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	345144	A. BUILDING _____ B. WING _____	01/27/2017

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of this complaint investigation conducted on 1/27/2017 exit Event ID #L3VU11	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to honor the wishes of Resident's #38 responsible party to discontinue obtaining weights when care and comfort measures were initiated. This was 1 of 3 residents in the sample reviewed for care and comfort measures. The findings included: Resident #38 was admitted to the facility on 12/16/10 with cumulative diagnoses which included dementia Review of the annual Minimum Data Set dated 10/24/16 revealed Resident #38 had impaired cognition. Review of the physician orders revealed on 3/4/16 an order to discontinue routine vital signs and weights secondary to comfort care. Continued review of the January 2017 physician	F 242	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through	2/20/17

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

Electronically Signed | 02/20/2017

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F 242	Continued From page 1 orders revealed the order for the discontinuation of weights was still in effect Review of the monthly Nurse Practitioner's (NP) note dated 3/4/16 revealed the goal for this resident was care and comfort. Further review of the NP note revealed a communication was held with the responsible party who agreed with the changes in the plan of care to discontinue vital signs and weights. Review of the Weights and Vitals Summary form revealed weights had been obtained on 3/15/16, 4/21/16, 4/29/16, 5/20/16, 6/18/16, 7/22/16, 8/25/16, 9/16/16, 10/21/16, 11/15/16 and 12/14/16 Interview on 01/26/2017 at 1:03 PM with the Administrator revealed weights should not be obtained if there were orders to discontinue obtaining weights. Interview on 01/26/2017 at 2:50 PM with the Restorative Nurse (RN) who was responsible for ensuring weights are obtained was interviewed. RN indicated she was not told about discontinuation to obtain weights for Resident #38. Continued interview indicated the nurse would notified me or the Restorative Aide (RA) to discontinue the weights. Interview on 01/26/2017 at 4:10 PM with the Administrator and Director of Nurses (DON) was held. During the interview the DON indicated the nurse who transcribed the order could notify the restorative department. Unable to interview the nurse who transcribed the order because the nurse could not be identified by the Administrator or DON.	F 242	Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag 0242 - 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (LONG TERM CARE FACILITIES) On 1/26/17, Residents #38□s responsible party□s wishes to discontinue obtaining weights was carried out. On 1/26/17, the orders to discontinue routine vital signs and weights secondary to comfort care was implemented for Resident #38. On 1/26/17, the director of nursing (DON) notified the restorative department of the order discontinuing weights for Resident #38. On 2/20/17, the DON, ADON, QI nurse, staff nurse, and/or corporate consultant completed a 100% review of physician orders to the past 30 days to look for orders relating to resident/responsible party self-determination- right to make choices to ensure self-determination □ right to make choices are followed, to include Resident #38□s wish to discontinue weights. On 2/20/17, the DON and staff facilitator initiated an in-service on F 242 Self-Determination □ Right to Make Choices, to include example orders and resident requests. 100% nursing staff (RNs, LPNs, and CNAs) were in-serviced	

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F 242	Continued From page 2	F 242	by the Staff Facilitator on the F 242 Self-Determination □ Right to Make Choices, completed on 2/20/17. After 2/20/17, no nursing staff will be allowed to work until completing the in-service. The in-service will be incorporated into orientation for newly hired nursing staff. On 2/20/17, the DON, ADON, QI nurse, staff nurse, and/or corporate consultant began using the on F 242 Self-Determination □ Right to Make Choices audit tool to ensure F 242 Self-Determination □ Right to Make Choices, to include responsible party and resident requests to discontinue weights and vital signs for comfort measure is honored. Negative audit results will immediately be addressed by the auditor and the corrective action noted on the audit tool. The director of nursing will present all findings at the monthly QI committee meeting x 3 months for review and recommendation for any modification of the monitoring process. The administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		2/20/17

