| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 03/09/2017 |

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| CARVER LIVING CENTER | 321 EAST CARVER STREET DURHAM, NC 27704 |

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| F 253 SS=D | 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 interviews the facility failed to repair 11 out of 26 closet doors located on 1 of 3 halls. Room #'s included 306, 313, 314, 315, 317, 321, 323, 324, 325, 326, and 327.<br><br>Findings included:<br><br>During an observation on 3/6/17 during the initial tour at 9:30 am, the following rooms were observed:<br><br>a. Room 317 closet door was off the sliding track and standing in an upright position against the resident's belongings.<br><br>b. Room 325 the closet door was off the sliding track and standing in an upright position against the resident's belongings.<br><br>During an observation on 3/7/16 at 9:36 am, the following rooms were observed:<br><br>a. Room 306 had a broken closet door. The door did not open or close.<br><br>b. Room 313 the closet door was not attached to the hinges/track and could not be opened or closed.<br>The door was not secured to the door frame. | F 253 | The doors for rooms 306,313,314,315,317,321,323,324,325,326,and 327 were reattached with new tracks and wheels on 3/8/17 and 3/9/17 by the maintenance director.<br><br>An audit of all the doors for the building was completed on March 14, 2017 by the maintenance director. Any doors found not to be secured on the track were repaired by the maintenance director.<br><br>All staff will be inserviced by the Administrator by 4/7/17 to notify the maintenance staff of needed repairs by using the TELS system (electronic notification). Maintenance staff were educated by the Administrator on 3/13/17 to ensure repairs are completed in a manner that maintains an orderly and comfortable interior.<br><br>Maintenance Director/designee will audit all closet doors weekly for four weeks, then will audit one hall area monthly ongoing. Maintenance Director will report findings of closet doors to the QAPI committee each month and ongoing. | 4/7/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/31/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 253 | Continued From page 1 | F 253 | | |

c. Room 314 the closet door was not attached to the hinges/track and could not be opened or closed.
The door was not secured to the door frame.

d. Room 315 the closet door was not attached to the hinges/track and could not be opened or closed.
The door was not secured to the door frame.

e. Room 321 the closet doors were not closing properly and were disengaged from the top track.

f. Room 323 the closet doors were not closing properly and were disengaged from the top track

g. Room 324 the closet door had both the right and left doors off the tracks and the doors were placed
against the resident's belongings.

h. Room 326 the closet doors were not closing properly and were disengaged from the top track.

i. Room 327 was missing a closet door.

An interview with NA #3 on 3/7/17 at 10:28 am revealed the doors have been broken for some time. The NA reported if there was a concern about anything needing to be repaired, we wrote the problem in the maintenance book at the nurse's desk.

An observation of rooms 306, 313, 314, 315, 317, 321, 323, 324, 325, 326 and 327 was done on 3/8/17 at 12:35 pm with the Maintenance Director. The closet doors were noted to still be in disrepair.

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| F 253 | Continued From page 2<br>An interview with the Maintenance Director (MD) on 3/8/17 at 12:45 pm revealed he was aware of the closet doors being in disrepair. He reported he fixed them almost every day. During the interview, the MD reported the door in room 317 was just fixed on the morning of 3/8/17 after receiving a work order via the facility's computer system. However, during the observation at this time, the door was noted to be disengaged from the track and standing in an upright position against the resident's belongings. The MD reported the doors needed to be replaced because they kept coming off the tracks. The MD reported the doors have been in disrepair since he started five months ago.<br><br>An interview with the Administrator on 3/9/17 revealed her expectation of the MD was to maintain and repair items that were not in working order in the facility. | F 253 | | |
| 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.<br><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. | F 278 | | 4/21/17 |

