criteria 3 Any issues or concerns raised in Resident Council will be recorded by the Activity Director as it relates to the number of residents who share the concern and the	

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F 244	Continued From page 11 telling them a long time the grits are not done, they are still hard and not cooked enough and the chicken for lunch today was hard/dry. You tell the staff, but it does no good, what can the nurses do? They need better cooks." 1b. Resident #14 was admitted to the facility on 02/09/16. Diagnoses included congestive heart failure, diabetes mellitus II, depression and hemiplegia, among others. A quarterly MDS dated 11/29/16, assessed Resident #14 with clear speech, able to be understood/understand, intact cognition and independent with eating, requiring set up help only. Resident #14 was interviewed on 02/15/17 at 3:44 PM and stated that she routinely attended Resident Council (RC) meetings. She stated that the food was currently better, but "We were having trouble with food not being hot for a few months and we did not get much follow up in our meetings." 1c. Resident #24 was admitted to the facility on 04/21/08. Diagnoses included diabetes mellitus II, reflux disease, and depression, among others. An annual MDS dated 01/24/17 assessed Resident #24 with clear speech, able to be understood/understand, impaired cognition and independent with eating, requiring set up help only. During an interview on 02/15/17 at 3:45 PM, Resident #24 stated she attended RC at times and confirmed that the facility did not provide written follow up to resident concerns expressed	F 244	nature of the concern/grievance. The Concern or Grievance will be documented by the Activities Director on the Departmental response form or if appropriate the facility grievance form for departmental response to include dates of proposed or completed actions and results expected. The Departmental response or grievances will be presented to the Resident Council by the Activities Director for agreement by resident if the issue has been resolved or if not the concern will be resubmitted with additional explanation required for resolution to the identified department. Criteria 4 The Activities Director will resubmit the Resident Council minutes and the completed Departmental Response forms to the Executive Director monthly for review and signature and tracking and trending of concerns/issues The results of the monitoring will be reported to the QAPI committee monthly for three months, then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	

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during RC for several months related to food palatability.

1d. Resident #20 was admitted to the facility on 01/09/07. Diagnoses included diabetes mellitus II, hyperlipidemia, and hypothyroidism, among others.

A quarterly MDS dated 12/27/16 assessed Resident #20 with clear speech, able to be understood/understand, intact cognition and independent with eating, requiring set up help only.

Resident #20 was interviewed on 02/16/17 at 9:00 AM. During the interview, Resident #20 stated she was the vice president (VP) of RC. The VP stated the food was currently better, but confirmed that the facility did not provide written follow up to resident concerns expressed during RC for several months related to food palatability.

1e. Resident #28 was admitted to the facility on 3/17/16. Diagnoses included hearing loss with the use of a hearing aid and depression, among others.

A quarterly MDS dated 12/13/16 assessed Resident #28 with clear speech, able to be understood/understand, moderately impaired cognition and required supervision/set up help with eating.

An interview was conducted on 02/16/17 at 9:06 AM with Resident #28 and she confirmed that she attended RC at times. Resident #28 stated that she had expressed during RC that the pasta was not cooked well, but that the residents did not receive follow up to this concern.

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2. Review of RC meeting minutes revealed food palatability was an unresolved concern in the following months:
·November 2, 2016, RC meeting minutes recorded as "New Business" that 3 of 3 residents voiced concerns that the food was not cooked properly. The follow-up was documented as "Will adjust accordingly to resident preference."
·December 7, 2016, RC meeting minutes recorded as "New Business" that 3 of 5 residents expressed concern that the food was not cooked properly. The resident example given was that noodles/pasta was not cooked completely. The follow-up was documented as "Cooks are monitoring food for doneness."
·January 4, 2017, RC meeting minutes recorded as "Old Business" that 5 of 6 residents expressed the food was not being cooked properly. There was no documentation for follow up.
·February 1, 2017, RC meeting minutes recorded "Old Business" that 5 of 5 residents expressed that the food was not being cooked properly. There was no documentation for follow up.

During an interview on 02/15/17 at 3:32 PM, the activity director (AD) stated she recorded minutes during RC meetings. If residents voiced grievances, the written grievance was provided to the department head responsible and the AD expected a written response from the department head within 7 days. The AD stated residents had expressed ongoing concerns related to food palatability for several months that were not resolved. The AD further stated that in January 2017 she provided a written grievance from the January 2017 RC meeting to the facility's interim dietary manager (IDM), but did not receive a written response. The AD stated she followed up

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with the IDM and was told the new DM would be notified and provide a written response. The AD stated that at the time of the February 2017 RC meeting, a written response regarding residents' concerns with food palatability still had not been received and so she documented it as unresolved "Old Business".

