| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SUNRISE REHABILITATION & CARE | 306 DEER PARK ROAD NEBO, NC 28761 |

| (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 |
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| F 174 SS=D | 483.10(g)(6)(7)(i) RIGHT TO TELEPHONE ACCESS WITH PRIVACY<br><br>(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.<br><br>(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:<br><br>(i) A telephone, including TTY and TDD services;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and resident and staff interviews the facility failed to provide private telephone access for 2 of 4 sampled residents (Residents #91 and #104).<br><br>The findings included:<br><br>1. Review of the medical record revealed Resident #91 was admitted to the facility on 04/24/15.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 12/19/16 revealed Resident #91's cognition was intact.<br><br>Observations of Resident #91 on 02/26/17 at 5:50 PM revealed he was standing in the hall talking on the telephone which was located on a over bed table just outside of the nurse's station. Staff members were in and around the nurse's station talking and staff and residents passed him in the | F 174 | This Plan of Correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.<br><br>One new cordless phone set-of-two for both North and South nurse units purchased, and is in operation.<br>South cordless phone has the second phone device placed in the Conference Room which allows all residents in the building to have access to conduct private, unobserved telephone conversations 24-hours a day. | 3/30/17 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/24/2017 |

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| F 174 | Continued From page 1<br>hall the entire time he was on the phone.<br><br>During an interview on 02/28/17 at 3:15 PM Resident #91 stated the facility used to have a portable phone but it was on the same line as the fax machine and did not work out well. Resident #91 further stated he would like to have access to a portable phone so he could have a private phone conversation when he wanted.<br><br>An interview with the Administrator on 03/02/17 at 4:21 PM revealed he had identified the lack of private telephone access for residents as a problem when he came to the facility approximately three months ago. The Administrator explained the first phone he ordered needed a Wi-Fi connection so he returned it. He noted there was a portable but it did not work well in all areas due to the concrete walls. The Administrator agreed the residents had the right to privacy while they were talking on the telephone.<br><br>2. Review of the medical record revealed Resident #104 was admitted to the facility on 05/30/16.<br><br>Observations of Resident #104 on 02/27/17 at 8:28 AM revealed he was sitting in his wheel chair in the hall talking on the telephone which was located on a over bed table just outside of the nurse's station. Staff members were in and around the nurse's station talking and staff and residents passed him in the hall the entire time he was on the phone.<br><br>During an interview on 03/02/17 at 9:15 AM Resident #104 stated he had not been offered the use of a portable phone since his admission to | F 174 | Res # 91 and #104 now have their right to telephone access with privacy.<br><br>This has the potential to affect all residents who have a right to telephone access with privacy.<br>Facility staff educated on the operations and use of the cordless telephones, to include maintaining control of the location of the phones in the building.<br>Long term solution for telephone access with privacy:<br>Contract signed for a new wireless phone system at Deer Park, and coordination with telephone company initiated.<br>This new system will include a land line telephone to be located in the Conference Room designed to offer access with privacy.<br>Additionally, this system includes two additional cordless telephones for use by residents in the privacy of their room.<br>When installed, facility staff will be educated on the operations and use of the new cordless telephones, to include maintaining control of the location of the phones in the building.<br>The Administrator or designee will re-educate facility staff:<br>Use of phones.<br>Responding to resident requests to use Conference Room for privacy.<br>Tracking the location of cordless telephones.<br><br>The Administrator or designee will audit for use and location of telephones once weekly for 4 weeks, then monthly x3 months and ongoing as needed to | |

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| F 174 | Continued From page 2<br>the facility and made his calls on the phone near the nurse's station. Resident #104 further stated he would like to have the option of a portable phone because he would sometimes like to have privacy when he was talking on the phone.<br><br>An interview with the Administrator on 03/02/17 at 4:21 PM revealed he had identified the lack of private telephone access for residents as a problem when he came to the facility approximately three months ago. The Administrator explained the first phone he ordered needed a Wi-Fi connection so he returned it. He noted there was a portable but it did not work well in all areas due to the concrete walls. The Administrator agreed the residents had the right to privacy while they were talking on the telephone. | F 174 | maintain compliance. Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |
| F 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and resident and staff interviews, the facility failed to promote residents' dignity when they did not provide incontinent care for extended periods of time for 2 of 4 residents reviewed for dignity (Residents #43 and #27).<br><br>The findings included:<br><br>1. Resident #43 was admitted on 09/27/16 with | F 241 | Residents #27 & #43 received appropriate incontinent care upon facility being notified and will continue to receive incontinent care as appropriate to ensure dignity is respected. Interview conducted with resident #27, Residents states incontinence care given in a timely manner,incontinence care given on rounds and prn. | 3/30/17 |

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| F 241 | Continued From page 3<br>diagnoses including hip fracture and legally blind.<br><br>Review of the admission Minimum Data Set (MDS) dated 10/04/16 revealed Resident #43's cognition was intact and she required extensive assistance with bed mobility, transfer, and toilet use.<br><br>Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 10/07/16 revealed Resident #43 was admitted to the facility with a hip fracture she sustained in a fall and had an incision to her right hip. The CAA Summary stated Resident #43 required extensive assistance with ADL and was continent of bowel and bladder. It was noted Resident #43 was blind and both eye balls were removed.<br><br>Review of a care plan dated 10/14/16 revealed Resident #43 required extensive assistance with all activities of daily living related to right hip fracture and blindness. Interventions included: call light in easy reach and mechanical lift for all transfers.<br><br>Review of a quarterly MDS dated 02/17/17 revealed Resident #43 was always incontinent of bowel and bladder.<br><br>An interview with Resident #43 on 02/27/17 at 12:02 PM revealed she waited for assistance with incontinent care for an hour approximately once a week. Resident #43 stated the nurse aides (NAs) tell her they can't provide incontinent care when they were assisting residents with meals.<br><br>During a follow up interview on 03/01/17 at 10:35 AM Resident #43 stated she had a diarrhea stool one evening last week and waited an hour for | F 241 | Resident #43 is in the hospital with an anticipated return and will be interviewed upon return.<br><br>This has the potential to affect all residents who require assistance with ADL□s. Interviews of alert & oriented residents who receive incontinent care was conducted to ensure care is being received in a timely and respectful manner.<br><br>The DON or designee will re-educate the Nursing staff regarding facility policy and procedures related to personal care, ADLs to include the timely provision of incontinent care, and Resident Rights to include dignity.<br>The DON or designee will include timeliness of providing ADL Care to include incontinent care and dignity in the orientation of newly hired nursing staff.<br><br>DON or designee will audit the provision of timely incontinent care and the preservation of dignity 5 times weekly X 4 weeks, then monthly X 3 months.<br>Audit results will be reviewed and analyzed monthly for three months at the monthly Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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| F 241 | Continued From page 4 | F 241 | | |

incontinent care. Resident #43 explained she was sick last week and could not recall the day of the week or the names of the NAs working when this incident occurred. Resident #43 noted she knew it had been an hour because she had a clock that tells her the time and also because she knew how long the television show she had been listening to ran. Resident #43 further stated this incident was embarrassing and degrading and she felt that providing incontinent care was more important than putting people to bed.

An interview with the Director of Nursing (DON) on 03/02/17 at 5:06 PM revealed she expected the NAs to answer call lights in 3 minutes and provide incontinent care. The DON further stated it was not acceptable for a resident to wait an hour for incontinent care.

2. Resident #27 was admitted on 11/18/16 with diagnoses which included hypertension, cardiomegaly, history of cerebral vascular accident with left hemiparesis, dysphagia, contracture, kyphosis, neuropathy, migraine headaches, depression/anxiety, overactive bladder, arthritis and spasms in left arm.

Review of the Care Area Assessment (CAA) Summary for activities of daily living (ADL) dated 11/23/2016 revealed Resident #27 was admitted to the facility with a history of cerebral vascular accident (CVA) with left hemiparesis, contracture of the left hand, kyphosis, and neuropathy. The CAA summary stated Resident #27 required extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. The CAA summary indicated that the resident fed herself with set up and was out of bed daily as tolerated in her wheelchair.

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| F 241 | Continued From page 5 | F 241 | | |

Review of the quarterly Minimum Data Set (MDS) dated 02/10/2017 revealed Resident #27's cognition was intact and she required extensive assistance with bed mobility, transfers, locomotion, dressing, personal hygiene and toilet use. The MDS also revealed that the resident was frequently incontinent of bowel and bladder.

Review of a care plan dated 02/11/2017 revealed Resident #27 required extensive assistance with all activities of daily living related to her left sided hemiparesis from history of a CVA. Measurable goals and appropriate interventions were in place for the resident which included extensive assistance with all ADL, set up for all meals and out of bed as tolerated daily.

An interview with Resident #27 on 02/28/17 at 2:56 PM revealed that after breakfast she woke up in a wet bed and stated that she was not changed all morning. She stated her bed was soaked and now she felt like she smelled like urine and she would like to have a shower. She stated that if she asked for a shower they would tell her they were too short staffed to give her a shower. She stated that a nursing assistant whose name she could not remember told her that it was okay to wet her pants if she had to go that everybody had accidents. Resident #27 stated she would be embarrassed if she wet her pants.

An interview with NA #5 on 03/01/2017 at 8:58 AM revealed that she was a medication aide on 02/28/17 and did not have a patient assignment. She stated that she changed Resident #27 on 02/28/2017 sometime after 11:00 AM and it was the first time that she had been changed that day.

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| F 241 | Continued From page 6 | F 241 | | |

NA #5 stated that Resident #27's bed was soaked and she changed the resident and her bed linens. NA #5 stated that she was giving medications yesterday but answered Resident #27's call light and stated that when she worked on the floor as a nurse aide she did incontinence care at least every 2 hours and as needed.

An interveiw on 03/01/2017 at 10:08 AM with the nurse aide (NA #9) revealed she was assigned to Resident #27 on 02/28/2017. She stated Resident #27 liked to get up after breakfast but did not ask to get up on 02/28/17. NA #9 stated that she checked her after she got to work (shift starts at 6:30 am) and she was dry. NA #9 stated that she checked Resident #27 after breakfast and she was wet so she changed her. She stated that she checked her again after lunch and changed her. NA #9 stated that they typically do rounds three times per shift and check residents for incontinence care. She stated that Resident #27's bed was never soaked yesterday when she checked her and changed her.

Follow up interview on 03/02/2017 at 12:36 PM with Resident #27 revealed that she had an incontinent accident last evening and wet herself. Resident #27 stated NA #10 was assigned to her the evening on 03/01/17 and stated to the resident "why did you do this, I just took you to the bathroom?" The resident was tearful and stated that she did not know what to do because she could not help that she wet herself.