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| F 278 | Continued From page 3<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 records review and staff interviews, the facility failed to accurately code a comprehensive Minimum Data Set (MDS) assessment for a Preadmission Screening Resident Review (PASRR) for 1 (Resident # 51) of 1 sampled resident reviewed for PASRR. The facility also failed to accurately code a quarterly MDS assessment of behavior for 1 (Resident #97) of 5 sampled residents reviewed for behavior.<br><br>Findings included:<br><br>1. Resident # 51 was admitted on 9/29/16. Her diagnoses included bipolar disorder. Review of Resident 51 ' s Minimum Data Set (MDS) assessments, beginning from admission, dated 9/29/16, 10/6/16, 10/13/16, 10/18/16 and 1/06/17, revealed that Section A1500, Level II PASRR, was not coded. | F 278 | A corrected MDS for resident #51 was completed on 3/31/17 by the MDS nurse. The documented behavior for resident #97 did not occur during the look back period, therefore no corrected MDS was completed.<br><br>An audit of the most recent MDS for residents with PASRR Level II was completed on Friday, March 31, 2017 by MDS Nurse. Any MDS found coded incorrectly will be resubmitted with correct coding by April 7, 2017. An audit of the most recent completed MDS for all resident and documentation during the look back periods for those MDS, will be completed by Social Workers by April 14, 2017 to ensure behaviors are coded appropriately on MDS. Any MDS found to | |

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F 278 Continued From page 4

The facility provided plan of care, dated 1/6/17, indicated that Resident #51 was assessed with Level II PASRR based on diagnosis of Bipolar Disorder and received PASRR number.

On 3/8/17 at 10:00 AM, during an interview, the MDS nurse indicated that she was responsible for MDS assessment documentation. She could not provide Resident 51 ' s MDS assessment with coded Section A1500, Level II PASRR condition.

On 3/8/17 at 10:10 AM, during an interview, the Social Worker, indicated that the admission staff received PASRR information and notified MDS staff. The Social Worker was not responsible for documentation of Section A1500, Level II PASRR condition for Resident #51.

On 3/8/17 at 10:20 AM, during an interview, the Admission staff indicated that she received Resident 51 ' s PASRR information from the hospital at the time of resident ' s admission and notified the MDS nurse.

On 3/8/17 at 10:30 AM, during an interview, the Director of Nursing indicated that she expected the staff to code the MDS assessment accurately and on time.
2. Resident #97 was admitted on 9/11/2015. Diagnoses included dementia with behavioral disturbance. The Minimum Data Set (MDS) assessment dated 1/30/17, revealed in section E0200 Resident #97 had no behaviors coded, and section E0800 revealed he had no rejection of care coded.

A record review of a nursing note dated 1/20/17, revealed Resident #97 was combative during

F 278

be coded incorrectly will be resubmitted by April 21, 2017.

MDS nurses were educated on March 31, 2017 by the Administrator to ensure correct coding for residents with Level II PASRR condition. Social Workers were educated by Administrator on March 31, 2017 to review electronic chart, ADL sheets, provider notes and interview staff to ensure behaviors are coded correctly on MDS. All nursing staff will be inserviced on documenting behaviors in the electronic chart or ADL sheets by the Administrator by April 10,2017.

MDS Nurses will audit all MDS's for residents with PASRR Level II monthly for 3 months to ensure proper MDS coding for residents with Level II PASRR condition. MDS nurse will report finding to QAPI committee monthly for 3 months at which time the QAPI committee will determine if further auditing is needed. SWs will monitor 10 charts weekly for six months for proper behavior documentation. SW will report findings of documentation to QAPI committee for 6 months at which time the QAPI committee will determine if further auditing is needed.

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| F 278 | Continued From page 5<br>care.<br><br>On 3/9/17 at 9:57AM, Nurse # 8 indicated Resident #97 had episodes of refusal of care.<br><br>On 3/9/17 at 11:39AM, during an interview, the MDS nurse indicated that she was responsible for MDS assessment documentation. The MDS nurse stated when a behavior was present, it was documented on the MDS during the assessment period. The MDS nurse confirmed the last assessment on Resident #97 was conducted on 1/30/17.<br><br>On 3/9/17 at 11:40AM, during an interview, the Administrator indicated Resident #97 had some refusal of care. The Administrator read the 1/20/17 nursing note from the medical record and the previous MDS nurse had failed to correctly code the 1/30/17 MDS.<br><br>On 3/9/17 at 1:35PM, during a follow up interview with the MDS nurse, she revealed the nursing note dated 1/20/17 was part of the 1/30/17 quarterly look back period and he should have been coded on the MDS for behaviors at that time.<br><br>On 3/9/17 at 3:24PM, the Administrator indicated when the behavior was documented the expectation was for the MDS to be coded correctly. | F 278 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 | F 279 | | 4/14/17 |