A telephone interview was conducted with the previous administrator on 02/15/17 at 4:05 PM. During the interview, he stated he was aware of the resident concerns expressed during the November 2016 - December 2016 RC related to food palatability. He stated that during that time he had 2 IDM and was also without a DM for a period of time. He stated the dietary department lacked consistency and a written follow up was not provided to RC. He stated that staff tried to address resident concerns individually. The previous administrator also stated that the facility tried to fix the dietary problems, but with 2 IDM and no consistency in the dietary department, the dietary concerns were almost daily and ongoing.

An interview was conducted on 02/15/17 at 5:49 PM with the certified dietary manager (CDM). During the interview, he stated that he started at the facility on Thursday, 02/09/17 and that he had not been informed of resident concerns related to food palatability expressed during RC and therefore had not provided residents with a written response regarding follow up to these concerns.

An interview with the interim administrator was conducted on 02/16/17 at 4:03 PM. During the interview the interim administrator confirmed that she was aware that a written response had not been provided to RC regarding their concerns

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F 244	Continued From page 15 with food palatability. She stated that she expected residents to have a written response regarding concerns voiced during RC and that now the dietary department was currently stable and had a CDM, the facility would provide a written response to the RC regarding food palatability.	F 244		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) 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 secure a commode to the floor (Room #212), repair 2 loose faucets on bathroom sinks (Rooms #212 and #318), replace a damaged over the bed table (Room #206), replace cracked window glass (Room #203), repair a wardrobe door (Room #203), replace a missing drawer (Room #313), repair broken floor tiles (Room #317), and paint chipped and scarred doors and door frames (Rooms #205, #206, #210, #215, #309, #318, and #319) for 12 of 29 sampled resident rooms. The facility also failed to repair a bottom metal heating unit panel in 1 of 4 activity/dining areas. The findings included: 1. a) Observation on 02/14/17 at 9:59 AM revealed loose faucets and broken laminate approximately 8 inches by 10 inches in the bathroom of Room #318 with chipped paint on the bathroom door.	F 253	Criteria 1 The areas/concerns identified in rooms #203, 205, 206, 210, 212, 215, 309, 313, 317, 318, 319 and activity room were repaired or replaced by the maintenance director and or maintenance assistant on or before 3/2/17. Criteria 2 Residents of the facility have the potential to be affected. The maintenance director or assistant maintenance director are completing audits of other patient rooms not identified with repairs being completed and reported by March 16, 2017. Criteria 3 The Executive Director and or Maintenance Director will provide reeducation and retraining to staff on	3/16/17

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F 253	Continued From page 16 Interview with Nurse Aide (NA) #3 on 02/15/17 at 1:50 PM revealed she had not reported the loose faucets to the maintenance department for repair since it did not leak. b) Observation on 02/16/17 at 10:55 AM revealed loose faucets and a toilet commode loose on the floor in the bathroom of Room #212. Interview with Resident #11 on 02/16/17 at 10:56 AM revealed transfer to the toilet required careful placement of both feet since the toilet was crooked. Resident #11 explained the faucets did not bother her. Interview with Nurse Aide (NA) #2 on 02/16/17 at 10:59 AM revealed she did not notice the loose commode and faucet. NA #2 reported she would put the repair request into the maintenance computer system. Interview with the maintenance director on 02/16/17 at 12:05 PM revealed he was not aware of the loose faucets and commode. The maintenance director reported the commode and faucet would be repaired easily. The maintenance director explained facility staff should notify him of repair needs through the facility's work order computer system. The maintenance director explained he checked for work orders upon arrival to work each day. Interview with the interim Administrator on 02/16/17 at 3:23 PM revealed she expected staff to observe and report items in need of repair. 2. Observation on 02/14/17 at 9:33 AM revealed 3 cracked glass panes of a 15 pane window in Room #203.	F 253	inputting housekeeping and maintenance issues/work orders and preventative maintenance tasks into the facility building engines automated maintenance program software when identified by staff on rounds to keep the facility equipment and building properly maintained. The Maintenance Director and or Maintenance Assistant using the facility census form will make a house wide rounds weekly to identify repairs needed. Criteria 4 The Executive Director will monitor building engines program weekly as well as Maintenance weekly census round forms to include sampling of 3 rooms per week or 12 rooms per month to ensure needed repairs are being reported and fixed. The results of the monitoring will be reported to the QAPI committee monthly for three months, then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	