A phone interview on 03/02/2017 at 3:40 PM with NA #10 revealed she was assigned to Resident #27 on the evening of 03/01/2017. NA #10 stated that she was in the North day room assisting residents with their meals and the nurse came

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| F 241 | Continued From page 7<br>and told her that Resident #27 needed to be changed. NA #10 stated that she went into the resident's room and provided incontinent care and changed her clothing. NA #10 stated that the resident apologized for wetting herself and NA #10 told the resident that it was fine, accidents happen. NA #10 denied saying to the resident "why did you do this, I just took you to the bathroom?" NA #10 stated that she would never say that to a resident, she was there to help residents, not talk ugly to them.<br><br>An interview with the Director of Nurses (DON) on 03/01/2017 at 4:15 PM revealed that her expectation was for residents to be changed after each incontinence episode. She stated that she expected residents to be checked at least every 2 hours and as needed. She stated she expected residents to be treated with dignity and respect and she did not expect any resident to be told to wet their pants. The DON stated that she would be doing education with the staff and suspensions as needed. | F 241 | | |
| F 253 SS=E | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff and resident interviews the facility failed to keep bathroom floors free of stains, black film and sticky substances; base of toilets free from brown rings and cracked and discolored caulking; bathroom doors free of scratches and gouged out paint; free of cracked caulking on the back of the sinks | F 253 | Housekeeping and maintenance services corrected as follows to maintain sanitary, orderly and comfortable interior:<br>Room 117: sink repaired, stained floor tile cleaned, inside bathroom doors repaired<br>Room 118: inside bathroom doors repaired. | 3/30/17 |

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| F 253 | Continued From page 8<br>that caused them to pull away from the walls; free of black spots on the metal ledges under the sinks; free of running toilets; free of constantly dripping faucets; free of stained toilet seats; walls outside of nurses stations free of black scratches and paint gouged out of walls; free of vinyl missing from tray tables; free of unbalanced bedside tables; free of scratched laminate on tray tables; free of unlockable closet doors; free of stained floors under windows, closets and bedroom doors; free of paint scraped off wall above baseboard of window wall in 15 of 76 rooms.<br><br>The findings included:<br><br>1. Observations of the shared bathroom in room 117 on 02/28/17 at 3:12 PM revealed, the sink pulling away from the wall and a black spot on the floor under the sink. In addition, the inside of both bathroom doors were scratched. Subsequent observations were 03/01/17 at 8:59 AM and 03/02/17 at 5:50 PM in which the conditions remained unchanged.<br><br>An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he made room repairs based on environmental rounds conducted by the administration and himself and requisitions received from the staff. The Maintenance Director further stated that the caulking where the sink and wall met needed to be replaced and the black spot on the floor looked as if the pipe had leaked.<br><br>2. Observations of the shared bathroom in room 118 on 02/28/17 at 3:12 PM revealed, the inside of both bathroom doors were scratched. Subsequent observations were 03/01/17 at 9:01 | F 253 | Room 123: metal shelf under mirror replaced<br>Room 126: sink repaired, inside bathroom doors repaired.<br>Room 211: sink repaired, bathroom floor tile cleaned, toilet caulk replaced.<br>Walls around both nurse stations: black marks and chipped paint repaired and painted.<br>Room 105/107 bathroom: toilet caulking replaced, stained floor tile cleaned.<br>Room 107: over-bed table &bedside table replaced<br>Room 106/108 bathroom: toilet caulking replaced, floor tile cleaned, door frame repaired.<br>Room 106: bedside table replaced, closet door latch repaired.<br>Room 112/114 bathroom: toilet caulking replaced, floor tile cleaned, dripping faucet repaired.<br>Room 114: over-bed table replaced.<br>Room 113: floor tile cleaned, walls under window repaired and painted.<br>Room 222: bathroom sink leak repaired.<br>Room 225: toilet seat & lid replaced.<br>Room 226: bathroom floor tiles cleaned, wall above sink repaired and painted.<br>Room 201/203 bathroom: leaking toilet repaired.<br>Room 207: bathroom floor tile cleaned.<br><br>This had the potential to affect all residents<br><br>A sweep of building was conducted by Admissions Coordinator to identify any environmental or housekeeping areas requiring correction. | |

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| F 253 | Continued From page 9<br>AM and 03/02/17 at 5:50 PM in which the conditions remained unchanged.<br><br>An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he made room repairs based on environmental rounds conducted by the administration and himself and requisitions received from the staff. The Maintenance Director further stated all the bathroom doors needed to be repainted.<br><br>3. Observations of the shared bathroom in room 123 on 02/27/17 at 8:40 AM revealed, a black spot on the left side of the metal shelf under the mirror. Subsequent observations were 02/28/17 at 3:00 PM and 03/02/17 at 5:50 PM in which the conditions remained unchanged.<br><br>An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he made room repairs based on environmental rounds conducted by the administration and himself and requisitions received from the staff. The Maintenance Director also stated the black spot on the shelf looked as if a wet wash cloth had been left on it.<br><br>4. Observations of the shared bathroom in room 126 on 02/28/17 at 10:04 AM revealed, the sink pulling away from the wall and both of the inside doors were scratched. Subsequent observations were 03/01/17 at 9:25 PM and 03/02/17 at 5:50 PM in which the conditions remained unchanged.<br><br>An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he made room repairs based on environmental rounds conducted by the administration and himself and requisitions received from the staff. The | F 253 | Repair schedule established for the maintenance and housekeeping departments:<br>Maintenance repairs required for resident rooms, bathrooms and common areas.<br>Housekeeping deep cleaning of resident rooms, stripping and re-waxing of floors.<br>Department managers conducting rounds were re-educated by the Administrator to also look at the following areas:<br>Bathroom floors<br>Toilets and caulking<br>Scratched doors<br>Sinks secured<br>Leaking toilets or faucets<br>Walls scratched or gouged<br>Overbed , bedside tables<br>Closet doors<br><br>The Administrator or designee will educate the Maintenance Director and department managers designated to do rounds to include:<br>Maintenance environmental rounds requirements. Department heads will complete a Work Request and/or Repair Request for issues identified as either maintenance or HK requests following the completion of documented rounds. These requests are located at each nurse station and directed to the Maintenance Director (responsible for both maintenance and housekeeping functions). Maintenance and HK will follow up with documented corrections made.<br>Completing and updating scheduled maintenance and housekeeping schedules.<br>The Administrator will monitor for | |

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| F 253 | Continued From page 10<br>Maintenance Director further stated the caulking where the sink and the wall met needed to be replaced and the doors needed to be repainted.<br><br>5. Observations of the shared bathroom in room 211 on 03/01/17 at 8:21 AM revealed, sink pulling away from the wall, black film on the tile on the bathroom floor and a brown ring around the base of the toilet. Subsequent observations were 03/02/17 at 8:30 AM and 03/02/17 at 5:50 PM in which the conditions remained unchanged.<br><br>An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he made room repairs based on environmental rounds conducted by the administration and himself and requisitions received from the staff. The Maintenance Director further stated the caulking where the sink and wall met and around the base of the toilet needed to be replaced as well as the floor tile.<br><br>6. Observations of the walls opposite both nursing stations on 02/26/17 at 5:00 PM revealed, black marks and chipped paint on the entire length of the walls. Subsequent observations were 02/28/17 at 4:00 PM and 03/02/17 at 5:50 PM in which the conditions remained unchanged.<br><br>An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he made room repairs based on environmental rounds conducted by the administration and himself and requisitions received from the staff. The Maintenance Director stated his plan was to remove the tables with the missing vinyl from the resident rooms since they could cause skin tears. Then he would get started on the bathrooms. The Maintenance Director stated that the painting | F 253 | completion of the repair or task.<br><br>The Administrator or designee will audit the resident environment by completing five resident rooms weekly for 4 weeks, then monthly x3 months.<br>Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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alone could be an everyday task to keep the facility looking nice and he agreed the residents deserved that since the facility was their home.

7. a. Observations of the shared bathroom for rooms 105 and 107 made on 02/27/17 at 10:39 AM, 03/01/17 at 11:41 AM, and 03/02/2017 at 10:01 AM revealed cracked and discolored caulking at the base of the toilet and the floor around the base of the toilet was stained a rust color. There was also a circular black stain on the floor under the sink.

b. Observations of room 107 bed B made on 02/27/17 at 10:39 AM, 03/01/17 at 11:48 AM, and 03/02/17 at 10:00 AM revealed the resident's overbed table had several inches of the vinyl missing from the edge of the table leaving an exposed rough surface and a bedside table that wobbled.

An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance Director stated he made room repairs based on environmental rounds conducted by administrative staff and himself and requisitions received from staff when he had the supplies to complete the repairs. The Maintenance Director agreed the caulking at the base of the toilet needed to be replaced and the bathroom floor needed to be replaced or the stains removed. The Maintenance Director stated he would need to replace the overbed table because the damaged one could cause skin tears.

8. a. Observations of the shared bathroom for

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rooms 106 and 108 made on 02/27/17 at 3:46 PM, 03/01/17 at 11:58 AM, and 03/02/17 at 10:01 AM revealed cracked and discolored caulking at the base of the toilet and the floor around the base of the toilet was stained a grey color. The lower half of the bathroom door frame had several areas of the paint gouged out.

b. Observations of room 106 bed A made on 02/27/17 at 3:46 PM, 03/01/17 at 11:58 AM, and 03/02/17 at 10:01 AM revealed the resident had a bedside table with large areas of scratched laminate and the closet did not lock.

An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance Director stated he made room repairs based on environmental rounds conducted by administrative staff and himself and requisitions received from staff when he had the supplies to complete the repairs. The Maintenance Director agreed the caulking at the base of the toilet needed to be replaced, the bathroom floor needed the stains removed, and the door frame needed to be painted. In addition, he stated the overbed table would need to be replaced because the damaged one could cause skin tears.

9. a. Observations of the shared bathroom for rooms 112 and 114 made on 02/27/17 at 8:25 AM, 02/28/17 at 8:39 AM, 03/01/17 at 8:38 AM, and 03/02/17 at 7:38 AM revealed cracked and discolored caulking at the base of the toilet and the floor around the base of the toilet was stained a grey color. The sink faucet also dripped constantly and would not turn off all the way.

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b. Observations of room 114 bed A made on 02/27/17 at 2:54 PM, 03/01/17 at 8:25 AM, and 03/02/17 at 10:02 AM revealed the corner of the overbed table had half-dollar sized area of laminate missing from the top leaving an exposed rough surface.

An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance Director stated he made room repairs based on environmental rounds conducted by administrative staff and himself and requisitions received from staff when he had the supplies to complete the repairs. The Maintenance Director agreed the caulking at the base of the toilet needed to be replaced,the bathroom floor needed the stains removed, and the faucet needed to be repaired. In addition, he stated the overbed table would need to be replaced because the damaged one could cause skin tears.