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| F 279 | Continued From page 6 | F 279 | | |

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

483.21
(b) Comprehensive Care Plans

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

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

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

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

(iv)In consultation with the resident and the

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| F 279 | Continued From page 7 | F 279 | | |

resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to accurately care plan behaviors for 1 (Resident #97) of 5 sampled residents reviewed for behavior. The findings included:

A record review of a nursing note dated 1/20/17, revealed Resident #97 was combative during care.

On 3/9/17 at 9:57AM, Nurse #8 indicated Resident #97 had episodes of refusal of care.

On 3/9/17 at 11:40 AM, during an interview, the Administrator indicated Resident #97 had some refusal of care. The Administrator read the 1/20/17 nursing note from the medical record and reported the previous MDS nurse failed to create the care plan

On 3/9/17 at 1:35PM, the MDS nurse revealed the nursing note dated 1/20/17 was part of the

A care plan for resident #97 was completed on 3/9/17 by MDS nurse for refusal of care and combativeness.

An audit of the most recent MDS assessments and documentation related to those assessments for all residents will be completed by Social Workers by 4/14/17 to ensure all behaviors are properly care planned. Social Workers will ensure care plans are completed for any resident found not to have a care plan for behaviors including refusal of care and combativeness.

Social Workers were educated on 3/27/17 to review electronic chart, ADL sheets, provider notes, and interview staff to ensure behaviors are properly care planned.

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| F 279 | Continued From page 8<br>1/30/17 quarterly look back period and a care plan for behaviors needed to be implemented. She indicated the nursing supervisor had reported to her this morning Resident #97 had refused care last night and no care plan was in place.<br><br>On 3/9/17 at 3:24PM, the Administrator indicated the expectation was that the MDS assessment coded correctly and a care plan put into place. | F 279 | Social Workers will audit 10 charts weekly to ensure residents have been care planned appropriately for behaviors for 6 months. Social Workers will report the findings of their audits to QAPI committee for 6 months at which time the QAPI committee will determine if further auditing is needed. | |
| 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 observation, record review and staff interviews the facility failed to provide incontinent care for 1 of 4 residents observed incontinent (Resident # 97). The findings included:<br><br>Resident #126 was admitted to the facility on 09/11/15, and had a diagnosis in part, of dementia and chronic kidney disease.<br>The resident's care plan initiated 10/11/16, noted the resident was at risk for skin breakdown related to incontinence and impaired mobility. The interventions included to check for incontinence and provide care as needed and keep the resident clean and dry.<br>The annual Minimum Data Set (MDS) assessment dated 1/30/17, revealed resident # 97 was cognitively impaired and required extensive assistance with all activities of daily living (ADLs). The MDS revealed the resident | F 312 | Incontinence care for resident #97 was provided by the CNA on 3/9/17. The CNA was suspended on 3/9/17 when the administrator was notified of the situation and then terminated on 3/10/17. There was no negative outcome noted for resident #97.<br><br>All residents who require assistance with activities of daily living, including incontinence care could be affected by the deficient practice . All residents needing incontinence care were audited 3/9/17 by Unit Coordinators to ensure incontinence care had been provided appropriately.<br><br>All nursing staff will be inserviced by the Administrator by April 7, 2017 regarding provision of assistance with activities of | 4/7/17 |