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F 253	Continued From page 3 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and record review the facility failed to have functional closet doors in Resident Rooms # 207,#209 and #211. The facility failed to have clean filters in the heating and air conditioning units. (Rooms #400, #405, #407 and #415) This was evident in 2 of 5 resident care units. Findings included: 1. a. Observation on 1/24/17 at 2:45 PM revealed the closet door in Room #207B was off track and could not be adjusted. b. Observation on 01/25/2017 at 10:42 AM revealed the closet door in Room #209 was off track. c. Observation on 01/25/2017 at 10:45 AM in Room #211 revealed the closet door was off track. d. Observation on 01/25/2017 at 01:15PM in Room #207 revealed missing closet door knob. One of the 2 closet doors was off track. 2. a. Observation on 1/24/17 at 2:45 PM revealed the filters in the HAV unit in Room 209had an accumulation of an off- white colored substance similar to dust. b. Observation on 01/25/2017 at 1:36 PM revealed the filters in the Heating and Air conditioning (HAV) unit in Room #209 had an accumulation of an off white colored substance similar to dust.	F 253	F 253 Housekeeping and Maintenance Services On 1/27/17, the maintenance supervisor and maintenance staff began repairing closet doors in resident rooms to include rooms: #207B, #211, and #207. The maintenance supervisor□s repair of resident room closet doors will be complete by 2/20/17. On 1/27/17, the maintenance director placed the closet door back on the track in room # 207B. On 1/27/17, the maintenance director placed the closet door back on the track in room #209. On 1/27/17, the maintenance director placed the closet door back on the track in room #211. On 1/27/17, the maintenance director replaced a closet door knob in room #207. On 1/27/17 through 2/6/17, the housekeeping staff cleaned all filters from an accumulation of an off-white colored substance similar to dust in the heating, ventilation, and air conditioning (HVAC) units, to include the HVAC units in rooms #209, #400, #405, #407, and #415. On 2/6/17, the administrator and housekeeping supervisor completed a 100% audit of all resident room HVAC ensure filters in the HVAC units are clean and not torn. Any negative findings were immediately addressed.	

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F 253	Continued From page 4 c. Observation on 01/26/2017 at 1:47 PM of the 400 hall revealed the filters in the HAV unit had an accumulation of an off white colored substance similar to dust in Rooms #400, #405, #407 and #415. Interview on 01/27/2017 at 9:50 AM with the Director of Housekeeping and Laundry Services revealed the housekeeping department was responsible for keeping the filters clean in the HAV unit. Interview on 01/27/2017 at 12:58 PM with Housekeeper (HK-1) revealed as we clean and sweep the rooms daily, we also check the filters in the HAV unit to determine whether they are torn or dirty. Interview on 01/27/2017 at 1:03 PM with HK-2 revealed she had been on leave and had not cleaned any filters in the HAV units.	F 253	On 2/15/17, the administrator re-educated the housekeeping supervisor, maintenance director, and dietary manager on the following: 1. Housekeeping and maintenance services must provide necessary services to maintain a sanitary, orderly, and comfortable interior. 2. These services must include clean filters in the HVAC units. 3. Functional resident room closet doors, on the tracks and with door knobs. 4. Refrigerators operational, without missing parts, without ice buildup, and clean. 5. Refrigerator food must have dates names. 6. Utility rooms must be clean without buildup of stains or food matter on the floors or base of the refrigerator 6. Any negative findings must be addressed immediately. This re-education will be provided by the housekeeping supervisor, maintenance director, and dietary manager to their respective department staff in housekeeping, maintenance, and dietary and completed by 2/20/17. All future housekeeping, maintenance, and dietary employees will be educated during their orientation process. On 2/20/17, the administrator initiated and in-serviced on the Physical Plant/Environmental Cleanliness tool which will be added to the Preventative Maintenance Log to be utilized by the maintenance director monthly on an ongoing basis. Any negative findings will be addressed immediately.	

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F 253	Continued From page 5	F 253	On 2/20/17, the director of nursing (DON), quality improvement (QI) nurse, maintenance director, dietary manager, supply coordinator and/or housekeeping supervisor initiated a QI tool titled, Physical Plant/Environmental Cleanliness to ensure all resident room closet doors are on the track, closet doors have door knobs, HVAC unit filters are clean, refrigerators are with parts and clean, and clean utility room floors are clean. This Physical Plant/Environmental Cleanliness tool will be completed weekly x 4 weeks, twice monthly x 8 weeks. Any negative findings will be addressed immediately. The administrator will monitor for proper completion and follow up of the Physical Plant/Environmental Cleanliness tool by initialing the bottom right hand corner of the audit tool. The administrator will present all findings at the monthly QI committee meeting x 3 months for review and recommendation for any modification of the monitoring process. The administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	
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	F 278		2/20/17