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F 253	Continued From page 17 Interview with Nurse Aide (NA) #4 on 02/16/17 at 8:55 AM revealed the glass panes had been cracked since she began her employment 10 years ago. Interview with Nurse #4 on 02/16/17 at 9:03 AM revealed he did not notice the cracked glass panes and would place a work order with an outside vendor. Interview with the maintenance director on 02/16/17 at 12:02 PM revealed he was not aware of the cracked glass panes and would arrange for replacement of the panes. The maintenance director explained facility staff should notify him of repair needs through the facility's work order computer system. The maintenance director explained he checked for work orders upon arrival to work each day. Interview with the interim Administrator on 02/16/17 at 3:23 PM revealed she expected staff to observe and report items in need of repair. 3. a) Observation on 02/13/17 at 3:18 PM revealed Resident #15 used an over the bed table with an area of approximately 12 inches peeled off the top in Room #206. Interview with Nurse Aide (NA) #5 on 02/16/17 at 8:57 AM revealed she did not notice the damaged over the bed table. Interview with Nurse #4 on 02/16/17 at 9:01 AM revealed he did not notice the condition of the over the bed table and immediately replaced it with an over the bed table in good condition.	F 253		

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b) Observation on 02/14/17 at 10:44 AM revealed the top drawer of a dresser missing in Room #313.

Interview with the maintenance director on 02/16/17 at 11:55 AM revealed he was not aware of the missing drawer and would replace the dresser.

c) Observation on 02/16/17 at 11:58 AM revealed a broken wardrobe door in Room #203.

Interview with the maintenance director on 02/16/17 at 12:03 PM revealed he was not aware of the broken wardrobe door and would repair it. The maintenance director explained facility staff should notify him of repair needs through the facility's work order computer system. The maintenance director explained he checked for work orders upon arrival to work each day.

Interview with the interim Administrator on 02/16/17 at 3:23 PM revealed she expected staff to observe and report items in need of repair.

4. Observation on 02/14/17 at 3:10 PM revealed a broken tile approximately 6 inches by 5 inches in front of the bed side table in Room #317.

Interview with the maintenance director on 02/16/17 at 11:54 am revealed he was not aware of the broken tile and would replace the tile. The maintenance director explained facility staff should notify him of repair needs through the facility's work order computer system. The maintenance director explained he checked for work orders upon arrival to work each day.

Interview with the interim Administrator on

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F 253	Continued From page 19 02/16/17 at 3:23 PM revealed she expected staff to observe and report items in need of repair. 5. Observation on 02/14/17 at 9:16 AM revealed chipped off paint approximately 2 inches diameter in 6 areas on the bathroom door of Room #206 Observation on 02/14/17 at 9:21 AM revealed a chipped door framed and scratched bathroom door in Room #205. Observation on 02/14/17 at 10:10 AM revealed scratches and paint scraped off of the bathroom door of Room #319. Observation on 02/14/17 at 10:19 AM revealed chipped paint on the bathroom door frame and door in Room #318. Observation on 02/14/17 at 10:56 AM revealed a chipped bathroom door and frame in Room #210. Observation on 02/14/17 at 3:13 PM revealed chipped paint on the bathroom door and frame in Room #309. Observation on 02/13/17 at 4:00 PM revealed scratches with peeled paint on the bathroom and door to Room #215. Interview with the maintenance director on 02/16/17 at 11:49 AM revealed the rooms required painting. The maintenance director explained it was difficult to complete painting when other maintenance repairs took precedence for the operation of the facility. Interview with the interim Administrator on 02/16/17 at 3:25 PM revealed she planned to	F 253		

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F 253	Continued From page 20 contract an outside vendor to paint the residents' rooms. 6. Observation on 02/14/17 at 3:04 PM revealed and broken and bent bottom metal panel of the wall heating unit in the third floor activity area. The corner of the panel was approximately 3 inches bent forward and off the unit. Interview with the maintenance director on 02/16/17 at 11:53 AM revealed he was not aware of the broken panel and it should be repaired. The maintenance director explained facility staff should notify him of repair needs through the facility's work order computer system. The maintenance director explained he checked for work orders upon arrival to work each day. Interview with the interim Administrator on 02/16/17 at 3:23 PM revealed she expected staff to observe and report items in need of repair.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 272		3/16/17

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F 272	Continued From page 21 (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview 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 cognition and use of psychoactive medications for 1 of 5 sampled	F 272	Criteria 1 For Resident #82 a significant correction to prior comprehensive assessment MDS was coordinated and will be complete as per RAI guidelines.	