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| F 312 | Continued From page 9<br>was always incontinent.<br>The Care Area Assessment (CAA) dated 08/04/16 for ADLs noted the resident required extensive assistance for all ADLs. The CAA noted the resident was alert, cognitively impaired, was usually understood and made wants/needs known with verbal and nonverbal expression.<br><br>On 03/09/17 at 9:48AM, an observation revealed a strong odor of urine permeating in his room. Resident # 97 was lying in bed on his side, dressed in jeans and a shirt. Resident #97 was observed in saturated jeans: the urine had soaked through the entire buttocks and a dark ring extended around to the sides of his thighs through his jeans.<br><br>On 03/09/17 at 9:48AM, during an interview with a visitor in Resident #97's room, the visitor revealed she had arrived at 8:45AM and the room smelled of urine.<br><br>On 3/9/17 at 9:50AM, Nurse #8 was asked for the location of the Aide for Resident #97. Nurse #8 indicated she was not sure where Aide#5 was and after she had checked all the rooms she indicated Aide #5 left the floor. Nurse #8 went into Resident #97's room and observed him in soaked jeans lying in his bed. Nurse #8 reported the night aide had said he refused care last night.<br><br>On 03/09/17 at 9:57AM, the Nursing Supervisor (NS) indicated the aides were expected to do rounds at the start of the shift by checking every resident to ensure residents were clean and dry. The NS added the aides were to check each resident at least every two hours and as needed for incontinent care. The NS indicated and confirmed the residents should not have urine | F 312 | daily living as needed, including incontinence care; and inserviced on completing an initial round at the beginning of their shift, checking residents every two hours and as needed to ensure incontinence care is provided appropriately.<br><br>Nurse supervisors/Weekend Manager on Duty will audit 5 residents each daily for 3 months to ensure incontinence care is provided by nursing staff and educate staff as needed. They will report the findings of their audit to the QAPI committee for 3 months at which time the QAPI committee will determine if further auditing is needed. | |

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| F 312 | Continued From page 10<br>soaking through their jeans.<br><br>On 03/09/17 at 10:03AM, Aide #5 returned to the assigned hall. During an interview, Aide #5 stated she was assigned to Resident#97 and she had not checked Resident #97 for incontinence. Aide #5 reported the night shift had gotten him dressed, but she confirmed that she had not offered him any toileting or incontinence care during this day shift. Aide #5 stated another staff member had just told her he was wet.<br><br>On 03/09/17 at 12:35 PM, the Administrator revealed her expectation was for the staff to provide incontinent care as needed. | F 312 | | |
| 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.<br><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. | F 371 | | 3/31/17 |

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| F 371 | Continued From page 11<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 observation and staff interviews, the facility failed to label foods in a manner consistent with its policy in 1 of 1 walk-in refrigerator, 1 of 1 walk-in freezer, and 1 of 1 reach-in refrigerator and failed to provide a clean ice scoop holder<br>Findings included:<br>1a. An observation of the walk-in refrigerator on 3/6/17 at 9:21 AM revealed a white transparent box labeled "sliced ham" and "3/5/17 "written on it. No use by date or expiration date was noted. Dietary Manager indicated that sliced ham was used during the previous day meal.<br><br>b. An observation of the walk-in freezer on 3/6/17 at 9:23 AM revealed five pre-made pie shells in an opened plastic bag with no label.<br>c. An observation of the walk-in freezer on 3/6/17 at 9:23 AM also revealed, three baking sheets covered with aluminum foil stored on the top rack with no labels. The Dietary Manager indicated that the trays contained biscuits that were prep for next day meals. Two green bottles of soda were observed behind the boxes of frozen pancakes. Dietary Manager stated that the bottles were ginger ale soda bottles. Dietary Manager indicated that he was unsure why it was stored in the freezer.<br>d. An observation of the reach- in refrigerator on 3/6/17 at 9:30 AM revealed a white container with "California sliced strawberry" printed on it. No open date, use by date or expiration date was noted. | F 371 | On 3/6/17, the box with the sliced ham was labeled with a "use by" label. On 3/6/17, the plastic bag with pie shells was closed and a "use by" label was applied. On 3/6/17, a "use by" label was applied to the foil covering the biscuits in the walk-in freezer. The two soda bottles found in the walk-in freezer were discarded on 3/6/17. On 3/6/17, a "use by" label was applied to the white container with "California sliced strawberry." The coleslaw from the reach-in refrigerator on 3/6/17. The container with the leftover gravy was labeled with a use by date on 3/6/17. The plastic container of soup was labeled with a "use by" label on 3/6/17. The container of sausage was Labeled with a "use by" label on 3/6/17. The container of chicken was labeled with a "use by" date on 3/6/17. The two containers of sloppy joe was labeled with a "use by" label on 3/6/17. The Styrofoam cup found in the ice scoop holder was discarded immediately. The ice scoop and holder were washed and sanitized immediately.<br><br>All refrigerators and freezers were audited by the dietary supervisor on March 6, 2017 to ensure proper labeling was used for any opened or left over food. Dietary Manager also audited all the ice freezers to ensure all ice scoops were stored properly. | |