10. Observations of room 113 made on 02/27/17 at 11:44 AM, 03/01/17 at 4:23 PM, and 03/02/17 at 10:02 AM revealed the floor had a grey colored film approximately 12 inches wide which extended from under the window to the bathroom door. In addition, the paint was scraped off the wall above the baseboard on the wall under the window.

An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance

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Director stated he made room repairs based on environmental rounds conducted by administrative staff and himself and requisitions received from staff when he had the supplies to complete the repairs. The Maintenance Director stated he had started on some of the floors 6 weeks ago and the buffer broke and had not dealt with that yet because the Administrator was out. The interview further revealed the wall needed to be painted.

11. Observations made on 02/27/17 at 8:15 AM, 02/28/17 at 8:00 AM, 03/01/17 at 8:21 AM and 03/02/17 at 7:31 AM revealed room 222's bathroom sink was leaking and would not turn off all of the way.

An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance Director stated he made room repairs based on environmental rounds conducted by administration and himself and requisitions received from staff. He stated the sink in room 222 should have been repaired so it didn't leak.

12. Observations made on 02/27/17 at 8:20 AM, 02/28/17 at 8:05 AM, 03/01/17 at 8:26 AM and 03/02/17 at 7:36 AM revealed room 225's toilet seat had brown stains on the lid and seat that would not wipe off.

An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance

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Director stated he made room repairs based on environmental rounds conducted by administration and himself and requisitions received from staff. He stated the toilet seat and lid in room 225 should have been replaced with a clean one.

13. Observations made on 02/27/16 at 8:25 AM, 02/28/17 at 8:10 AM, 03/01/17 at 8:31 AM and 03/02/17 at 7:41 AM revealed room 226's bathroom floor with brownish/yellow stains in front of the toilet and tape peeling off the wall directly above the sink.

An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance Director stated he made room repairs based on environmental rounds conducted by administration and himself and requisitions received from staff. He stated the floor needed to be cleaned or replaced in front of the toilet in room 226 and the tape above the sink needed to be removed and the wall repainted.

14. Observations on made on 02/27/17 at 10:39 AM, 02//28/17 at 8:17 AM, 03/02/17 at 8:39 AM, and 03/02/17 at 3:58 PM revealed room 203 and 201's shared bathroom on the right side of the toilet floor was soaked and Resident #154 stated that it was a leaking toilet.

An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance

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| F 253 | Continued From page 16<br>Director stated he made room repairs based on environmental rounds conducted by administration and himself and requisitions received from staff. He stated the toilet in the shared bathroom for rooms 201 and 203 needed to be repaired so that it did not leak on the floor and the floor needed to be repaired where it was sticky from the toilet leaking.<br><br>15. Observations on 02/27/17 at 4:19 PM. 02/28/17 at 8:20 AM, 03/01/17 at 4:01 PM, 03/02/17 at 8:46 AM and 03/02/17 at 4:08 PM revealed room 207's bathroom had brownish ring around the toilet in the bathroom.<br><br>An interview conducted on 03/02/17 at 5:50 PM with the Maintenance Director revealed he was the only full time person in the Maintenance Department and received help occasionally with large tasks such as painting. The Maintenance Director stated he made room repairs based on environmental rounds conducted by administration and himself and requisitions received from staff. He stated the brown ring around the toilet in room 207 needed to be repaired. | F 253 | | |
| F 272 SS=E | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>(b) Comprehensive Assessments<br><br>(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: | F 272 | | 3/30/17 |

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| F 272 | Continued From page 17<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the<br>care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct<br>observation and communication with the resident, as well as communication with licensed and<br>non-licensed direct care staff members on all shifts.<br><br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the | F 272 | A Significant Correction completed for | |

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| F 272 | Continued From page 18<br>facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for psychotropic drug use, activities of daily living, and falls for 9 of 25 sampled residents (Residents #108, #46, #122, #43, #15, #82, #97, #146, #27).<br><br>The findings included:<br><br>1. Resident #108 was admitted to the facility on 04/22/16 with diagnoses of insomnia, anxiety and depression.<br><br>Review of the annual Minimum Data Set (MDS) dated 04/29/16 revealed Resident #108 was cognitively intact and received antianxiety medication one day and antidepressant and hypnotic medications daily during the assessment period.<br><br>Review of the Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 05/04/16 revealed Resident #58 was at risk for adverse reactions from medications and received antidepressants and hypnotic medications as ordered for depression and insomnia. Administer medications as ordered and report to the physician as needed. The CAA summary did not analyze how the psychotropic medications actually affected Resident #108's day to day function and activities. The CAA summary also did not indicate if there had been any adverse drug reactions or attempted dose reductions.<br><br>During an interview conducted on 03/02/17 at 6:20 PM MDS Nurse #1 stated she had been an MDS Nurse for 10 years and received training from the corporate office. She stated she completed the CAA summary for Resident #108 | F 272 | residents #15, #27, #43, #46, #82, #97, #108, #122, and #146 has been reviewed for accuracy and to ensure it is comprehensive per the RAI manual to ensure that underlying causes and contributing factors are addressed.<br><br>This had the potential to affect all residents.<br>MDS staff in-serviced March 10th by the Corporate MDS Consultant regarding:<br>RAI guidelines.<br>CAA completion.<br>Care planning.<br>CAAs that trigger will be worked and care planned for residents as appropriate on the comprehensive MDS.<br><br>The DON or Designee will audit all comprehensive MDS assessments per the MDS schedule weekly for three months to ensure the CAAs triggered adhere to RAI guidelines that require documentation of complications and risk factors impacting resident function and that they are care planned appropriately. Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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and was not aware it should have included how the medications affected the resident's day to day function and day to day activities. She stated the CAA summary should have included more resident specific information and a more in-depth analysis of findings.

2. Resident #46 was admitted to the facility on 11/19/15 with diagnoses of chronic pain syndrome, anxiety and depression.

Review of the annual Minimum Data Set (MDS) dated 11/15/16 revealed Resident #46 was cognitively intact and received antianxiety and antidepressant medications daily during the assessment period.

Review of the Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 11/26/16 revealed Resident #46 was at risk for adverse reactions from medications and received antidepressant and antianxiety medications as ordered for anxiety and depression. Administer medications as ordered. Monitor for signs and symptoms of adverse reactions and report to the physician. The CAA summary did not analyze how the psychotropic medications actually affected Resident #46's day to day function and activities. The CAA summary also did not indicate if there had been any adverse drug reactions or attempted dose reductions.

During an interview conducted on 03/02/17 at 6:20 PM MDS Nurse #1 stated she had been an MDS Nurse for 10 years and received training from the corporate office. She stated she completed the CAA summary for Resident #46 and was not aware it should have included how the medications affected the resident's day to day

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function and day to day activities. She stated the CAA summary should have included more resident specific information and a more in-depth analysis of findings.

3. Resident #122 was admitted to the facility on 02/11/16 with diagnoses of heart failure, depression and schizophrenia.

Review of the annual Minimum Data Set (MDS) dated 02/09/17 revealed Resident #122 was cognitively intact and received antipsychotic and antidepressants daily during the assessment period.

Review of the Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 02/15/17 revealed Resident #122 received antidepressant and antipsychotic medications with no adverse reactions noted. The CAA summary did not analyze how the psychotropic medications actually affected Resident #122's day to day function and activities. The CAA summary also did not indicate if there had been any adverse drug reactions or attempted dose reductions.

During an interview conducted on 03/02/17 at 6:25 PM MDS Nurse #2 stated she had been an MDS Nurse for a few years with most of that time working in another state. She stated she had not had any training since she had been doing MDS at the facility but was scheduled to attend the next state MDS training in Black Mountain. She stated she completed the CAA summary for Resident #122 and was not aware it should have included how the medications affected the resident's day to day function and day to day activities. She stated the CAA summary should have included

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more resident specific information and a more in-depth analysis of findings.

4. Resident #43 was admitted on 09/27/16 with diagnoses including depression and anxiety.

Review of the admission Minimum Data Set dated 10/04/16 revealed Resident #43 was cognitively intact and received antidepressant and antianxiety medications daily during the 7 day look-back period.

Review of the Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 10/07/16 revealed Resident #43 received Cymbalta for depression and nerve pain and had prn (as needed) Ativan prescribed for anxiety. The CAA Summary noted there were no adverse reactions at this time. The CAA summary did not analyze how the psychotropic medications actually affected Resident #43's day to day function and activities or if they were effective in treating her symptoms. The CAA summary did not indicate if a referral was necessary or if mental health services had seen Resident #43.

During an interview conducted on 03/02/17 at 6:25 PM MDS Nurse #2 stated she had been working at the facility for one year and had received some MDS training at her previous job in another state. She stated she had not had any training since she had been doing MDS at the facility but was scheduled to attend the next state MDS training in Black Mountain. MDS Nurse #2 confirmed she completed the CAA summary for Resident #43 and was not aware it should have included how the medications affected her day to day function and activities and more resident specific information. MDS Nurse #2 indicated

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she knew Resident #43 well and agreed the CAA summary needed to include a more in-depth analysis of findings.

5. Review of the medical record revealed Resident #15 was admitted on 01/21/16 with diagnoses including right hemiplegia and contracted right hand.

Review of the annual Minimum Data Set (MDS) dated 01/10/17 revealed Resident #15 had moderately impaired cognition, unclear speech, and was usually understood. The annual MDS noted Resident #15 required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. He required set up help with eating and had impaired range of motion of the upper and lower extremity on one side of his body. The annual MDS further revealed Resident #15 was always incontinent of urine and had one episode of bowel incontinence during the 7 day look-back period.

Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 01/16/17 revealed Resident #15 required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. He was able to feed himself after his tray was set up. The CAA Summary noted Resident #15 was out of bed daily to his wheelchair and was able to self propel. The CAA Summary did not explain why Resident #15 required extensive assistance with most of his ADL or if any referrals were needed. There was no mention of his contracted right hand. The CAA summary and analysis of findings did not include his strengths and weaknesses or how the triggered area impacted his day to day life.

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An interview with MDS Nurse #1 on 03/02/17 at 6:35 PM revealed she had been an MDS Nurse for 10 years and had not had any training in several years. MDS Nurse #1 stated when she completed an MDS assessment she observed the resident, interviewed staff, and reviewed the medical record. MDS Nurse #1 confirmed she completed Resident #15's CAA Summary and indicated she usually just put what ADL assistance the resident required in the analysis of findings. MDS Nurse #1 agreed it was not a complete analysis of findings and she should include more resident specific information.