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F 278	Continued From page 6 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 record reviews and staff interviews the facility failed to code the Minimum Data Set (MDS) in 1 of 3 residents to reflect Hospice services. (Resident #3). The facility failed to accurately code the dental status on the MDS for 2 of 3 residents reviewed for oral care. (Resident #78 and Resident #70). Findings included: 1.Record review revealed Resident #3 was started Hospice Services on 10/11/16. Review of the significant change MDS dated	F 278	F 278 Assessment Accuracy/Coordination/Certified 1.On 1/27/17 resident #3 significant change assessment was modified to accurately code resident receiving hospice services by the Minimum data set (MDS) nurse. On1/27/17 resident # 78 annual assessment dated 9/11/2016 was modified to accurately code the resident oral status by the MDS nurse. On 1/28/17 resident #70 significant change	

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F 278	Continued From page 7 10/11/16 revealed Hospice was not coded. Interview on 01/26/2017at 12:45 PM with the MDS Nurse #1 revealed the purpose of the significant MDS assessment dated 10/11/16 was to address Hospice. MDS nurse #1 stated she forgot to code Hospice when completing the assessment. Interview on 01/26/2017 at 1:00 PM with the Administrator revealed her expectation was Hospice be coded when appropriate. 2. Record review of the annual MDS dated 9/11/16 revealed the oral/dental status was not checked. Record review of the dental history and record form dated 11/26/16 indicated Resident #78 with missing and broken teeth. Additionally, it was noted that this resident did not want any services to address these teeth. Observation on 1/25/17 at 1:23 PM revealed Resident #78 had several missing teeth and fragments. Interview on 01/27/2017 at 2:30 PM with MDS Nurse # 1 revealed that she missed correctly coding the oral status of Resident #78 when the 9/11/16 annual MDS was completed. Interview on 01/27/2017 at 3:00 PM with the administrator revealed an expectation for staff to code the MDS accurately. 3. Resident #70 was admitted on 8/19/16 with the current diagnosis of dysphagia, cellulitis and dementia. The resident's significant change Minimum Data Set (MDS) dated 12/21/16 revealed the resident was severely cognately impaired. The resident	F 278	assessment dated 12/21/16 was modified to accurately code resident oral status by the MDS nurse. On 1/30/17 the modified assessments were transmitted to the National Repository by the MDS nurse. 2. On 2/20/17 the facility consultant audited all in progress and export ready MDS assessments completed for accuracy of hospice services and oral status. Assessments will be modified for accuracy of hospice services and oral status as necessary. 3. On 2/17/17 the MDS coordinator and MDS nurse received an in-serviced by the administrator related to accurately coding the MDS assessment including the coding of hospice services and dental status. 4. On 2/27/17 the administrator, Director of Nursing (DON), Quality Improvement (QI) nurse, Restorative Nurse, or facility consultant will begin auditing MDS assessments for correct coding of hospice services and dental services using the Accuracy Audit Tool. 5 completed assessments will be audited weekly x 4 weeks, then 5 completed assessment biweekly x 8 weeks, then 5 of completed assessments monthly x 3months. 5.The monthly Quality Improvement (QI) committee will review the results of the Accuracy 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	

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F 278	Continued From page 8 had no swallowing disorder and no dental problems. The note from the dentist dated 5/19/15 stated the resident had been seen and the resident was edentulous and had no appliances. The resident's tissue was normal and the resident did not have any problems with chewing or pain. MDS nurse #1 was interviewed on 1/26/16 at 4:31 PM. She stated the resident did not have any teeth. She stated she saw what was coded on the MDS and she was the person that coded the dental section of the MDS. The resident was interviewed on 1/27/17 at 8:26 AM. He stated he did not have any dentures and did not have any teeth. The resident was observed on 1/27/17 at 8:31 AM. The resident did not have any teeth or dentures. The Administrator was interviewed on 1/27/17 at 2:02 PM. She stated her expectation was for the MDS to be coded accurately and timely.	F 278	continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive Quality Assurance (QA) committee for further recommendations and oversight.	
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	F 279		2/20/17