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| F 371 | Continued From page 12<br>e. An observation of the reach-in refrigerator on 3/6/17 at 9: 30 AM revealed a container with aluminum foil and a label with prep date 2/24/17 written on it. The Dietary Manager stated that the container contained coleslaw. Dietary Manager stated that the coleslaw was a pre-made product and that it was removed from the coleslaw carton with expiration date of 3/11/17. He further stated that as coleslaw was a pre-made and purchased product, the "Use by" date of the coleslaw was the "expiration date" of the coleslaw carton. He further stated that all leftover pre-made purchase products were discarded based on the expiration date of that product.<br><br>f. An observation of the reach- in refrigerator on 3/6/17 at 9: 30 AM revealed a container with aluminum foil and "3/5/17" written on it. Dietary Manager indicated that it was leftover gravy that was prepared on 3/5/17. Observation also revealed a plastic container of soup, a container of sausage and a container of chicken with label indicating "Prep date - 3/5/17". No "Use by" date noted.<br><br>g. An observation of the reach- in refrigerator on 3/6/17 at 9: 30 AM revealed two containers covered with aluminum foil and "3/4/17" written on it. Dietary Manager indicated that the two containers contained Sloppy Joe that was prepared on 3/4/17. Dietary Manager stated that the left over Sloppy Joe was used in dinner preparation on 3/6/17.<br><br>During an interview with the Dietary Manager on 3/6/17 at 9:36 AM, he stated that the staff uses the cooked left overs within 48 hour of preparation, all processed product were used by staff based on the product expiration date on the | F 371 | All dietary staff were inserviced on 3/6/17 by the dietary manager regarding proper labeling of left over and opened food according to facility policy/regulation, using the "use by" date on all food; as well as proper storage for ice scoops.<br><br>The dietary manager/supervisor will monitor all refrigerators and freezers daily for 6 months to ensure proper labeling on all opened or left-over food. The dietary manager/supervisor will monitor all ice machines for proper storage of the ice scoop for 6 months to ensure proper storage. The dietary manager will report findings of his monitoring to the QAPI committee at which time the QAPI committee will determine if further auditing is needed. | |

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| F 371 | Continued From page 13 | F 371 | | |

container or carton. He further stated that all mayonnaise based items were used within 7 days and all processed meats were used within 7 days after slicing. He indicated that "Use by" dates were not needed on processed products as the expiration dates were on the product container.

During an interview with facility Cook # 1 on 3/6/17 at 12:49 PM, he stated that all leftovers were labeled with product name, prep date and use by date. He indicated that all left over foods were used within 24 hours. Cook also stated that not all dietary staff before storing leftover use the correct labels with product name, prep date and use by date printed on it. He also stated that leftover foods should be discarded within 48 hours.

During an interview with the facility Cook #2 on 3/08/2017 at 12:15 PM, Cook stated that leftovers were discarded after each meal. He also stated that if leftovers were stored then the food was discarded within 7 days. He further stated that after 7 days it was not safe to use leftover foods.

Review of the facility's Refrigerator and Freezer Policy dated May 05 2015 read in part: all foods shall be appropriately dated to ensure proper rotation by expiration dates. "Use by" date will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by date indicated once food is opened.