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F 272	Continued From page 22 residents who received psychoactive medication (Resident #82). The findings included: Resident #82 was admitted to the facility on 12/13/16 with diagnoses which included depression, post-traumatic stress disorder, blindness and cerebral cryptoccosis. Review of Resident #82's admission physician's orders dated 12/13/16 revealed medications included Seroquel (an anti-psychotic) 150 milligrams (mg.) three times daily, Lorazepam (an anti-anxiety) 2 mg. three times daily, Lexapro (an anti-depressant) 10 mg. daily and Restoril 15 mg. at bedtime for insomnia. Review of Resident #82's admission Minimum Data Set (MDS) dated 12/20/16 revealed no documentation of an assessment of cognition. The MDS indicated Resident #82 rejected care and received antipsychotic, antianxiety and antidepressant medications. Review of Resident #82's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/05/17 revealed no documentation of findings with a description of the problem, name and dose of medications, contributing factors and risk factors related to psychotropic drug use. The CAA indicated Resident #82 had decreased ability to be understood with hearing or vision impairment with description of the problems. There was no documentation of an analysis of the findings supporting the decision to proceed or not proceed to the care plan. Observation of Resident #82 on 02/14/17 at 2:47	F 272	Criteria 2 Comprehensive Assessments with psychotropic CAA completed from the last 30 days will be audited by the Director of Nursing or Assistant Director of Nursing or other trained RNAC to identify any potential residents that may have been affected by the cited deficient practice. If any residents are identified through the audit a significant correction to prior comprehensive assessment will be coordinated per RAI guidelines. Criteria 3 Staff that complete CAA questions will receive training on guidelines of CAA completion. The Clinical Assessment and Reimbursement Specialists will conduct the training on 3/9/17. The education will ensure that the deficient practice does not recur. Criteria 4 The DNS, ADNS or trained RNAC will complete audits of CAA documentation to ensure the CAA's contain the description of the problem and the analysis of findings to support the continuance to the care plan. Comprehensive Assessments (admission, annual, significant changes will have review to audit CAA documentation for analysis of findings and description of problem. 10% of census population will be audited on a monthly basis for 3 months and findings reported	

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F 272	Continued From page 23 PM revealed Resident #82 spoke in a flat, loud tone and could not hear questions. Resident #82 continued a monologue of his prior work life. Interview with the MDS Coordinator on 02/16/17 at 9:47 AM revealed a temporary MDS nurse assessed Resident #82. The MDS Coordinator reported the CAA should contain a description and analysis of findings. The MDS Coordinator could not provide a reason for the lack of an assessment. Interview with the interim Administrator on 02/16/17 at 10:03 AM revealed she expected Resident #82's Psychotropic Drug Use CAA to be complete and contain documentation of the description of the problem and analysis of findings to support continuance to the care plan.	F 272	to QAPI. The results of the monitoring will be reported to the QAPI committee monthly for three months, then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		3/16/17

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F 278	Continued From page 24 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code the minimum data set assessment accurately to reflect a resident's upper extremity range of motion for 1 of 1 residents sampled for upper extremity range of motion (Resident #59). Findings Included: Resident #59 was admitted on 04/21/15 with the following diagnoses: Alzheimer's disease, depression and arthritis. Review of the therapy to nursing communication/functional maintenance program dated 06/23/16 revealed Resident #59's goal was to maintain current range of motion in bilateral hands and digits for contracture management. An occupational therapy order dated 06/23/16 revealed Resident #59 had bilateral hand	F 278	Criteria 1 A new quarterly MDS assessment was completed for resident #59. This assessment accurately reflects residents ROM status. Criteria 2 Because other residents in the facility have the potential to be affected MDS assessments from the last 30 days were reviewed by the DNS, ADNS or other trained RNAC to check for ROM status with a current physical assessment. Any residents that were identified during the audit to have a discrepancy will have a new MDS assessment coordinated and completed. Criteria 3	

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F 278	Continued From page 25 contractures. Review of the most recent comprehensive minimum data set (MDS) assessment dated 08/30/16 revealed Resident #59 had severely impaired cognition and required extensive assistance with most activities of daily living. Functional limitation in range of motion (ROM) for the upper extremities was coded as no impairment. An interview with the occupational therapist on 02/16/17 at 10:19 AM revealed bilateral hand contractures were first noted on 02/12/16. An interview with the MDS coordinator on 02/16/17 at 12:17 PM revealed she had been completing MDS assessments since 2012. She indicated that she gathered information for the MDS assessment from the chart which included the discharge summary, therapy and nurses notes. The MDS coordinator further stated that for the ROM section of the MDS she would talk to nurse aides and therapists to gather information. The MDS coordinator stated she should have assessed Resident #59's upper extremities ROM and that the MDS is incorrect. An interview with the director of nursing on 02/16/17 at 2:52 PM revealed she expected MDS's to be accurate and completed timely according to regulatory standards.	F 278	The RNAC received section G training via the facility online learning center on 3/7/17. Criteria 4 MDS accuracy of section G0400 will be monitored by DNS, ADNS, and or other trained RNAC. 10% of the census will be audited on a monthly basis. The results of the monitoring will be reported to QAPI committee monthly for three months, then quarterly there after until the QAPI committee determines the ongoing need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15	F 279		3/16/17

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F 279	Continued From page 26	F 279		

months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) 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 §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the