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F 279	Continued From page 9 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 interviews and record review, the facility failed to create a care plan for a resident with weight loss for 1 of 4 residents (Resident #169) reviewed for nutrition. Findings included: 1. Resident #169 was admitted to the facility on 12/19/16 with diagnoses including end stage renal disease, diabetes, depression and sacral wound. Resident #169's Admission Minimum Date Set (MDS) dated 12/26/16 revealed the resident had moderately impaired cognition and needed extensive assistance with eating. The resident's Nutritional Status Care Area Assessment (CAA) dated 12/26/16 indicated that nutritional status and functional status would be addressed in the care plan. The overall objective for the care plan was to improve, avoid complications and minimize the risk of weight loss. A review of the comprehensive care plan dated 1/9/17 revealed there was no care plan that addressed resident's nutritional status or risk of weight loss. The Registered Dietician (RD) and MDS nurse were interviewed on 1/26/17 at 3:01pm. The RD	F 279	F 279 Develop Comprehensive Care Plans 1. A care plan was developed for Resident # 169 by the dietary manager and minimum data set nurse (MDS) to address nutritional status and risk for weight loss on 1/30/17. 2. A 100% audit was completed by the facility consultant on 2/17/17 for all residents who are at risk for weight loss based on the Care Area Assessment (CAA) to ensure a nutrition status care plan is in place to include interventions. 3. The MDS nurses and dietary manager were in-serviced by the administrator on 2/17/17 related to all residents at risk for weight loss must have a nutritional status care plan in place to include interventions. 4. The administrator, QI nurse, DON, restorative nurse, or facility consultant will	

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F 279	Continued From page 10 stated he typically completes the MDS, CAA and care plan all at the same time and inadvertently missed completing the care plan. The MDS nurse reported that the care plan was due 7 days after completion of the CAA, which would have been 1/9/17. An interview was completed with the Administrator on 1/27/17 at 12:50pm and she stated her expectation was that the care plans would be completed on time.	F 279	begin auditing residents that are at risk for weight loss, based on the CAA to ensure a nutritional status care plan in place to include interventions using the Care Plan audit tool. 5 care plans will be audited weekly x 4 weeks, then 5 care plans will be audited biweekly x 8 weeks, then 5 care plans will be audited monthly x 2 months. 5. The monthly QI committee will review the results of the Care Plan Audit Tool monthly for 3 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.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, medications were prepared and crushed by a Medication Aide (Med Aide) to be administered to Resident #95 via a gastrostomy tube (GT) by a	F 282	F282 Services by Qualified Persons Per Care Plan On 1/26/2017, Nurse # 2 discarded	2/20/17

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F 282	Continued From page 11 nurse. The medications were unidentifiable to the nurse. This was evident in 1 of 1 resident observed during the medication pass with a GT. Findings included: Observation on 01/26/2017 at 8:13AM revealed Medication Aide #1 (Med Aide) provided Nurse #2, an unidentifiable plastic cup of crushed medications that she prepared for Nurse #2 to administer to Resident #95 via the gastrostomy tube (GT). Interview on 01/26/2017at 8:14AM with Med Aide #2 and Nurse #2 was held. Med Aide #2 stated she just crushed Plavix 75 milligrams (mg), Certagen 1 pill, Lopressor 25 mg, Vitamin C 500 mg and Glucophage 500 mg and opened a capsule of Prilosec 20 mg and 2 capsules of Gabapentin 300 mg. Nurse #2 prepared to administer these unidentifiable crushed medications prepared by another individual until an inquiry was made. Nurse #2 indicated she was unable to identify the medications provided to her. Continued interview with Nurse #2 revealed the facility practice was Med Aides would prepare medications to be given via the GT and the nurse would administer. Additionally, Nurse #2 stated she was told by other staff (could not identify staff) that she could let Med Aides prepare and crush medications for administration via the GT. Interview on 01/26/2017 at 4:05 PM with the Administrator and the Director of Nurses was held. Both indicated the expectation was the person who prepares medications administers the medication. Interview on 01/27/2017 at 10: AM with Med Aide #2 revealed crushed medications prepared for	F 282	medications that were prepared and crushed by Medication Aide (Med Aide) for resident #95. Nurse # 2 prepared and crushed medications prior to administration to resident # 95. On 2/16/17, the Director of Nursing (DON), performed a medication pass audit with Med Aide and the administrator completed a medication pass audit with Nurse #2. Any negative findings were addressed immediately. On 2/17/17, the IDON began a Medication Pass Quiz with all Nurses and Med Aides involved with the medication pass procedure which includes medication preparation. This quiz must be completed and reviewed by the DON, Administrator, or Restorative Nurse before any Nurse or Med Aide can perform a medication pass after 2/20/17 On 2/20/17, the DON began an in-service with all Nurses and Med Aides on 1. Provide care by qualified persons in accordance with resident□s plan of care, 2. Facility must make sure the medication error is less than 5%, 3. A licensed nurse or Medication Aide shall not administrator medications that have been prepared by different licensed nurse or licensed nurse. 4. Medication to be administered via G tube should be prepared and administered separately, 5. Medications may NOT be mixed together in diluting liquid before administration via tube, 6. Medications must be administered per physician order, and 7.You must follow the	