During an interview with the administrator on 03/08/2017 at 1:52 PM, she stated that it was her expectation that foods were labeled accurately and that labels used include the "Use by date" and "Prep on date" on them. She further stated

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| F 371 | Continued From page 14<br>that food should be discarded according to the "expiration date" or per "Use by date".<br><br>2 a. An observation of the ice machine on 3/6/17 at 9:35 AM revealed the ice scooper holder containing an ice scooper and a 20 ounce Styrofoam cup in it. Dietary Manager indicated that he was unsure why the Styrofoam cup was placed in the bin along with the ice scooper.<br><br>During an interview with the Dietary Manager on 3/6/17 at 9:40 AM he stated that the staff was aware not to use Styrofoam cups as ice scoop and Styrofoam cup not be placed in the ice scooper holder. He further stated that he was unsure why the Styrofoam cup was placed along with the ice scoop in the ice scoop holder. | F 371 | | |
| 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<br><br>(g)(2) The quality assessment and assurance committee must : | F 520 | | 4/21/17 |

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| F 520 | Continued From page 15<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 record reviews, staff and residents 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 three recited deficiencies which were originally cited in July of 2015 on the recertification survey and on the current recertification survey. The deficiency was in the area of food procure, store, sanitary condition. Also, there were four recited deficiencies, which were originally cited in April 2016 on the recertification survey and on the current recertification survey. The deficiencies were in the areas of maintenance service and assessment accuracy. The continued failure of | F 520 | 1a. 371<br>"Use by" labels were applied and properly labeled on 3/6/17 for the sliced ham dated 3/5/17, pie shells with no date, biscuits unlabeled, California sliced strawberry, left over gravy dated 3/5/17, and sloppy joe dated 3/4/17,plastic container of soup, the container of sausage, and the container of chicken labeled with prep date 3/5/17. The two soda bottles and cole slaw were discarded on 3/6/17. The Styrofoam cup was discarded immediately. The scoops were washed and sanitized immediately.<br><br>All refrigerators and freezers were audited by the dietary supervisor on March 6, | |

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| F 520 | Continued From page 16<br>the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.<br><br>Findings included:<br><br>This tag is cross referred to:<br><br>1a. F371: Food procure, store, sanitary condition: Based on observation, policy review and staff interviews, the facility failed to label and date foods in the walk-in refrigerator, walk-in freezer, and reach-in refrigerator and failed to have a clean ice scoop bin.<br><br>The facility was originally cited for F371 for failing to maintain clean kitchen equipment in June 2015 and recited for F371 for failing to label and date food items in April 2016.<br><br>2a. F253: Housekeeping and maintenance service: Based on observation and staff interviews, the facility failed to maintain the closet door in good repair and had one missing closet door for 9 of 14 residents ' rooms.<br><br>The facility was originally cited for F253 for failing to keep bathroom door in resident rooms in good repair in April 2016.<br><br>b. F278: Accuracy of assessment: Based on records review and staff interviews, the facility failed to accurately code a comprehensive Minimum Data Set (MDS) assessment for a Preadmission Screening Resident Review (PASRR) for 1 (Resident # 51) of 1 sampled resident reviewed for PASRR. The facility also | F 520 | 2017 to ensure proper labeling was used for any opened or left over food. Dietary Manager also audited all the ice freezers to ensure all ice scoops were stored properly.<br><br>All dietary staff were inserviced on 3/6/17 by the dietary manager regarding proper labeling of left over and opened food according to facility policy/regulation, using the "use by" date on all food; as well as proper storage for ice scoops.<br><br>The dietary manager/supervisor will monitor all refrigerators and freezers daily for 6 months to ensure proper labeling on all opened or left-over food. The dietary manager/designee will monitor all ice machines for proper storage of the ice scoop for 6 months. The dietary manager will report finings of his monitoring to the QAPI committee each month, make revisions as needed to ensure all left-over and opened food are labeled properly, and the ice scoops are stored properly. After 6 months, the QAPI committee will determine if further auditing is needed.<br><br>2a. 253<br>The doors for rooms 306,313,314,315,317,321,323,324,325,326,and 327 were reattached with new tracks and wheels on 3/8/17 and 3/9/17 by the maintenance director.<br><br>An audit of all the doors for the building was completed on March 14, 2017 by the maintenance director. Any doors found not to be secured on the track were | |

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failed to accurately code a quarterly MDS assessment of behavior for 1 (Resident #97) of 5 sampled residents reviewed for behavior.