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F 279	Continued From page 27 resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to develop a discharge care plan for 1 of 3 residents with active discharge plans (Resident #36). The findings included: Resident #36 was admitted to the facility on 10/14/16 with diagnoses which included diabetes mellitus and bilateral below the knee amputations. Review of Resident #36's admission Minimum Data Set (MDS) dated 10/21/16 revealed an assessment of intact cognition and no active discharge plan. The MDS indicated Resident #36 intended to remain in the facility. Review of Resident #36's quarterly MDS dated 01/17/17 revealed an assessment of intact cognition and an active discharge plan with	F 279	Criteria 1 Resident #36 was identified to not have a discharge planning care plan in place. Resident #36's care plan has been updated to include a discharge planning focus. Criteria 2 To identify any other residents that have been affected an audit will occur an audit of care plans will occur to ensure residents have an active discharge planning focus. The audit will be conducted by the DRA, DNS, ADNS or designee. Criteria 3 The Social Worker will receive	

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F 279	Continued From page 28 referral to an outside agency not required. Review of Resident #36's care plan dated 01/19/17 revealed no documentation regarding a discharge plan. Interview with Resident #36 on 02/13/17 at 11:36 AM revealed the intention to move to an apartment. Resident #36 reported he did not want to remain in the facility or move into another group living situation. Interview with the facility's social worker (SW) on 02/15/17 at 2:01 PM revealed Resident #36 refused an assisted living room and desired to move to an apartment. The SW explained she was working with Resident #36 to secure the funds and make arrangements for a safe discharge to an independent living apartment. The SW reported discussions regarding Resident #36's discharge occurred with Resident #36, Resident #36's friends and the local government agencies. A second interview with the SW on 02/16/17 at 8:21 AM revealed the lack of documentation in the care plan and Resident #36's social work notes was an oversight. The SW reported the care plan should contain a discharge plan and goal. Interview with the interim Administrator on 02/16/17 at 10:06 AM revealed awareness of Resident #36's desire to be discharged. The interim Administrator reported she expected Resident #36's discharge plan to be included in the care plan.	F 279	rein-service training and reeducation from the Director of Resident Assessment on how to update care plans to include a discharge planning focus. Criteria 4 The Director of Resident Assessment will review/monitor 5% of the census population on a monthly basis to determine that residents have discharge planning care plan focus in place. The results of the monitoring will be reported to the QAPI committee monthly for three months, then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	
F 313	483.25(a)(1)(2) TREATMENT/DEVICES TO	F 313		3/16/17

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F 313 SS=D	Continued From page 29 MAINTAIN HEARING/VISION (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with a resident (Resident #28), a nurse practitioner, and staff and review of the medical record, the facility failed to assist Resident #28 with a medical appointment for an Ear, Nose and Throat consult per order of the nurse practitioner for 1 of 7 sampled residents reviewed for physician referrals. The findings included: Resident #28 was admitted to the facility on 3/17/16. Diagnoses included hearing loss with the use of a hearing aid, pain (unspecified), osteoporosis, allergic rhinitis, and depression. Review of an admission Minimum Data Set (MDS) assessment and Care Area assessment dated 03/28/16, assessed Resident #28 with moderate difficulty hearing, the use of a hearing aid, clear speech, able to be understood and to understand, impaired cognition, and without the	F 313	Criteria 1 Resident #28 was scheduled and transported for ENT consultation appointment during the survey process on 2/16/17. Criteria 2 The facility will identify other residents having the potential to be affected by the same deficient practice by completing a 100% audit by the DNS or ADNS of physician and NP orders for consultative referrals for the past 3 months. Criteria 3 The Unit Nurse, Floor Charge Nurse or Nursing Supervisor will review daily MD / NP orders and initiate all prescribed orders, Ex., consultative referrals, to the	

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F 313	Continued From page 30 presence of pain or indicators of pain. Review of a nurse practitioner's (NP) progress note dated 9/21/16 revealed Resident #28 was assessed with cerumen (ear wax blockage). A physician's order was written for Debrox Ear Drops to bilateral ears twice daily (BID) for 4 days. Review of a quarterly MDS dated 12/13/16 assessed Resident #28 with moderate difficulty hearing, the use of a hearing aid, clear speech, able to be understood and to understand, moderately impaired cognition, receipt of scheduled pain medication for occasional pain described as severe, but pain that did not affect daily function. A care plan revised December 2016 identified Resident #28 was hard of hearing and wore hearing aids. Interventions included, in part, for staff to provide hearing consultation as needed. Review of a NP's progress note dated 12/21/16 revealed Resident #28 was assessed with acute sinusitis due to complaints of sinus congestion, ear pain/pressure and a fever. A physician's order was written for Levaquin (antibiotic) 500 milligrams daily for 10 days. On 12/28/16, the NP wrote a physician's order for Resident #28 to have an Ear, Nose and Throat (ENT) consultation due to ongoing ear pain. On 02/14/17 at 12:00 PM, Resident #28 was observed seated in a chair with a hearing aid to her left ear. She stated in interview that she was not experiencing any discomfort at the time, had occasional joint pain and denied ongoing pain	F 313	transportation scheduler and the DNS daily prior to their shift ending. In-service training will be completed by March 16, 2017 for Nurses and Transportation/Scheduler and Medical Records Coordinator by DNS and or ADNS. Criteria 4 The Unit Nurse, Floor Charge Nurse or Nursing Supervisor will review daily a physician order report and follow up on physician orders. The DNS and or Assistant Director of Nursing will provide weekly random physician order report audits on 5% of the current census. The results of the monitoring will be reported to the QAPI committee monthly for three months, then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	

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with no relief.