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F 282	Continued From page 12 Nurse #2 would be difficult to identify.	F 282	6 rights of medication administration (Right Medication, Right Dose, Right Resident, Right Time, Right Route, and Right Method). This in-service will be completed by 2/20/17 After 2/20/17 no Nurse or Med Aide will be allowed to perform medication pass until in-service is completed. Starting 2/27/17, the IDON, Restorative Nurse, Consultant Pharmacist, or Facility Consultant will complete 3 Medication Pass Audits weekly with 3 different staff members on varying shifts x 4 weeks, then 2 Medication Pass Audits weekly x 6 weeks on varying shifts. Audits will be completed using the Medication Pass Audit tool. Any negative findings will be addressed immediately. The Administrator will monitor for proper competition and frequency of Medication Pass Audit Tools by initialing the bottom right hand corner of the audit tool. The Administrator will present all findings at the monthly Quality Improvement (QI) committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. The Administrator will present all findings at the next quarterly Executive QI committee to discuss the quality improvement process and/or any recommendations for sustaining compliance and continues monitoring.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		2/20/17

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F 332	Continued From page 13 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 (two) medication errors out of 25 opportunities, resulting in a medication error rate of 8%, for 2 of 7 residents (Resident #95 and Resident #130) observed during medication pass. The findings included: 1.Resident #130 was admitted to the facility on 4/16/15 with cumulative diagnoses which included diabetes mellitus. Review of the Finger stick for Blood Glucose levels revealed on: 09/09/16 139 milligrams per deciliters (mg/dl) reference range 70-139 mg/dl 09/15/16 95 mg/dl 9/26/16 85 mg/dl 11/16/16 116 mg/dl 12/4/16 62 mg/dl Observation during the medication pass on 1/24/17 at 12:50 Pm revealed Nurse #4 prepared for administration a sliding scale coverage of 2 units of Humalog (a rapid-acting insulin) in a syringe for a blood sugar level of 187 mg/dl. An inquiry was made regarding the dose. Nurse #4 adjusted the dose of Humalog to 3 units in the syringe as ordered. Interview at the time of the adjusted dose of Humalog with Nurse #4	F 332	F332 Free if Medication Error Rates of 5% or More On 1/24/17, Nurse # 4 drew up and administered 3 units of Humalog to resident # 130 according to the resident□s physician ordered sliding scale. On 1/26/17, the Staff Facilitator obtained an order for resident #95 to receive medications via gastrostomy (G Tube) cocktailed (mixed together) at one time for resident preference and GI comfort. Responsible party of resident made aware of order and in agreement. On 1/26/17, the Staff Facilitator checked resident for gastrointestinal discomfort after 4pm with no negative findings. On 2/16/17, the Director of Nursing (DON), performed a medication pass audit with Med Aide, and nurse involved the administrator completed an medication pass audit with Nurse #2. Any negative findings were immediately addressed. On 2/17/17, the DON began a Medication Pass Quiz with all Nurses and Med Aides involved with the medication pass	