The facility was originally cited for F278 for failing to accurately code the MDS assessments on behaviors, hospice, medications, vision, dental and activities of daily living for 7 residents in April 2016.

c. F279: Develop Comprehensive care plan: Based on records review and staff interviews, the facility failed to develop the comprehensive plan of care for behavior for 1 (Resident #97) of 5 sampled residents reviewed for behavior.

The facility was originally cited for F279 for failing to develop the plan of care for behavior for 1 of 5 residents in April 2016.

On 09/12/14 at 4:20 PM, during an interview, the Administrator and Director of Nursing (DON) indicated that the of Quality Assessment and Assurance Committee meetings occurred monthly and based on the results of the several previous surveys the facility created and implemented the plan of correction. The Administrator and DON explained that after the last survey in April 2016 they experienced the transition from traditional paper to electronic medical records and replaced the MDS team to improve the area of assessment/care planning documentation. The Administrator confirmed that the facility still not in compliance in some areas and continued to work under improvement of the role of quality assessment and assurance committee.

F 520

repaired by the maintenance director.

All staff will be inserviced by the Administrator by 4/7/17 to notify the maintenance staff of needed repairs by using the TELS system (electronic notification). Maintenance staff were educated by the Administrator on 3/13/17 to ensure repairs are completed in a manner that maintains an orderly and comfortable interior.

Maintenance Director/designee will audit all closet doors weekly for four weeks, then will audit one hall area monthly ongoing. Maintenance Director will report findings of closet doors to the QAPI committee ongoing and make revisions to the plan of correction as needed to ensure repairs are completed in a manner that maintains an orderly and comfortable interior.

2b. 278
A corrected MDS for resident #51 was completed on 3/31/17 by the MDS nurse. The documented behavior for resident #97 did not occur during the look back period, therefore no corrected MDS was completed.

An audit of the most recent MDS for residents with PASRR Level II was completed on Friday, March 31, 2017 by MDS Nurse. Any MDS found coded incorrectly will be resubmitted with correct coding by April 7, 2017. An audit of the most recent completed MDS for all resident and documentation during the

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| F 520 | Continued From page 18 | F 520 | look back periods for those MDS, will be completed by Social Workers by April 14, 2017 to ensure behaviors are coded appropriately on MDS. Any MDS found to be coded incorrectly will be resubmitted by April 21, 2017.<br><br>MDS nurses were educated on March 31, 2017 by the Administrator to ensure correct coding for residents with Level II PASRR condition. Social Workers were educated by Administrator on March 31, 2017 to review electronic chart, ADL sheets, provider notes and interview staff to ensure behaviors are coded correctly on MDS. All nursing staff will be inserviced on documenting behaviors in the electronic chart or ADL sheets by the Administrator by April 10,2017.<br><br>MDS Nurses will audit all MDS's for residents with PASRR Level II monthly for 3 months to ensure proper MDS coding for residents with Level II PASRR condition. MDS nurse will report finding to QAPI committee monthly for 3 months at which time the QAPI committee will determine if further auditing is needed. SWs will monitor 10 charts weekly for six months for proper behavior documentation. SW will report findings of documentation to QAPI committee monthly for 6 months and make revisions as needed to ensure MDS are coded correctly for behaviors.<br><br>2c. 279<br>A care plan for resident #97 was completed on 3/9/17 by MDS nurse for | |

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| F 520 | Continued From page 19 | F 520 | refusal of care and combativeness.<br><br>An audit of the most recent MDS assessments and documentation related to those assessments for all residents will be completed by Social Workers by 4/14/17 to ensure all behaviors are properly care planned. Social Workers will complete a care plan for any residents found not having care plans for behaviors including refusal of care and combativeness.<br><br>Social Workers were educated on 3/27/17 to review electronic chart, ADL sheets, provider notes, and interview staff to ensure behaviors are properly care planned.<br><br>Social Workers will audit 10 charts weekly to ensure residents have been care planned appropriately for behaviors for 6 months. Social Workers will report the findings of their audits to QAPI committee for 6 months and make revisions to the plan of correction as needed. | |