A follow up observation/interview with Resident #28 occurred on 02/16/17 at 9:06 AM. Resident #28 was observed with a hearing aid to her left ear, no signs of distress and complained of ongoing difficulty hearing in her left ear despite the use of a hearing aid. She stated that a few months back she had an ear infection that was treated with an antibiotic and some ear wax build up that was treated with ear drops. She stated she didn't know if the ear wax buildup was back and causing the hearing difficulty; the doctor told her she would be referred to a specialist, but she had not heard any more about it.

An interview with the social worker (SW) occurred on 02/16/17 at 9:35 AM and revealed she had spoken to Resident #28 several times, but the Resident had not complained of ear pain or that she was expecting a referral due to hearing loss/ear pain. The SW stated she had not made a referral for an ENT Consult because that was something the nurses did.

An interview with Nurse #2 (7 - 3 PM shift) occurred on 02/16/17 at 9:38 AM. Nurse #2 stated Resident #28 had hearing loss, wore a hearing aid to her left ear and had complaints of ear pain in the past. Nurse #2 stated she was not aware of current complaints of ear pain/further hearing loss or a current ENT referral for Resident #28. Nurse #2 reviewed the medical record for Resident #28 and stated that she recalled that Resident #28 had an ENT Consult "back in the summer", but could not find documentation of that. Nurse #2 stated that in September 2016, Resident #28 complained of ear pain again and an order was written for ear

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drops BID for 4 days. Nurse #2 reviewed the physician's order dated 12/28/16 for an ENT referral and stated that she could not locate documentation to support that Resident #28 had an appointment from that physician's order. Nurse #2 stated the nurse who wrote the physician's order should have given a copy of the order to the scheduler to make the appointment, documented the appointment on the master calendar, and given a copy of the order to the nurse/director of nursing (DON) to make her aware of the referral/appointment. Nurse #2 stated that if the scheduler was not available, the nurse supervisor would be responsible for scheduling the consult. Nurse #2 assessed Resident #28 at the time of the interview and stated the Resident complained of slight ear pain.

Nurse #1 (7 - 3 PM shift) was interviewed on 02/16/17 at 9:46 AM. Nurse #1 stated that she was the nurse supervisor, but at times she was scheduled to "work the cart". Nurse #1 stated that when she was not working cart, she pulled the physician's orders list and gave any physician's orders for referrals to the scheduler to make the appointment. Nurse #1 stated that if the referral was urgent and the scheduler was not working, she would make the appointment, otherwise the appointment would be made either when the scheduler returned or made by the DON. Nurse #1 stated that if she worked a cart, she did not pull the physician's orders list and when she did pull the list, she only pulled it for that day. Nurse #1 also stated that the DON or assistant DON (ADON) were responsible for pulling the physician's orders list, but in December 2016 the facility did not have an ADON. Nurse #1 stated she worked a cart on 12/28/16 and did not pull the physician's orders list that day, nor did she

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make an appointment for Resident #28's ENT consult. Nurse #1 stated the DON in December 2016 no longer worked at the facility.

An interview with nurse aide (NA) #1 (scheduler/central supply) (7 - 3 PM shift) occurred on 02/16/17 at 10:01 AM and revealed Resident #28 had not complained to her of current ear pain or further hearing difficulty. NA #1 stated she was on medical leave in December 2016 through January 2017, but that she could not recall the specific date she returned to work. NA #1 stated that when a physician wrote an order for a referral, the nurse gave her a copy of the order, she made the appointment and notified the nurse so that the appointment could be logged on the calendar. NA #1 stated she transported the resident to the appointment or made arrangements for transport. NA #1 reviewed the copies of orders she received in December 2016 and stated she did not receive a physician's order for Resident #28's ENT referral and if she had received it, she would have checked to see if the appointment had been made when she returned to work in January 2017.