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F 332	Continued From page 14 revealed the dose now "looks better" (referring to the correct dose of Humalog 3 Units). 2.Resident # 95 was admitted to the facility on 11/23/15 with cumulative diagnoses which included dysphagia and diabetes mellitus. Review of the January 2017 physician orders included: Prilosec capsule 20 milligram (mg) via gastrostomy tube (GT) every morning. Plavix 75mg daily via GT at 8 AM. Certagen with anti-oxidants 1 tablet via the GT daily. Lopressor 25 mg twice a day via the GT. Gabapentin 300 mg (2) capsules twice daily via the GT. Vitamin C 500 mg twice a day via the GT Metformin 500 mg po at 9 AM via GT Observation during the medication pass on 1/26/17 starting at 8:12 AM revealed Nurse #2 prepared for administration Prilosec capsule 20 mg, Plavix 75mg, Certagen with anti-oxidants 1 tablet, Lopressor 25 mg, Vitamin C 500 mg, Metformin 500 mg and Gabapentin 300 mg (2) capsules. All the medications were crushed together except the capsules which were opened and mixed with crushed medications. Continued observation revealed Nurse #2 checked the GT placement then administered these medications via the GT tube. Interview on 01/26/2017 at 3:27 PM with Nurse #2 revealed "I should have administered the medications individually but they do not do it that way at the facility." Interview on 01/26/2017 at 4:05 PM with the Administrator and the Director of Nurses (DON)	F 332	procedure which includes medication preparation, administration via gastrostomy tube, and subcutaneous medication administration. This quiz must be completed and reviewed by the IDON, Administrator, or Restorative Nurse before any Nurse or Med Aide can perform a medication pass after 2/20/17. Any negative findings were immediately addressed. On 2/20/17, the DON began an in-service with all Nurses and Med Aides on 1. Provide care by qualified persons in accordance with resident□s plan of care, 2. Facility must make sure the medication error is less than 5%, 3. A licensed nurse or Medication Aide shall not administrator medications that have been prepared by different licensed nurse or licensed nurse. 4. Medication to be administered via G tube should be prepared and administered separately, 5. Medications may NOT be mixed together in diluting liquid before administration via tube, 6. Medications must be administered per physician order, and 7.You must follow the 6 rights of medication administration (Right Medication, Right Dose, Right Resident, Right Time, Right Route, and Right Method). This in-service will be completed by 2/20/17 After 2/20/17 no Nurse or Med Aide will be allowed to perform medication pass until in-service is completed. Starting 2/27/17, the DON, Restorative Nurse, Consultant Pharmacist, or Facility Consultant will complete 3 Medication	

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F 332	Continued From page 15 was held. The DON indicated medications administered via the gastrostomy tube should have been given separately with water flushed between administrations.	F 332	Pass Audits weekly with 5 different staff members on varying shifts x 4 weeks, then 2 Medication Pass Audits weekly x 6 weeks on varying shifts. Audits will be completed using the Medication Pass Audit tool. Any negative findings will be addressed immediately. The Administrator will monitor for proper competition and frequency of Medication Pass Audit Tools by initialing the bottom right hand corner of the audit tool. The Administrator will present all findings at the monthly Quality Improvement (QI) committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. The Administrator will present all findings at the next quarterly Executive QI committee to discuss the quality improvement process and/or any recommendations for sustaining compliance and continues monitoring.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		2/20/17

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F 371	Continued From page 16 by: Based on observation and staff interviews the facility failed to maintain 1 of 1 nourishment refrigerator and area clean. Findings included: Observation on 01/24/2017 at 12:31 PM in the clean utility room on Unit 100/200 (where the nourishment refrigerator was located) revealed: a Dried yellow colored and sticky dried multiple brown colored splatter on the base of the freezer. b. A buildup of ice in the freezer section c. There was a missing bar on the freezer door. There was a missing plastic bin in the refrigerator section. d. The refrigerator had an undated pizza box with 4 dried slices of pizza. e. The floor behind a cart near the nourishment refrigerator had multiple stained floor tiles and 8 spoons mixed with an accumulation of a black gritty substance. Observation on 1/25/16 at 10 am and 01/26/2017 at 3:29 PM revealed no change in the condition of the refrigerator section, freezer section or floor. Interview on 01/27/2017 at 9:50AM with the Housekeeping and Laundry Director revealed the Housekeepers (HK) staff record the daily temperatures of the refrigerator and freezer. The HK director indicated if there was a spill the housekeeper would be cleaned the spill after checking the daily temperatures. Interview on 01/27/2017 at 10:13AM with HK#4 revealed she mopped the floor on 1/24/17 but did not move the cart.	F 371	F 371 Food Procure, Store/Prepare/Serve - Sanitary On 1/27/17, the housekeeping supervisor and dietary manager began cleaning the clean utility room on Unit 100/200, to include removing dried yellow colored and sticky dried multiple brown colored splatter on the base of the refrigerator freezer. Also cleaned was the buildup of ice in the freezer section and the floor behind the cart near the nourishment refrigerator. All undated/unlabeled food was removed from the nourishment refrigerator. On 1/27/17 through 2/6/17, the housekeeping staff cleaned all filters from an accumulation of an off-white colored substance similar to dust in the heating, ventilation, and air conditioning (HVAC) units, to include the HVAC units in rooms #209, #400, #405, #407, and #415. On 2/20/17, the housekeeping supervisor and the dietary manager completed a 100% audit of all utility rooms and nourishment refrigerators to ensure they are clean, parts are not missing, and food is labeled, and floors are clean. Any negative findings were immediately addressed. On 2/15/17, the administrator re-educated the housekeeping supervisor, maintenance director, and dietary manager on the following: 1. Housekeeping and maintenance services	