6. Resident #82 was admitted on 02/04/16 with diagnoses including hemiplegia of the right dominant side, chronic pain, depression, contracture of right hand, and insomnia.

Review of the annual Minimum Data Set (MDS) dated 02/26/17 revealed Resident #82 was cognitively intact and had unclear speech but was able to make her needs known. The annual MDS noted Resident #82 required extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene and required set up help with eating. The annual MDS stated Resident #82 had impaired range of motion of her upper and lower extremities on one side of her body. The annual MDS indicated she received antidepressant and hypnotic medications daily during the 7 day look-back period.

a. Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 01/30/17 revealed Resident #82 required extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene and set up

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help with eating. The annual MDS indicated Resident #82 propelled herself in her wheelchair and received therapy as ordered. The CAA Summary did not explain why Resident #82 required extensive assistance with most of her ADL and there was no mention of her contracted right hand. The CAA summary and analysis of findings did not include his strengths and weaknesses or how the triggered area impacted his day to day life.

b. Review of the Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 01/30/17 revealed Resident #82 received Lexapro for depression and Restoril for insomnia and was at risk for adverse reactions. The CAA Summary noted Resident #82 was monitored for reactions from medications which would be reported to the Physician as needed. The CAA summary did not analyze how the psychotropic medications actually affected Resident #82's day to day function and activities or if they were effective in treating her symptoms. The CAA summary did not indicate if a referral was necessary or if mental health services had seen Resident #82. There was no mention if Resident #82 had any adverse reactions to her medications or if a gradual dose reduction had been recommended or attempted.

An interview with MDS Nurse #1 on 03/02/17 at 6:35 PM revealed she had been an MDS Nurse for 10 years and had not had any training in several years. MDS Nurse #1 stated when she completed an MDS assessment she observed the resident, interviewed staff, and reviewed the medical record including medications. MDS Nurse #1 confirmed she completed Resident #82's CAA Summary for ADL and Psychotropic

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Drug Use and indicated she usually just put what ADL assistance the resident required what medications they were on in the analysis of findings. MDS Nurse #1 agreed they were not complete analysis of findings and she should include more resident specific information.

7. Review of the medical record revealed Resident #97 was admitted on 04/12/16 with diagnoses including heart failure, gout, and clostridium difficile infection (c-diff).

Review of the admission Minimum Data Set (MDS) dated 04/19/16 revealed Resident #97 had moderately impaired cognition and was able to make his needs known. The admission MDS noted Resident #97 required limited assistance with dressing, toilet use, personal hygiene and extensive assistance with bathing, He was independent with bed mobility, transfer, walking and eating after set up help. The admission MDS stated he was occasionally incontinent of urine and bowel movements.

Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 04/25/16 revealed Resident #97 was admitted on 04/12/16 with diagnoses including c-diff, shingles, and methicillin-resistant staphylococcus aureus infection. The CAA Summary noted Resident #97 required limited assistance with dressing, toilet use, personal hygiene and extensive assistance with bathing, He was independent with bed mobility, transfer, walking and eating after set up help. It was also noted he was continent with incontinent episodes. The CAA summary and analysis of findings did not include his strengths and weaknesses or how the triggered area impacted his day to day life. There was no

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mention if referrals were needed.

An interview with MDS Nurse #1 on 03/02/17 at 6:35 PM revealed she had been an MDS Nurse for 10 years and had not had any training in several years. MDS Nurse #1 stated when she completed an MDS assessment she observed the resident, interviewed staff, and reviewed the medical record. MDS Nurse #1 confirmed she completed Resident #97's CAA Summary and indicated she usually just put what ADL assistance the resident required in the analysis of findings. MDS Nurse #1 agreed it was not a complete analysis of findings and she should include more resident specific information.

8. a. Resident #146 was admitted to the facility on 10/25/16 with diagnoses of Alzheimer's disease, falls, cerebral vascular accident (CVA), incontinent of bowel and bladder, Parkinson's disease, and left glass eye.

Review of the quarterly Minimum Data Set (MDS) dated 01/27/17 revealed Resident #146 was severely cognitively impaired and unable to make needs known. Resident #146 required extensive assistance of 1 to 2 persons with bed mobility, transfer, dressing, toilet use and personal hygiene. He required set up help with eating and was up in his wheelchair daily as tolerated. The quarterly MDS further revealed Resident #146 was always incontinent of bowel and bladder during the assessment period.

Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 11/02/16 revealed Resident #146 required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. He

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was able to feed himself after his tray was set up. The CAA Summary noted Resident #146 was out of bed daily to his wheelchair and was able to self propel. The CAA Summary did not explain why Resident #146 required extensive assistance with most of his ADL or if any referrals were needed. The CAA summary and analysis of findings did not include his strengths and weaknesses or how the triggered area impacted his day to day life.

An interview with MDS Nurse #1 on 03/02/17 at 6:35 PM revealed she had been an MDS Nurse for 10 years and had not had any training in several years. MDS Nurse #1 stated when she completed an MDS assessment she observed the resident, interviewed staff, and reviewed the medical record. MDS Nurse #1 confirmed she completed Resident #146's CAA Summary and indicated she usually just put what ADL assistance the resident required in the analysis of findings. MDS Nurse #1 agreed it was not a complete analysis of findings and she should include more resident specific information.

b. Resident #146 was admitted to the facility on 10/25/16 with diagnoses of Alzheimer's disease, falls, cerebral vascular accident (CVA), incontinent of bowel and bladder, Parkinson's disease, and left glass eye.

Review of the quarterly Minimum Data Set (MDS) dated 01/27/17 revealed Resident #146 was severely cognitively impaired and unable to make needs known. Resident #146 had a history of falls and was at risk for further falls during the assessment period.

Review of the Care Area Assessment (CAA) Summary for Falls dated 11/02/16 revealed

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Resident #146 required extensive assistance with transfers. The CAA Summary noted Resident #146 was at risk for falls related to history of falls, dementia and poor safety awareness, dependent on staff for transfers and used a wheelchair for mobility The CAA Summary did not explain why Resident #146 was at risk for falls. The CAA summary and analysis of findings did not include his strengths and weaknesses or how the triggered area impacted his day to day life.

An interview with MDS Nurse #1 on 03/02/17 at 6:35 PM revealed she had been an MDS Nurse for 10 years and had not had any training in several years. MDS Nurse #1 stated when she completed an MDS assessment she observed the resident, interviewed staff, and reviewed the medical record. MDS Nurse #1 confirmed she completed Resident #146's CAA Summary and indicated she usually just put what fall risks the resident had in the analysis of findings. MDS Nurse #1 agreed it was not a complete analysis of findings and she should include more resident specific information.

9. Resident #27 was admitted to the facility on 11/18/16 with diagnoses of hypertension, cerebral vascular accident (CVA) with left hemiparesis, left hand contracture, kyphosis, overactive bladder, anxiety and depression.

Review of the quarterly Minimum Data Set (MDS) dated 02/10/17 revealed Resident #27 was cognitively intact and able to make needs known. Resident #27 required extensive assistance of 1 to 2 persons with bed mobility, transfer, dressing, toilet use and personal hygiene. She required set up help with eating and was up in her wheelchair daily as tolerated. The quarterly MDS further

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| F 272 | Continued From page 29<br>revealed Resident #27 was frequently incontinent of bowel and bladder during the assessment period.<br><br>Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 11/18/16 revealed Resident #27 required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. She was able to feed herself after her tray was set up. The CAA Summary noted Resident #27 was out of bed daily to her wheelchair. The CAA Summary did not explain why Resident #27 required extensive assistance with most of her ADL or if any referrals were needed. The CAA summary and analysis of findings did not include her strengths and weaknesses or how the triggered area impacted her day to day life.<br><br>An interview with MDS Nurse #1 on 03/02/17 at 6:35 PM revealed she had been an MDS Nurse for 10 years and had not had any training in several years. MDS Nurse #1 stated when she completed an MDS assessment she observed the resident, interviewed staff, and reviewed the medical record. MDS Nurse #1 confirmed she completed Resident #27's CAA Summary and indicated she usually just put what ADL assistance the resident required in the analysis of findings. MDS Nurse #1 agreed it was not a complete analysis of findings and she should include more resident specific information. | F 272 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. | F 278 | | 3/30/17 |

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| F 278 | Continued From page 30<br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(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<br><br>(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.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility failed to accurately code information on a quarterly Minimum Data Set (MDS) regarding a physician prescribed weight loss regimen for 1 of 4 sampled residents. (Resident #30).<br><br>The findings included: | F 278 | MDS section K0300 improper coding was corrected for Res #30 on March 20th when MDS Coordinator completed a Correction MDS. The correct coding is Code 2.<br><br>This had the potential to affect all | |

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| F 278 | Continued From page 31<br><br>Resident #30 was admitted to the facility 11/1/16 with diagnoses including heart failure, hypertension and Alzheimer's disease.<br><br>Review of Resident #30's quarterly MDS dated 01/30/17 revealed she had severely impaired cognition and required extensive assistance with most activities of daily living. The MDS also noted that Resident #30 was on a Physician prescribed weight loss regimen.<br><br>Review of the Nutrition Care Area Assessment (CAA) dated 11/11/16 revealed Resident #30 received a regular diet and supplements were discussed at the weight meetings. The CAA also noted that the solid supplements were provided by the dietary department while the liquid supplements were given to the residents by the nurses.<br><br>Review of Resident #30's care plan dated 11/11/16 revealed she was above her Ideal Body Weight, had a Body Mass Index above 24 and triggered weight loss. The goal for Resident #30 was for her to maintain her weight through the next review by interventions including: serving her diet as ordered, weighing her as ordered, assisting her with feeding and providing solid supplements three times a day with meals.<br><br>Review of Registered Dietician's (RD) Progress note dated 01/31/17 revealed Resident #30's current weight was 139 which triggered a weight loss of 5% in 30 days and 7.5% in 90 days. Resident #30 fed herself at times and a solid supplement three times a day with meals was added on 12/20/16. The RD noted Resident #30 had diagnosis of hypertension and edema in | F 278 | residents.<br>MDS audits were completed by the MDS team beginning March 1st for residents with planned weight loss to ensure each is coded correctly in Section K regarding significant weight change.<br><br>MDS RN in-serviced the Dietary Manager on March 20th on:<br>The difference between weight-loss regimen that is physician prescribed or not physician prescribed.<br>The proper coding of Section K0300 Weight Loss.<br>Taking the proper time to be accurate in the coding of an MDS.<br><br>MDS Coordinator will audit comprehensive MDS□s weekly per the MDS schedule for accuracy of coding not only to ensure Section K in regards to planned weight loss, but to insure coding accurately reflects each resident and their functioning levels.<br>Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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| F 278 | Continued From page 32<br>which she planned to monitor her weights and nutritional status.<br><br>An interview with the Dietary Manager (DM) on 03/02/17 2:22 PM revealed that on Resident #30's MDS the DM checked that Resident #30 was on a Physician prescribed weight loss regimen. The DM stated she made a mistake and checked the wrong box that she should have checked the second box that Resident #30 was not on a Physician prescribed weight loss regimen. The DM stated she needed to focus more on an accurate completion of the MDS. | F 278 | | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based observations, record review and staff interviews the facility failed to follow the care plan for oral care for 1 of 3 residents reviewed for activities of daily living (Resident #58).<br><br>The findings included:<br><br>Resident #58 was admitted to the facility on 03/25/12 with diagnoses of hypertension and Alzheimer's disease.<br><br>Review of the annual Minimum Data Set (MDS) | F 282 | Resident #58 was provided thorough oral care upon the facility being made aware and will continue to receive oral care as appropriate.<br><br>This had the potential to affect all residents who have the need for assistance with oral care.<br>Nursing staff in-serviced by the DON or designee on facility policy and procedures for ADL and oral care. | 3/30/17 |