An interview occurred on 02/16/17 at 11:15 AM with the interim DON and revealed she was not the facility's DON in December 2016, but that she expected the nurse who processed the 12/28/16 physician's order for the ENT consult to ensure the scheduler was notified to make the appointment. The interim DON further stated that if the scheduler was not available, the charge nurse should make the appointment and that working a cart did not relieve the charge nurse of her supervisory responsibilities. The interim DON stated that referral appointments should be made

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F 313	Continued From page 34 within 24 - 48 hours of the written physician's order. A telephone interview with nurse #3 (3 - 11 PM shift) occurred on 02/16/17 at 12:52 PM and revealed she processed the 12/28/16 physician's order for Resident #28 regarding the ENT Consult, she recorded the order on the 24 hour nurse's report sheet, but that she did not make the appointment. Nurse #3 stated she expected that the order would have been discussed during the next morning meeting with the DON present and that the DON would have made the appointment. Nurse #3 further stated that sometimes she would make the appointments, but in that case, she did not and it "may have slipped through the cracks." A telephone interview with the NP occurred on 02/16/17 at 1:45 PM. The NP stated that she did write an order for Resident #28 to have an ENT Consult due to ongoing ear pain after acute sinusitis and the referral should have been made. The NP stated that she expected orders to be carried out and that she followed up on the order several times, but kept getting answers that it was someone else's job. An interview with the interim administrator occurred on 02/16/17 at 3:52 PM and revealed she expected nursing staff to follow the physician's order and to make referrals per physician's order. She stated that the previous DON no longer worked at the facility. Attempts to interview the previous DON during the survey were unsuccessful.	F 313		
F 431	483.45(b)(2)(3)(g)(h) DRUG RECORDS,	F 431		3/16/17

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F 431 SS=D	Continued From page 35 LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws,	F 431		

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GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 431	Continued From page 36 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. (2) 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 facility policy review, the facility failed to remove from use expired medication in 2 of 4 medication carts and 1 of 2 medication storage rooms. Findings included: A review of the Facility Policy entitled Medication Storage in the Facility, Storage of Medications, with a revised date of August, 2014, revealed the following, "All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner." 1a: An observation on 2/13/17 at 10:58 AM of the 100 Hall medication cart revealed an opened bottle of 500 milligram (mg) Vitamin C. The bottle was originally filled with 1,000 tablets. The bottle was found in the bottom drawer with an expiration date of 01/17.	F 431	Criteria 1 The expired medications identified during the survey process were removed and immediately destroyed by the Nurses on the units and the OTC's by the Central Supply/Transportation Scheduler Criteria 2 A 100% medication cart audit on all medication carts was completed by ADNS on 2/16/17. The Nurses on night shift will check daily for expired medications and turn in their findings to the DNS and or ADNS. The Central Supply / Transportation Scheduler and or Medical Records Coordinator will check the OTC's storage rooms randomly weekly and monthly. Criteria 3	

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F 431	Continued From page 37 An interview was conducted on 2/13/17 at 11:02 AM with Nurse #1 on the 100 Hall. Nurse #1 acknowledged the expiration date on the 500 mg Vitamin bottle was 01/17. During this interview, Nurse #1 stated the bottle of Vitamin C was expired. Nurse #1 took possession of the expired Vitamin C and did not return it to the medication cart. 1b: An observation on 2/15/17 at 11:49 AM of the 300 Hall medication cart revealed an opened bottle of 500 mg Vitamin C. The bottle was originally filled with 1,000 tablets. The bottle was found in the bottom drawer with an expiration date of 01/17. An interview was conducted on 2/15/17 at 11:51 AM with Nurse #2 on the 300 Hall. Nurse #2 acknowledged the expiration date on the 500 mg Vitamin bottle was 01/17. During this interview, Nurse #1 stated the bottle of Vitamin C was expired. Nurse #2 went on to say the night nurse staff checks the cart for expired medications. Nurse #2 provided further clarification that she did not use the 1,000 tablet bottle of Vitamin C. Nurse #2 displayed a smaller bottle that she stated was what she used. Nurse #2 showed the medication was not expired, dated when opened, and stored with the other over the counter medications that were frequently used, all in one drawer. Nurse #2 took possession of the expired Vitamin C and did not return it to the medication cart. 2a: An observation of the supply room for the over the counter (OTC) medications located on the 300 hall on 2/15/17 at 11:57 AM revealed a 130 tablet sized bottle of Vitamin B-12 100 microgram (mcg) with an expiration date of 08/16.	F 431	Licensed Nursing staff will be reeducated and rein-serviced on the Medication Policy and Medication Storage by DNS and or ADNS by March 16, 2017. Criteria 4 The DNS and or ADNS will review/monitor medication cart 2 times weekly for expired medications as well as Central Supply OTC storage areas monthly. Central Supply/Transportation Scheduler and or Medical Records Coordinator will conduct weekly random monitoring for over the counter medication in the Central Supply area/department. The results of the monitoring will be reported to the QAPI committee monthly for three months, then quarterly thereafter. The QAPI committee will determine the ongoing or expanded need for monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	

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An interview was conducted on 2/15/17 at 12:01 PM with the Central Supply Coordinator (CSC). The CSC acknowledged the expiration date on the Vitamin B-12 bottle was 08/16. During this interview, the CSC stated the bottle of Vitamin B-12 was expired. The CSC provided further information that she had started in November. She stated when she started, she ordered Over the Counter (OTC) medications and disposed of all of the expired medications that were on hand. The CSC stated she understood the importance of rotating stock to minimize the risk of having expired medications. She stated she must have missed the bottle of Vitamin B-12. The CSC provided further information that the nurse who stocks the medication carts come to the medication supply room to obtain the needed medications to stock the carts. The CSC stated she did not stock the medication carts. The CSC took possession of the expired Vitamin B-12 and did not return it to the shelf stock supply of Vitamin B-12.