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F 371	Continued From page 17	F 371	must provide necessary services to maintain a sanitary, orderly, and comfortable interior. 2. These services must include clean filters in the HVAC units. 3. Functional resident room closet doors, on the tracks and with door knobs. 4. Refrigerators operational, without missing parts, without ice buildup, and clean. 5. Refrigerator food must have dates names. 6. Utility rooms must be clean without buildup of stains or food matter on the floors or base of the refrigerator 6. Any negative findings must be addressed immediately. This re-education will be provided by the housekeeping supervisor, maintenance director, and dietary manager to their respective department staff in housekeeping, maintenance, and dietary and completed by 2/20/17. All future housekeeping, maintenance, and dietary employees will be educated during their orientation process. On 2/20/17, the administrator initiated and in-serviced on the Physical Plant/Environmental Cleanliness tool which will be added to the Preventative Maintenance Log to be utilized by the maintenance director monthly on an ongoing basis. Any negative findings will be addressed immediately. On 2/20/17, the director of nursing (DON), quality improvement (QI nurse, maintenance director, dietary manager, supply coordinator and/or housekeeping supervisor initiated a QI tool titled, Physical Plant/Environmental Cleanliness	

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F 371	Continued From page 18	F 371	to ensure all resident room closet doors are on the track, closet doors have door knobs, HVAC unit filters are clean, refrigerators are with parts and clean, and clean utility room floors are clean. This Physical Plant/Environmental Cleanliness tool will be completed weekly x 4 weeks, twice monthly x 8 weeks. Any negative findings will be addressed immediately. The administrator will monitor for proper completion and follow up of the Physical Plant/Environmental Cleanliness tool by initialing the bottom right hand corner of the audit tool. The administrator will present all findings at the monthly QI committee meeting x 3 months for review and recommendation for any modification of the monitoring process. The administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	
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	F 520		2/20/17

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F 520	Continued From page 19 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, review records, and staff interview, the facility's Quality Assessment and Assurance (QAA) failed the implementations and monitor these interventions that the facility put into place December 2015, June 2016 and July 2016. This were for 4 recited deficiencies which were originally cited in December 2016 on a Recertification survey. The deficiencies were in the areas of F253 (Housekeeping), F 278 (Assessment Accuracy), F279 (Develop Comprehensive Care Plan), and F 371 (Food Procure) on the Recertification survey of January 27, 2017. A second 1 (F332) recited deficiency which was originally cited in June 2016 on a complaint survey in the area of free of medication error rate of 5% or more and again on the Recertification Survey on January 27, 2017. A third 1 (F282) recited deficiency which was originally cited in July 2016 in the area of Services by Qualified Person and cited again on the Recertification survey on January 27, 2017. The	F 520	F 520 QAA Committee On 1/16/17, the facility Executive QAA Committee held a meeting. The Medical Director, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), MDS nurse, treatment nurse, staff facilitator, medical records, dietary manager, and/or housekeeping supervisor will attend monthly QI Committee Meetings and quarterly QAA meetings on an ongoing basis and will assign additional team members as appropriate. On 2/20/17, the corporate facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, and housekeeping supervisor related to the appropriate functioning of the QI and QAA committees and the purpose of the	