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| F 282 | Continued From page 33<br>dated 12/15/16 revealed Resident #58 was severely cognitively impaired. The MDS further revealed Resident #58 required extensive assistance with personal hygiene.<br><br>Review of the care plan with onset problem date of 02/13/15 revealed resident #58 required extensive assistance to total assist from staff with activities of daily living. The goal was to feed herself after set up thru the next review on 03/2017. The interventions included: verbal ques to help prompt. Break tasks up into smaller steps. Provide clean clothes every day and as needed. Ask to choose clothing if able. Set up for meals. Up in wheelchair every day to tolerance. Allow to propel self throughout the community. Oral care at least twice a day to keep mouth clean and moist. Fingernails and toenails cleaned and checked during shower/bath. Assist with shower. Transfers with extensive assist x 2.<br><br>Observations made on 02/28/17 at 8:30 AM, 03/01/17 at 8:11 AM, 03/01/17 at 11:30 AM, 03/02/17 at 7:09 AM, 03/02/17 at 9:44 AM and 03/02/17 at 12:32 PM revealed Resident #58's teeth to have a thick brownish/yellowish substance covering them.<br><br>An interview conducted on 03/02/17 at 6:05 AM with Nurse Aide (NA) #1 revealed she assisted Resident #58 out of bed this morning. She stated she washed her face and hands, helped her get dressed and took her to the 200 hall Dayroom to wait on breakfast. NA #1 stated she did not provide oral care for Resident #58 because she forgot and didn't have time.<br><br>An interview conducted on 03/02/17 at 12:32 PM with NA #2 revealed she assisted Resident #58 | F 282 | The DON or designee will educate Nursing staff regarding the provision of ADL care, to include oral care.<br>The DON or Designee will include the provision of ADL assistance, to include oral care in the orientation of newly hired nursing staff.<br><br>The DON or designee will conduct random audits to ensure the provision of oral care as appropriate for 5 residents weekly X 4 weeks, then weekly for 4 weeks, then monthly x3 months.<br>Audit results will be reviewed and analyzed monthly for three months and the monthly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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| F 282 | Continued From page 34<br>back to her room after breakfast and provided incontinence care for her but no oral care. She stated the 11:00 PM to 7:00 AM shift staff provided oral care for residents when they got them out of bed and ready for the day.<br><br>During an interview conducted on 03/02/17 at 4:59 PM the Director of Nursing stated it was her expectation for staff to follow the care plan and oral care should have been provided for Resident #58 at least two times every day. | F 282 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and resident, family and staff interviews, the facility failed to provide nail care for 1 of 3 residents (Resident #146, incontinence care for 2 of 3 residents (Resident #146 and Resident #27), and mouth care for 1 of 3 residents (Resident #58) reviewed for activities of daily living.<br><br>The findings included:<br><br>1. a. Resident #146 was admitted to the facility on 10/25/2016 with diagnoses which included cerebral vascular accident (CVA), Alzheimer's disease, dysphagia, Parkinson's disease and left glass eye.<br><br>Review of Resident #146's Care Area Assessment (CAA) summary dated 11/01/2016 | F 312 | Resident #146 received appropriate nail care upon facility notification and is not interviewable.<br>Resident #58 received appropriate oral care upon facility notification and is not interviewable.<br>Residents #27, #43 & #146 have received appropriate incontinent care upon facility notification." Interview conducted with resident #27, resident states incontinence care given in a timely manner and incontinence care given on rounds and prn.<br>Resident #43 is in the hospital with an anticipated return. #43 is interviewable and will be interviewed upon return regarding incontinent care.. | 3/30/17 |

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| F 312 | Continued From page 35<br>for ADL indicated that he was admitted with CVA and dementia, he was alert with confusion and incontinent of bowel and bladder and dependent on staff for ADL<br><br>Review of Resident #146's quarterly Minimum Data Set (MDS) dated 01/27/2017 revealed an assessment of severely impaired cognition. The MDS indicated Resident #146 required extensive assistance of 1 to 2 persons with all activities of daily living (ADL).<br><br>Review of Resident #146's care plan dated 02/02/2017 revealed that he was dependent on staff assistance for all ADL related to his diagnosis of dementia.<br><br>Observation of Resident #146 on 02/27/2017 at 8:33 AM revealed him sitting in his wheelchair in the North day room eating his breakfast. He was neatly dressed with socks and slippers on. His fingernails were noted to be long, extending approximately 1/8 inch from the fingertips. The fingernails had brownish colored debris under all nails on both hands.<br><br>Observation of Resident #146 on 02/27/2017 at 12:37 PM revealed him sitting in his wheelchair in the North day room eating lunch. Again his fingernails were noted to have brownish colored debris under all nails on both hands.<br><br>Observations of Resident #146 on 02/28/2017 at 8:20 AM and 03/01/2017 at 8:30 AM revealed resident sitting in the North day room eating breakfast. On both mornings his fingernails were noted to have brownish colored debris under the nails on both hands. | F 312 | This has the potential to affect all residents care planned for assistance with ADL□s. Interview conducted with resident #27, resident states incontinence care given in a timely manner and incontinence care given on rounds and prn.<br>Resident #43 is in the hospital with an anticipated return. #43 is interviewable and will be interviewed upon return regarding incontinent care. Interviews were conducted with other alert and oriented residents to ensure the timely provision of incontinent care, nail care and oral care.<br><br>The DON or designee will re-educate the Nursing staff regarding facility policy and procedures related to personal care, ADLs to include the timely provision of incontinent care, nail care, oral care and Resident Rights to include dignity. The DON or Designee will include timeliness of providing ADL Care in the orientation of new nursing personnel.<br><br>DON or Designee will conduct random audits and interviews of 5 residents weekly X 4 weeks to ensure the provision of ADLs to include incontinent care, nail care, and oral care, then monthly X 3 months.<br>Audit results will be reviewed and analyzed monthly for three months at the monthly Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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Observation of Resident #146 on 03/02/2017 at 10:22 AM revealed resident sitting in the North day room watching TV, dressed neatly with socks and slippers on his feet. His fingernails again were noted to have brownish colored debris under the nails on both hands.

An interview with Resident #146's family member on 02/28/2017 at 9:21 AM revealed that the resident's hair was not combed and he looked disheveled, his nails were long and dirty, and the family member also noted staff did not wash his hands before he ate.

An interview on 03/02/2017 at 10:01 AM with nurse aide (NA) #6 who typically worked on the North hall revealed that residents who were in their rooms get their hands washed before they are brought into the dining rooms for their meals. She stated that resident's nails are usually trimmed after their showers as needed. NA #6 stated that she was not aware of how the residents already in the day room got their hands washed before they ate their meals.

An interview on 03/02/2017 at 5:27 PM with nurse aide (NA) #7 who typically worked the North hall on second shift revealed that residents have their nails trimmed after their shower. She also stated when the residents are in the dining room prior to meal time their hands are not washed prior to eating their meal.

An interview on 03/02/2017 at 5:30 PM with the Unit Manager on second shift for the North hall revealed that she was not sure how residents already in the day room at meal time got their hands washed before meals. She stated that the residents should have their hands washed before

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meal time and have their nails trimmed and clean at all times not just at the time of their showers.

An interview on 03/02/2017 at 6:00 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed that it was their expectation that all residents have their hands washed before eating their meals and that their nails are kept trimmed and clean at all times.

b. Resident #146 was admitted to the facility on 10/25/2016 with diagnoses which included cerebral vascular accident (CVA), Alzheimer's disease, dysphagia, Parkinson's disease and left glass eye.

Review of Resident #146's Care Area Assessment (CAA) summary dated 11/01/2016 for ADL indicated that he was admitted with CVA and dementia, he was alert with confusion and incontinent of bowel and bladder and dependent on staff for ADL. Resident #146's urinary incontinence CAA summary dated 11/01/2016 indicated that he was incontinent of bowel and bladder and dependent on staff for toileting and hygiene.

Review of Resident #146's quarterly Minimum Data Set (MDS) dated 01/27/2017 revealed an assessment of severely impaired cognition. The MDS indicated Resident #146 required extensive assistance of 1 to 2 persons with all activities of daily living (ADL).

Review of Resident #146's care plan dated 02/02/2017 revealed that he was dependent on staff assistance for all ADL related to his diagnosis of dementia. It was noted that resident could be resistant to care at times and hit staff at

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times while providing care. The goal for the provision of ADL care was measurable and appropriate interventions provided for the resident's care.

Observation of Resident #146 on 03/02/2017 at 10:18 AM revealed him sitting in his wheelchair in the day room watching TV with a noticeable odor of urine.

Interview on 03/02/2017 at 10:21 AM with nurse aide (NA) #6 revealed she was assigned to Resident #146 that day (7:00 AM to 3:00 PM). NA #6 noted third shift (11:00 PM to 7:00 AM) had gotten had gotten Resident #146 up with the lift into his wheelchair. NA #6 stated she was getting ready to check him for incontinence and change him. NA #6 stated that she had not checked or changed him on her shift yet which started at 6:30 AM. She stated that she would check and change him again after he ate lunch. She stated that he had not been checked since before 5:30 AM when it was reported to her that third shift changed him prior to getting him up with the lift into his wheelchair. NA #6 stated that they usually do rounds and check and change residents that require assistance at least every 2 hours and as needed but she had not thought to check and change Resident #146 yet today.

An interview on 03/02/2017 at 4:15 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed that it was their expectation that all residents be provided incontinence care at least every 2 hours and as needed.

2. Resident #27 was admitted to the facility on 11/18/2016 with diagnoses which included

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hypertension, cerebral vascular accident (CVA) with left sided weakness, dysphagia, kyphosis, overactive bladder, depression and anxiety and contracture of left hand.