An interview was conducted on 2/16/17 at 3:59 PM with the Interim Director of Nursing (DON) regarding the expired Vitamin B-12, and the Vitamin C on the 100 Hall and 300 Hall medication carts. The Interim DON stated her expectation was that the nurses should be checking the cart on a daily basis and disposing of any expired medications. In addition, the Interim DON stated that there are medication card exchange days and the nurses should be checking for expired medications on those days also.

An interview was conducted on 2/16/17 at 4:14 PM with the Interim Administrator regarding the

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F 431	Continued From page 39 expired Vitamin B-12, and the Vitamin C on the 100 Hall and 300 Hall medication carts. The Interim Administrator stated her expectation was that the nurses should be checking the expiration date on medications daily. She further clarified that if expired medications are discovered, the expired medication needs to be disposed of immediately. She added, there was not supposed to be anything that out of date. The Interim Administrator provided a copy of Facility Policy Medication Storage in the Facility, Storage of Medications, revised August 2014.	F 431		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are	F 520		3/16/17

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F 520	Continued From page 40 necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 4/29/2016 recertification survey. This was for one recited deficiency in the area of Housekeeping and Maintenance Services (F253). The deficiency was cited again on the current recertification survey of 2/16/2017. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: F 253 Housekeeping and Maintenance: Based on observations and resident and staff interviews, the facility failed to secure a commode to the floor	F 520	Criteria 1 A meeting of the QAPI Committee will be held on 3/7/17 to discuss their role in the correction process for F253 as it relates to F520. Reporting and monitoring as outlined in plans of correction will be addressed. A review of the QAPI process and access to QAPI resources on the facility intranet homepage accessible to all members of the QAPI committee will be completed by the Executive Director by 3/16/17. Criteria 2 The QAPI committee will meet monthly. The monthly meeting will include attention and focus on the plans of correction for the cited alleged deficient practice, and	

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F 520	Continued From page 41 (Room #212), repair 2 loose faucets on bathroom sinks (Rooms #212 and #318), replace a damaged over the bed table (Room #206), replace cracked window glass (Room #203), repair a wardrobe door (Room #203), replace a missing drawer (Room #313), repair broken floor tiles (Room #317), and paint chipped and scarred doors and door frames (Rooms #205, #206, #210, #215, #309, #318, and #319) for 12 of 29 sampled resident rooms. The facility also failed to repair a bottom metal heating unit panel in 1 of 4 activity/dining areas. During the recertification survey of 4/29/2016 the facility was cited F253 for failing to repair and replace floor tiles, repair holes in the wall and a bathroom door, repair a leaking toilet and replace a missing outlet cover. On the current recertification survey of 2/16/2017, the facility failed to maintain multiple facility constructional components in good repair. An interview was conducted with the Interim Administrator on 2/16/2017 at 10:29 AM. The Interim Administrator stated that the facility had Quality Assessment and Assurance (QAA) Review Committee. The QAA committee consisted of the Administrator, the Director of Nursing (DON), the Medical Director, the Activities Director, the Social Worker, the Medical Records Director, The Minimum Data Set Coordinator, the Business Office Manager, the Dietary Manager, the Therapy Director, the Maintenance Director, the Housekeeping Director, and the Wound Care Nurse. The QAA committee met monthly and that the QAA committee identified issues that required quality assessment and assurance activities. The Interim Administrator stated that both she and the	F 520	the committee will develop ongoing plans for process improvement and deficiency correction. Criteria 3 Results from the monitoring and action plan steps will be discussed in detail at each QAPI meeting for three months and existing actin steps will be updated, revised or amended as needed to ensure compliance and correction. Criteria 4 The Executive Director and or the Director of Nursing will ensure the QAPI committee will determine the ongoing or expanded need for monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI meeting.	

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F 520	Continued From page 42 DON were only recently hired and have had limited time to address issues and concerns during QAA meetings. During the most recent QAA meeting concerns regarding environment had been discussed and there was a plan for environmental issues and concerns. The Interim Administrator further clarified that with the recent change in in leadership that the new leadership had planned on identifying areas of quality improvement and implement appropriate plans of corrections.	F 520		