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F 520	Continued From page 20 continued failure of the facility during three Federal surveys of record show a pattern of the facility's in ability to sustain an effective Assurance Program. Finding included: This tag is cross referred to: F 253 Housekeeping: Based on observation, interviews with staff and record review the facility failed to have functional closet doors in Resident Rooms #207, #209 and #211. The facility failed to have clean filters in the heating and conditioning units. (Room #400, #407 and #415) This was evident in 2 of 5 resident care units. During the recertification survey dated December 17, 2015: Based on observation and staff interview the facility failed to maintain clean resident bathroom on 2 of 5 halls (100 and 200 halls) and failed to maintain a resident bathroom toilet in good repair on one of 2 halls (100 hall). F278 Assessment Accuracy: Based on record review, observation and staff and resident interviews the facility failed to code the Minimum Data Set (MDS) in 1 of 3 residents to reflect Hospice services. (Resident #3) The facility failed to code correctly the dental status of 2 of 3 residents reviewed for dental status. (Resident #78 and Resident #70) During the recertification survey dated 12/17/2015: Based on medical record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) for medication for three (3) of five (5) residents reviewed for unnecessary medication (Resident	F 520	committees to include identifying issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 253 Housekeeping, F 278 Assessment Accuracy, F 279 Develop Comprehensive Care Plan, and F 371 Food Procure, and F 520 Quality Assessment and Assurance Committee. As of 2/20/17, 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 of Physical Plant/Environment Cleanliness audit tool, review of work orders, review of Point Click Care (Electronic Medical Record) comprehensive care plans, medication pass audits/medication error rate, and regional facility consultant recommendations. The QI Committee will continue to meet at a minimum of monthly. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facilities progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring QI Committee and Executive QI Committee concerns are addressed through further training and/or other interventions. The administrator, DON, and/or ADON will report back to the Executive QI Committee at the next	

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F 520	Continued From page 21 #118 #47 #70 and failed to accurately code MDS for incontinence for two (2) of two (2) residents reviewed for incontinence. (Residents #15 #144) F 279 Comprehensive Care Plan: Based on interviews and record review the facility failed to create a care plan for a resident with weigh loss for 1 of 4 resident (Resident #169) reviewed for nutrition. During the recertification survey dated December 17, 2015. Based on staff interview and record review the facility failed to develop a care plan for 1 of 1 resident on dialysis (Resident # 179). F 371 Food Procure: Based on observation and staff interviews the facility failed to maintain 1 of 1 nourishment refrigerator and area clean. During the recertification survey dated December 17, 2015: Based on observation and staff interview the facility failed to discard eight serving packets of sour cream by their expiration date and failed to label and date a four quart storage container of shredder cheese located in the reach inn Refrigerator. F 332 Medication error rate: Based on observations, record review, and staff interviews the facility failed to be free of a medication error rate greater than 5% as evident by 2 (two) medication error out of 25 opportunities, resulting in a medication error rate of 8% for 2 of 7 residents (Resident #95 and Resident #130) observed during medication pass. During the complaint survey dated June 11, 2016: Based on observation, resident, physician, pharmacy consultant and staff interviews the	F 520	scheduled meeting.	

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F 520	Continued From page 22	F 520		

facility failed to ensure that the medication error rate was 5% or below by not administering a renal medication at meals as ordered by the physician (Resident # 6 and #7). There were 2 errors of 25 opportunities for error resulting in an 8% error rate.

F 282 Services by Qualified Person: Based on observation and staff interviews, medication were prepared and crushed by a Medication Aide (Med aide) to be administered to Resident#95 via a gastrostomy tube (GT) by a nurse. The medication were unidentifiable to the nurse. This was evidence in 1 of 1 resident observed during the medication pass with GT.

During the complaint survey dated July 28, 2016: Based on record review, observations, staff interviews and physician interview the facility failed to follow the care plan and skin protocol by not providing wound assessment and overseeing wound treatment of a pressure ulcer which progressed to an unstageable pressure ulcer with eschar for 1 of 3 resident (Resident #2) reviewed for pressure ulcers.

During an interview with Administrator on 1/27/2017 at 4 PM, she indicated that she was aware of several recited areas of concerns by talking with other surveyors. Administrator indicated that her expectation for MDS to be coded accurately and timely, care plan would be completed an on time. Administrator stated she had just hired someone in environment and her expectation for any all issues to be fixed in a timely manner. That the QAA committee will continues to maintain procedures and monitor the interventions that are put in place for this facility.