Review of Resident #27's Care Area Assessment (CAA) summary for activities of daily living (ADL) dated 11/18/2016 indicated that she was admitted with a history of CVA with left sided weakness, kyphosis, and overactive bladder and required extensive assistance for ADL. Resident #27's urinary incontinence CAA summary dated 11/18/2016 indicated that she was frequently incontinent of bowel and bladder and dependent on staff for toileting and hygiene.

Review of Resident #27's quarterly Minimum Data Set (MDS) dated 02/10/2017 revealed an assessment of intact cognition. The MDS revealed Resident #27 required extensive assistance of 1 to 2 persons with all activities of daily living (ADL).

Interview on 02/28/2017 at 2:56 PM was conducted with Resident #27 at her request. Resident #27 stated she woke up before lunch in a wet bed and had not been changed since some time during the night. She stated the bed was soaked underneath her and her pull up was full of urine. She stated that she felt like she smelled like pee and would like to have a shower but knew if she asked that she would be told they were too short staffed to give her a shower. The resident had a noticeable odor of urine.

An interview with NA #5 on 03/01/2017 at 8:58 AM revealed that she was a medication aide on 02/28/17 and did not have a patient assignment. She stated that she changed Resident #27 on

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02/28/2017 sometime after 11:00 AM and it was the first time that she had been changed that day. NA #5 stated that Resident #27's bed was soaked and she changed the resident and her bed linens. NA #5 stated that she was giving medications yesterday but answered Resident #27's call light and stated that when she worked on the floor as a nurse aide she did incontinence care at least every 2 hours and as needed.

An interveiw on 03/01/2017 at 10:08 AM with the nurse aide (NA #9) revealed she was assigned to Resident #27 on 02/28/2017. She stated Resident #27 liked to get up after breakfast but did not ask to get up on 02/28/17. NA #9 stated that she checked her after she got to work (shift starts at 6:30 am) and she was dry. NA #9 stated that she checked Resident #27 after breakfast and she was wet so she changed her. She stated that she checked her again after lunch and changed her. NA #9 stated that they typically do rounds three times per shift and check residents for incontinence care. She stated that Resident #27's bed was never soaked yesterday when she checked her and changed her.

Interview on 03/01/2017 at 4:15 PM with the Director of Nursing (DON) revealed that her expectation is that residents be changed when they have an incontinent episode and that residents are checked and changed at least every 2 hours and as needed. The DON stated she believed Resident #27 would not have complained if she and her bed would not have been wet and that she believed the resident and NA #5 were telling the truth about her care. She stated that NA #9 would be educated regarding proper procedure for incontinence care.

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3. Resident #58 was admitted to the facility on 03/25/12 with diagnoses of hypertension and Alzheimer's disease.

Review of the annual Minimum Data Set (MDS) dated 12/15/16 revealed Resident #58 was severely cognitively impaired. The MDS further revealed Resident #58 required extensive assistance with personal hygiene.

Review of the care plan with onset problem date of 02/13/15 revealed resident #58 required extensive assistance to total assist from staff with activities of daily living. The goal was to feed herself after set up through the next review on 03/2017. The interventions included: verbal cues to help prompt. Break tasks up into smaller steps. Oral care at least twice a day to keep mouth clean and moist.

Observations made on 02/28/17 at 8:30 AM, 03/01/17 at 8:11 AM, 03/01/17 at 11:30 AM, 03/02/17 at 7:09 AM, 03/02/17 at 9:44 AM and 03/02/17 at 12:32 PM revealed Resident #58's teeth to have a thick brownish/yellowish substance covering them.

An interview conducted on 03/02/17 at 6:05 AM with Nurse Aide (NA) #1 revealed she assisted Resident #58 out of bed this morning. She stated she washed her face and hands, helped her get dressed and took her to the 200 hall Dayroom to wait on breakfast. NA #1 stated she did not provide oral care for Resident #58 because she forgot and didn't have time.

An interview conducted on 03/02/17 at 12:32 PM with NA #2 revealed she assisted Resident #58 back to her room after breakfast and provided

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| F 312 | Continued From page 42<br>incontinence care for her but no oral care. She stated the 11:00 PM to 7:00 AM shift staff provided oral care for residents when they got them out of bed and ready for the day.<br><br>During an interview conducted on 03/02/17 at 4:59 PM the Director of Nursing stated it was her expectation for oral care to be provided to every resident on all three shifts. | F 312 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced | F 323 | | 3/30/17 |

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| F 323 | Continued From page 43<br>by:<br>Based on observations, record reviews, and staff interviews the facility failed to secure loose bed side rails for 3 of 6 resident reviewed for accidents (Residents #15, #32, and #66).<br><br>The findings included:<br><br>1. Review of the medical record revealed Resident #15 was admitted on 01/21/16 with diagnoses including right hemiplegia and contracted right hand.<br><br>Review of the annual Minimum Data Set (MDS) dated 01/10/17 revealed Resident #15 had moderately impaired cognition, unclear speech, and was usually understood. The annual MDS noted Resident #15 required extensive assistance with bed mobility and transfer and had impaired range of motion of the upper and lower extremity on one side of his body.<br><br>Observations of Resident #15's side rails on his bed on 02/27/17 at 10:36 AM, 03/01/17 at 10:50 AM, and 03/02/17 at 10:04 AM revealed the left side grab rail and right 1/2 side rail were loose and when the rails were grasped they moved up and down approximately 2 inches and could be pulled away from the bed frame leaving approximately 2 inches of space between the mattress and the side rails.<br><br>An interview with Resident #15 on 03/02/17 at 4:57 PM revealed he used the side rails on his bed for turning and repositioning. Resident #15 indicated he had noticed the side rails on his bed were loose but had not told anyone.<br><br>During an interview on 03/02/17 at 5:00 PM the | F 323 | Residents #15, #32, and #66 side rails have been tightened and inspected by the maintenance.<br><br>This had the potential to affect all residents who have side rails on their bed.An audit of beds currently in the facility was completed to ensure side rails were tight and secure with corrections made as appropriate.<br><br>Maintenance staff and department managers were educated on the importance of routinely inspecting bed rails to ensure properly attached and not creating a safety hazard.<br>Maintenance and department manager rounds have been adjusted to include checking bed rails to ensure properly attached.<br>The Administrator or designee will educate the Nursing, Maintenance and Department Head staff regarding proper rounding observations including:<br>Documenting rounds to include checks for side rails.<br>Observations of resident environment to ensure free of safety hazards.<br><br>The Administrator or designee will audit documented rounding sheets for safety concerns identified and to ensure those are corrected timely.<br>Audit of rounding records completed five times weekly for 3 weeks, then weekly for four weeks, monthly x3 to ensure ongoing compliance.<br>Audit results will be reviewed and | |

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| F 323 | Continued From page 44<br>Administrator stated department heads and administrative staff were assigned a block of residents' rooms to monitor every weekday morning and bring the forms to the morning meeting so the responsible department could take care of the issues. The interview further revealed the weekday room rounds did not include checking residents' side rails.<br><br>An interview with the Maintenance Director on 03/02/17 at 5:25 PM revealed there was a clip board at both nurses stations for staff to write down repairs and he and his assistant checked the clip boards several times a day. The Maintenance Director further stated they checked side rails every couple of weeks but did not record this monitoring anywhere.<br><br>On 03/02/17 at 5:29 PM the Maintenance Director was accompanied to Resident #15's room to observe the side rails. The Maintenance Director stated the loose side rails were not acceptable and would need to be tightened. He noted that after a while the older side rails needed a channel lock on the black knob to tighten them down. The Maintenance Director further stated he and his assistant would need to go around and check side rails more frequently.<br><br>2. Review of the medical record revealed Resident #32 was admitted on 07/10/15 with diagnoses including cerebral palsy.<br><br>Review of the annual Minimum Data Set (MDS) dated 07/04/16 revealed Resident #2 had short and long-term memory loss and moderately impaired cognitive skills for daily decision making. The annual MDS noted Resident #32 required extensive assistance with bed mobility and | F 323 | analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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transfers and had impaired range of motion in all 4 extremities.

Observations of Resident #32's side rails on her bed on 02/27/17 at 3:11 PM, 03/01/17 at 8:41 AM, and 03/02/17 at 10:02 AM revealed the left side grab rail and right 1/2 side rail were loose and when the rails were grasped they moved up and down approximately 2 inches and could be pulled away from the bed frame leaving approximately 2 inches of space between the mattress and the side rails.

An interview with Nurse Aide (NA) #4 on 03/02/17 at 2:02 PM revealed Resident #32 used the side rails on her bed for turning and repositioning. NA #4 further stated when she noticed a loose side rail she reported it to the Maintenance Director.

During an interview on 03/02/17 at 5:00 PM the Administrator stated department heads and administrative staff were assigned a block of residents' rooms to monitor every weekday morning and bring the forms to the morning meeting so the responsible department could take care of the issues. The interview further revealed the weekday room rounds did not include checking residents' side rails.

An interview with the Maintenance Director on 03/02/17 at 5:25 PM revealed there was a clip board at both nurses stations for staff to write down repairs and he and his assistant checked the clip boards several times a day. The Maintenance Director further stated they checked side rails every couple of weeks but did not record this monitoring anywhere.

On 03/02/17 at 5:32 PM the Maintenance Director

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| F 323 | Continued From page 46 | F 323 | | |

was accompanied to Resident #32's room to observe the side rails. The Maintenance Director stated the loose side rails were not acceptable and would need to be tightened. He noted that after a while the older side rails needed a channel lock on the black knob to tighten them down. The Maintenance Director further stated he and his assistant would need to go around and check side rails more frequently.

3. Resident #66 was admitted to the facility on 02/11/14 with diagnoses of hypertension.

Review of the annual Minimum Data Set (MDS) dated 01/16/17 revealed Resident #66 was moderately cognitively impaired and required extensive assistance with bed mobility and transfers.

Observations made on 02/27/17 at 10:30 AM, 03/01/17 at 8:00 AM and 03/02/17 at 7:32 AM revealed the left side rail on Resident #66's bed was loose and moved back and forth 4 to 5 inches from the bed. The right side rail was not loose and fit properly.

An interview conducted on 03/02/17 at 2:09 PM with Nurse Aide #5 revealed Resident #66 used her side rails for positioning and turning in bed.

During an interview on 03/02/17 at 5:00 PM the Administrator stated department heads and administrative staff were assigned a block of residents' rooms to monitor every weekday morning and bring the forms to the morning meeting so the responsible department could take care of the issues. The interview further revealed the weekday room rounds did not include checking residents' side rails.

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| F 323 | Continued From page 47<br><br>An interview with the Maintenance Director on 03/02/17 at 5:30 PM revealed there was a clip board at both nurses stations for staff to write down repairs and he and his assistant checked the clip boards several times a day. The Maintenance Director further stated they checked side rails every couple of weeks but did not record this monitoring anywhere.<br><br>On 03/02/17 at 5:34 PM the Maintenance Director was accompanied to Resident #66's room to observe the side rails. The Maintenance Director stated the loose side rails were not acceptable and would need to be tightened. He noted that after a while the older side rails needed a channel lock on the black knob to tighten them down. The Maintenance Director further stated he and his assistant would need to go around and check side rails more frequently. | F 323 | | |
| F 325 SS=D | 483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; | F 325 | | 3/30/17 |

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| F 325 | Continued From page 48<br>(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and interviews with the Dietary Manager and Registered Dietitian, the facility failed to assess a resident with significant weight loss and evaluate the need for dietary interventions for 1 of 4 residents reviewed for nutritional status (Resident #82).<br><br>The findings included:<br><br>Review of the medical record revealed Resident #82 was admitted on 02/04/16 with diagnoses including hemiplegia of the right dominant side, contracture of the right hand and dysphagia. Resident #82 was readmitted to the facility on 01/13/17 after a hospitalization.<br><br>Review of a care plan dated 02/04/16 revealed Resident #82 required assistance with activities of daily living and was able to feed herself after her tray was set up. Interventions included set up assistance with all meals, encourage to consume all meals, and to give cues and assist as needed. The next quarterly review of the care plan was scheduled for 04/26/17.<br><br>Review of Resident #82's recorded weights revealed the following:<br>09/06/16- 235.8 pounds<br>10/03/16- 229.4 pounds<br>10/05/16- 231.6 pounds<br>11/02/16- 225.0 pounds<br>11/07/16- 232.0 pounds<br>12/01/16- 224.6 pounds | F 325 | Resident #82 was seen and reviewed by the RD on March 20th which also included the documentation of a progress note. Resident #82 interview revealed resident□s desire to lose weight; to include refusing caloric supplements, snacks, etc.<br><br>This had the potential to affect all residents who have weight loss.<br>Audit completed by the Dietary Manager of all residents to ensure nutritional intervention has been made for any resident experiencing significant weight loss.<br><br>RD in-serviced by the Dietary Manager on weight change nutrition evaluation requirements on 3/20/17.<br>The DON or designee will ensure any resident triggering for significant weight loss is reviewed weekly or monthly as appropriate, to ensure weight loss is evaluated, referrals to RD are made as appropriate and interventions are implemented as appropriate.<br><br>DON or designee to complete a weight loss audit weekly x4 weeks and then monthly x3 months.<br>Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance | |

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| F 325 | Continued From page 49<br>01/13/17- 215.6 pounds<br>01/15/17- 214.4 pounds<br><br>Review of an annual Minimum Data Set (MDS) dated 01/26/17 revealed Resident #82 was cognitively intact and had unclear speech but could be understood. The annual MDS noted she required set up help with eating and received a mechanically altered and therapeutic diet. The annual MDS stated Resident #82 was 64 inches tall and weighed 214 pounds. The annual MDS further revealed Resident #82 had weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. In addition, it was noted Resident #82 was not on a physician-prescribed weight loss program.<br><br>Review of the Care Area Assessment (CAA) Summary for Nutritional Status completed by the Dietary Manager (DM) on 01/25/17 revealed Resident #82 was on a low-fat, mechanical soft diet and required set up help and was able to feed herself. The CAA Summary revealed Resident #82 had a good appetite and was on weekly weights due to readmission to the facility. The DM noted the current body weight of 214 pounds had triggered Resident #82 for a 10% weight loss in 180 days. The CAA summary further revealed Resident #82 was over her ideal body weight range of 108 pounds to 132 pounds and she had a body mass index of 37. The DM indicated and weight loss was desired.<br><br>Further recorded weights included:<br>01/31/17- 205.2 pounds<br>02/06/17- 208.0 pounds<br><br>Review of the significant weight loss report printed on 02/09/17 revealed Resident #82 had a | F 325 | Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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| F 325 | Continued From page 50 | F 325 | | |

weight loss of 7.6% in 3 months and 14.4 % in 6 months.

Continued record review revealed Resident #82 weighed 202.0 pounds on 02/13/17

Observations of Resident #82 during breakfast on 02/28/17 and 03/01/17 revealed she did not eat her breakfast tray and requested a bowl of cereal. On 02/27/17 she consumed 50% of her lunch meal tray. Resident #82 was able to feed herself without difficulty.

An interview with the DM on 03/02/17 at 10:43 AM revealed the Registered Dietitian (RD) came to the facility twice a month and typically waited until after the 10th of the month for all of the weights to be recorded. The DM stated she made the RD a list of new admissions and residents receiving tube feeding, and printed off the list of residents with significant weight loss from her computer for the RD to review during her visits. The DM explained the RD made a list of recommendations every visit and gave a copy to the DM and the Director of Nursing (DON). The DM reviewed the recommendations left by the RD on 02/09/17 and 02/15/17 and confirmed the RD did not review Resident #82 for significant weight loss during either visit. The interview further revealed the RD would have had a copy of the significant weight loss data printed on 02/09/17 to review which indicated Resident #82 had significant weight loss over the last 3 and 6 months. The DM also stated she had not interviewed Resident #82 to determine if the weight loss was intentional or desired.

A telephone interview was conducted with the RD on 03/02/17 at 2:18 PM. The RD stated she

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| F 325 | Continued From page 51<br>came to the facility two days a month and reviewed the significant weight loss report and the wound report for new wounds or wounds that were not improving. The RD further stated she also reviewed dialysis residents and residents with tube feeding at least once a month. The interview revealed the RD put her recommendations on a form and gave a copy to the DM and DON. The RD indicated she was not sure why she had not reviewed Resident #82 when she came to the facility on 02/09/17 or 02/15/17. The RD explained she usually started with the residents with significant weight loss over the last 30 days and noted that 3 month and 6 month weight loss would have been less of a priority in her routine.<br><br>During an interview on 03/02/17 at 4:09 PM the DON stated she would have expected the RD to assess Resident #82's significant weight loss and make recommendations as needed when she came to the facility on 02/09/17. | F 325 | | |
| F 371 SS=E | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. | F 371 | | 3/30/17 |

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| F 371 | Continued From page 52<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to store ice scoops in draining containers in 2 of 2 nourishment rooms and failed to date and label a clear container of tea ready for resident use in 1 of 2 nourishment room refrigerators.<br><br>The findings included:<br><br>Observations during the initial tour of the building on 02/26/17 at 5:20 PM revealed the following:<br><br>- The ice scoop in nourishment room on the 100 hall was stored in a container without a drain hole and was standing in approximately 2 inches of water with a black substance in the bottom of the container.<br><br>- The ice scoop in nourishment room on the 200 hall was stored in a container without a drain hole and was standing in approximately 2 inches of water with a black substance in the bottom of the container.<br><br>- An unlabeled, undated ½ full clear pitcher of what appeared to be tea was stored in the 200 | F 371 | Ice scoop holders were replaced with new open drainage holders.<br>Items stored in refrigerator for resident use were labeled and dated upon facility being made aware.<br><br>This had the potential to affect all residents<br><br>The DON or designee will re-educate the Nursing & Dietary staff regarding storage of refrigerated items being labeled and dated.<br>The DON or designee will include education in the orientation of new personnel.<br><br>The DON or designee will audit nourishment rooms 3x weekly for 4 weeks, then monthly x3 months.<br>Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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| F 371 | Continued From page 53<br>hall nourishment room ready for resident use.<br><br>An interview conducted on 02/26/17 at 6:00 PM with the Nursing House Supervisor revealed it was the kitchen staffs responsibility to date all juices, teas and other items sent out for resident use with the date it was delivered to the nourishment rooms. She further stated the ice scoops should be stored in a draining container and not stored in standing water.<br><br>During an interview conducted on 03/01/17 at 10:53 AM the Dietary Manager (DM) stated she was not aware the ice scoops in the nourishment rooms were being stored in non-draining containers. She stated the ice scoops should be washed in the dishwasher daily and stored in a draining container. The DM further stated it was the kitchen staff's responsibility to label and date all items sent to the nourishment rooms for resident use and the tea pitcher should have been dated with the date it was sent out of the kitchen. | F 371 | | |
| F 431 SS=D | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and | F 431 | | 3/30/17 |

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| F 431 | Continued From page 54 | F 431 | | |

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, 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.

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| F 431 | Continued From page 55<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to discard expired medications from 2 of 2 medication carts and 1 of 2 medication rooms.<br><br>1. Observation of the Seafoam medication cart for South hall on 03/02/2017 at 4:36 PM revealed the following medications currently on the cart and expired:<br>a. A box of Rugby hemorrhoid suppositories - with 23 in the box expired 02/2017.<br>b. Sodium Bicarbonate 5 gr (325 mg) tablets 100 in bottle and bottle was almost full and expired 02/2017.<br>c. Geri-Care Oyster Shell Calcium 500 mg tablet 100 in bottle and bottle was almost full and expired 02/2017.<br>d. Major cherry flavor sore throat spray - 6 fluid ounces - bottle was almost full and expired on 12/2016.<br><br>2. Observation of the Silver medication cart for North hall on 03/02/2017 at 4:56 PM revealed the following medication currently on the cart and expired.<br>a. Geri-Care Aspirin 325 mg (milligrams) 100 tablets in bottle and bottle was about half full and expired on 02/2017.<br><br>3. Observation of the North side Medication Room on 03/02/17 at 5:17 PM revealed the following medication currently in the room and expired.<br>a. Geri-Care Slow Magnesium Chloride with calcium 60 tablets - 2 bottles that were full and expired on 01/2017<br>b. Spring Valley Garlic 1000 mg 120 softgels - 1/3 | F 431 | Identified expired medications on the medication carts and in the medication rooms were discarded upon facility notification.<br><br>This had the potential to affect all residents who receive medications. Medication rooms and medication carts have been inspected for expired medications and if found, discarded as appropriate.<br><br>The DON or designee will educate licensed nurse staff, CMA and Central Supply Coordinator regarding the expired medication interventions including: Nurses/CMAs will check all medication expiration dates prior to dispense of meds to residents daily.<br>The DON or designee will check all med rooms for expired stock and rotate current stock to ensure removal of any out of date medications weekly. oThe DON or Designee will include safe delivery of medications in the orientation of new nurse or CMA personnel.<br><br>The DON or designee will review and audit medication carts and medication rooms weekly for 4 weeks, then monthly x3 months.<br>Audit results will be reviewed and analyzed weekly for four weeks then monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as | |

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| F 431 | Continued From page 56<br>bottle and expired on 02/2017.<br><br>An interview with the Unit Manager on 03/02/2017 at 5:31 PM revealed the medications on the two medication carts and in the medication room were all available to be administered to residents. The interview further revealed the medications should have been removed and discarded once they expired.<br><br>An interview with the Director of Nursing (DON) on 03/02/2017 at 6:00 PM revealed that she would have expected the medications to have been removed from the medication carts and medication room when they expired and discarded. | F 431 | indicated. | |
| F 441 SS=E | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: | F 441 | | 3/30/17 |

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| F 441 | Continued From page 57<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the | F 441 | | |

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| F 441 | Continued From page 58<br>spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility failed to follow the facility infection control policy to reduce the risk of acquiring and transmitting infections by not following droplet and contact isolation precautions for 3 of 5 resident's reviewed on isolation precautions (Resident's #39, #43, and #76).<br><br>The findings included:<br><br>Review of the facility Infection Control Policy dated 11/18/14 read in part: The infection control program will identify and reduce the risk of acquiring and transmitting infections among residents, staff, volunteers, students and visitors.<br><br>1. Resident #39 was admitted to the facility on 01/14/12 with current diagnosis of extended-spectrum beta-lactamases (ESBL), enzymes that are resistant to most antibiotics including penicillin's and cephalosporin's, in her sputum and was on Droplet Precautions.<br><br>An observation made on 02/26/17 at 6:15 PM revealed Nurse #1 coming out of Resident #39's room administering her medications without a gown, gloves or mask on. Nurse #1 was observed leaving Resident #39's room without washing her hands or using hand sanitizer and began documenting on the medication administration record. | F 441 | Residents #43 & #39 & # 76 have received appropriate isolation precautions by staff upon facility being notified and will continue to receive proper isolation precautions as appropriate.<br><br>This has the potential to affect all residents who have the risk of acquiring and transmitting infections.<br><br>Facility staff will be in-serviced by the DON or designee on policy & procedures for residents requiring contact and/or droplet precautions.<br>The facility will include infection control and isolation precautions in the orientation of newly hired facility staff.<br><br>The DON or designee will audit care being provided to residents on isolation weekly for 4 weeks, then monthly x3 months. Audit results will be reviewed and analyzed monthly for three months at the monthly Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. | |

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An interview conducted on 02/26/17 at 6:16 PM with Nurse #1 revealed Resident #39 was on droplet precautions but she did not wear a mask into the room when she administered her medications because the resident wasn't coughing. She stated she also did not wash her hands before exiting Resident #39's room.

During an interview conducted on 02/27/17 at 11:54 AM the Assistant Director of Nursing (ADON) stated she was over the facility infection control program. She stated it was her expectation for all staff who entered resident rooms on Droplet Precautions to wear a mask, gown and gloves and to wash their hands before leaving the room if they were to be within 6 feet of the resident. She stated it was not acceptable to choose when to wear a mask due to the resident's cough.

An interview conducted on 03/01/17 at 8:21 AM with the Director of Nursing revealed it was her expectation for staff to follow all isolation procedures.

2. Resident #43 was admitted to the facility on 02/10/17 and was currently on contact precautions for Carbapenem-resistant Enterobacteriaceae (CRE), a group of germs that are difficult to treat because they have high levels of resistance to antibiotics.

An observation made on 02/26/17 at 6:25 PM revealed NA #3 took Resident #43's supper tray into her room and did not put on a gown or gloves. NA #3 was observed moving Resident #43's over bed table closer to the resident and leaning against her table as she moved it. NA #3 was also observed removing items from the table

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to have room to place the tray on the table. NA #3 exited Resident #43's room without washing her hands or using hand sanitizer and went to the meal cart and started to remove another tray before being stopped by the surveyor.

During an interview conducted on 02/26/17 at 6:35 PM NA #3 stated Resident #43 was on contact precautions. She stated she did not put a gown and gloves on to deliver meal trays for residents on isolation. NA #3 stated she did move Resident #43's over bed table, leaned against it and moved items on the table to make room for the tray. She stated she didn't wash her hands when she left Resident 43's room and she should have.

During an interview conducted on 02/27/17 at 11:54 AM the Assistant Director of Nursing (ADON) stated she was over the facility infection control program. She stated it was her expectation for all staff who entered resident rooms on Contact Precautions to wear a gown and gloves and to wash their hands before leaving the room. She stated NA #3 should have put a gown and gloves on when delivering Resident #43's meal tray and washed her hands before leaving her room.

An interview conducted on 03/01/17 at 8:21 AM with the Director of Nursing revealed it was her expectation for staff to follow all isolation procedures.

3. Resident # 76 was admitted to the facility on 04/15/2016 and was currently on contact precautions for diagnosis of Carbapenem-resistant Enterobacteriaceae (CRE), which was difficult to treat because they

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| F 441 | Continued From page 61 | F 441 | | |

have high levels of resistance to antibiotics.

An observation on 02/26/17 at 6:16 PM revealed nurse aide (NA) #8 going in to deliver Resident #76's meal tray with no gown and gloves donned prior to entering his room. NA #8 was observed to move his bedside table and set up his meal tray, and observed moving and touching items on the bedside table. NA #8 did not wash her hands before leaving his room.

An interview on 02/26/17 at 7:34 PM with NA #8 revealed she had worked at the facility for over 3 years. NA #8 stated that contact precautions means that you put on gown and gloves prior to entering the residents room if you have direct contact with the resident. NA #8 stated that she did not put on gloves and gown because she was not going to have direct contact with the resident. She stated that she forgot to wash her hands after leaving the room.

An observation on 02/27/17 at 11:16 AM revealed Nurse #2 walked into the resident's room without putting on gloves and gown. Nurse #2 was observed leaning on the nightstand, taking money from the resident, walked out of the room and did not wash her hands, walked to the drink machine and purchased a drink for the resident and took it back into the room to him. All of this activity was done with no personal protective equipment (PPE) being donned. Nurse #2 came out of the room and washed her hands.

An interview on 02/27/17 at 11:32 with Nurse #2 revealed that she did not put on gloves and gown because she did not have direct contact with the resident. Nurse #2 stated she should have put on gloves and a gown prior to entering the resident's

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| F 441 | Continued From page 62<br>room as indicted by contact precautions and she should have washed her hands each time prior to leaving his room.<br><br>During an interview conducted on 02/27/17 at 11:54 AM the Assistant Director of Nursing (ADON) stated she was over the facility infection control program. She stated it was her expectation for all staff who entered resident rooms on Contact Precautions to wear a gown and gloves and to wash their hands before leaving the room. She stated NA #8 and Nurse #2 should have put a gown and gloves on prior to entering the room and they should have washed their hands before exiting Resident #76's room.<br><br>An interview conducted on 03/01/17 at 8:21 AM with the Director of Nursing (DON) revealed it was her expectation for staff to follow all isolation procedures. | F 441 | | |
| F 520 SS=E | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(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 | F 520 | | 3/30/17 |

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| F 520 | Continued From page 63<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(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 necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(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.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in April of 2016. This was for two recited deficiencies which were originally cited in March of 2016 and subsequently recited in March of 2017 on the current recertification survey. The deficiencies were in the areas of Accuracy of Assessment and Food Procurement, Storage, Preparation and Distribution. In addition, the facilities Quality Assessment and Assurance | F 520 | The facility will ensure the QAPI committee maintains an effective plan to monitor continued compliance of deficiencies identified.<br><br>This has the potential to affect all residents.<br><br>Facility Quality Assurance Performance Improvement committee members were educated by the Director of Clinical Operations on March 22nd, 2017 regarding the QAPI process. This | |

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| F 520 | Continued From page 64<br>Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2016. This was for one recited deficiency which was cited in October of 2016 on a complaint investigation. The deficiency was in the area of Accident Hazards/Supervision/Devices. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.<br><br>The findings included:<br><br>The tags were cross referred to:<br><br>F 278: Accuracy of Assessment: Based on record reviews and staff interviews the facility failed to accurately code information on a quarterly Minimum Data Set (MDS) regarding a physician prescribed weight loss regimen for 1 of 4 sampled residents. (Resident #30).<br><br>The facility was recited for F 278 for failing to code a quarterly MDS accurately regarding a physician prescribed weight loss regimen. F 278 was originally cited in March of 2016 on the recertification survey for failing to code an MDS accurately to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for a resident.<br><br>F 371: Food Procurement, Storage, Preparation and Distribution: Based on observations and staff interviews the facility failed to store ice scoops in draining containers in 2 of 2 nourishment rooms and failed to date and label a clear container of tea ready for resident use in 1 of 2 nourishment room refrigerators. | F 520 | includes:<br>Facility will identify areas of continuous quality monitoring and the monitoring tools to be used.<br>Monitoring activities should focus on the process that effect resident outcomes most significantly to include survey deficiencies.<br>Ongoing monitoring is used to establish the facility□s baseline and predictability of various outcomes.<br><br>The QAPI Committee will continue to meet on a monthly basis to continue monitoring identified areas of improvement, to include survey deficiencies for compliance.<br>The QAPI Committee will address the identified areas, examine and improve the identified need through improvement (action) plans and monitoring the effectiveness of such plans.<br>The Director of Clinical Operations or Designee will review the facility QAPI Committee meeting minutes for six months or until substantial compliance is achieved. | |

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| F 520 | Continued From page 65 | F 520 | | |

The facility was recited for F 371 for storing the ice scoops in both nourishment rooms in containers without drainage and failing to date a pitcher of tea ready for resident use in one of the nourishment room refrigerators. F 371 was originally cited in March of 2016 on the recertification survey for failing to remove dented cans from the shelf for resident use, date open containers of food in the walk-in cooler and an open bag of frozen food in the walk-in freezer. The facility also failed to remove dented cans of high calorie supplement, remove expired foods, and label and date items in the resident refrigerator in both nourishment rooms.

F 323: Accident Hazards/Supervision/Devices: Based on observations, record reviews, and staff interviews the facility failed to secure loose bed side rails for 3 of 6 resident reviewed for accidents (Residents #15, #32, and #66).

The facility was recited for F 323 for failing to secure loose bed side rails for 3 residents. F 323 was originally cited in October of 2016 on a complaint investigation for protect a resident from repeated falls resulting in lacerations and hematomas.

An interview was conducted with the Administrator on 03/02/17 at 7:22 PM. The Administrator stated the facility had monthly Quality Assessment and Assurance meetings and he was present for the December 2016 and January 2017 meetings but not for the February 2017. The Administrator shared several on-going areas that were audited and discussed monthly but stated he did not recall any audits or monitoring of MDS assessments, the

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| F 520 | Continued From page 66<br>nourishment rooms, or residents' bed side rails. | F 520 | | |