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	345080	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

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F 000	INITIAL COMMENTS No deficiencies were cited as result of the complaint investigation on 06/30/17. Survey event ID# BMNF11.	F 000		
F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and	F 156		8/15/17

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

Electronically Signed | 07/26/2017

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F 156	Continued From page 1	F 156		

email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;

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F 156	Continued From page 2 [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs,	F 156		

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F 156	Continued From page 3 and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;	F 156		

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F 156	Continued From page 4 (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 156		

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F 156	Continued From page 5 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to ensure 3 of 3 residents (Resident #41, #64 and #73) who attended Resident Council, were informed of the location of the contact information for the Regional Long Term Care Ombudsman and the Ombudsman's role as a resident advocate. The findings included: 1.A. The Resident Council President, (Resident #64) was coded as cognitively intact on her most recent Minimum Data Set (MDS) dated 3/13/17. During an interview on 06/29/17 at 3:11 PM, the Resident Council President stated she had not	F 156	Preparation, submission and implementation of this plan of Correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. our plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The administrator informed resident numbers #64 (resident council president), #41 and #73 the location of the contact information for the Regional Long Term Ombudsman. An explanation was also	

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F 156	Continued From page 6 been introduced to the Regional Long Term Care Ombudsman, did not know about any resident advocate and was unaware of where contact information would be found for a resident advocate. B. Resident #41 regularly attended Resident Council meetings and was coded on an MDS dated 03/17/17, as making decisions that were consistent and reasonable. During an interview on 06/30/17 at 8:29 AM, Resident #41 stated he did not know who or what the Ombudsman did or how to contact a resident advocate. Resident #41 stated, "I go to Resident Council meetings and I can tell you there hasn't been anyone like that at our meeting in a right long time." C. Resident #73 regularly attended Resident Council meetings and was coded on an MDS dated 04/18/17, as cognitively intact. During an interview on 06/30/17 at 11:22 AM, Resident #73 stated he did not know who or what the Ombudsman did or how to contact a resident advocate. During an interview on 06/30/17 at 11:55 AM, the Activity Director (AD) revealed he had worked as the AD for 2 years. The AD stated that although the Ombudsman was often at the facility and met with individual residents, the Ombudsman had not been invited to attend Resident Council meetings and the residents had not been informed of the Ombudsman role as a resident advocate. During an interview conducted on 06/30/17 at 4:15 PM, the Administrator stated residents should be informed of their right to contact the Ombudsman and where the contact information	F 156	given to the residents #64, #41 and #73 about the Ombudsman's role as a resident advocate. The Ombudsman met with the resident council on 7/22/17 to educate them of the role she has as resident advocate. The residents were also shown where the contact information was located (across from the nursing station next to the 300 hallway). The administrator / designee will inform residents of the Ombudsman role as a resident advocate and the location of the Ombudsman phone number. The admission coordinator/designee will review with all new admission the Ombudsman's role as a resident advocate and the location of the contact information. The Activity Director and Admissions Coordinator was in-serviced on 7/26/17, by the Ombudsman and Administrator on the Ombudsman role as a resident advocate and the location of the ombudsman contact phone number. The Activity Director will randomly ask ten(10) residents weekly for the next three (3) months if they know the Ombudsman's role and the location of the Ombudsman's phone number. The results will be presented by the Activity Director monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 156	Continued From page 7 was located.	F 156		
F 205 SS=C	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family	F 205	The administrator contacted the resident	8/15/17

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F 205	Continued From page 8 interview, the facility failed to provide 1 of 1 resident representative with written notice of the bed hold policy upon a resident's transfer to the hospital (Resident #118). Findings included: Resident #118 was admitted to the facility on 04/13/16 with a diagnosis of dementia. On 06/26/17 at 8:15 PM, Resident #118's Responsible Representative was interviewed and stated he had not received the Bed-Hold Policy when his family member was transferred during the most recent hospitalization. During an interview on 06/30/17 at 1:54 PM, the facility Social Worker, stated that the Business Office Manager was responsible for bed-hold notification when a resident was transferred to the hospital. The Business Office Manager was interviewed on 06/30/17 at 3:45 PM and was asked about notification of the Bed Hold Policy when a resident was transferred to the hospital. The Business Office Manager stated, "We give them [residents or representatives] the Bed Hold Policy at admission and they sign it. We expect them to contact us if they want to hold the family member's bed [while the resident is in the hospital]." She specified that she used to call some family members, but had not called anyone since July 2016 when they switched to an electronic record system for residents. The Business Office Manager was unable to provide evidence of Bed Hold notification to residents or resident representatives during the last year. An interview was conducted with the	F 205	representative for (resident #118) and explained to him the bed hold policy. A written notice of the bed hold policy was given to the resident representative for (resident #118) on 7/26/17. All of the current residents were given a copy of the bed hold policy. The bed hold policy was also mailed out to the resident representatives. In the resident council meeting on 7/22/17 the Administrator reviewed the bed hold policy and a copy given to the resident council president and residents. The admission coordinator / designee will give a copy of the bed hold policy to the resident representative and/or resident upon admission. The Director of Nursing/ Designee conducted an in-service /re-education for all Nursing staff and the Social Worker that a written bed hold policy has to go with the transfer of a resident to a hospital or if the resident goes on a therapeutic leave. The written bed hold notice will also be given to the resident or the resident representative, by a licensed staff member. The residents that are transferred to the hospital or therapeutic leave will be called within 24 hours by the social worker / designee to determine bed hold status. The social worker will audit all of the discharges weekly for the next three (3) months to ensure that a bed hold notice was given to the resident representative and/or resident and were notified within 24 hours regarding the bed hold policy.	

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F 205	Continued From page 9 Administrator on 06/30/17 at 4:15 PM. The Administrator stated he expected residents or resident representatives to receive written notice of the bed hold policy within 24 hours after the resident was admitted to the hospital. During an interview on 06/30/17 at 4:26 PM, the Director of Nursing indicated she was not familiar with the Bed Hold Policy notification at the time of resident transfers.	F 205	The results will be presented by the Social Worker monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility neglected to answer a call light and provide incontinent care for 1 of 2	F 224	Director of Nursing met with resident #47 and her toileting pattern was identified.	8/15/17

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F 224	Continued From page 10 sampled residents (Resident #47). The findings included: 1. Resident #47 was admitted to the facility on 01/20/16 with diagnoses that included atrial fibrillation, hypertension, diabetes mellitus, gastroparesis and others. Review of the most recent quarterly minimum data set (MDS) dated 04/11/17 revealed that Resident #47 was cognitively intact for daily decision making and had no behaviors. The MDS further revealed that Resident #47 required extensive assistance of 2 staff members for toileting and was frequently incontinent of bowel and bladder. The MDS also revealed that Resident #47 vision was impaired and she wore corrective lenses. Review of a concern form dated 06/13/17 from Resident #47 read in part, She stated that on 06/13/17 she turned her call light on and no one came to assist her and she ended up "going on herself" and then still had to wait to be cleaned up. The resolution of the concern form dated 06/16/17 read in part, Administrator spoke with resident regarding her concern and told Resident #47 staff would be in serviced to answer call lights more timely. The Unit Coordinator (UC) and the Assistant Director of Nursing (ADON) would have a morning huddle and customer service training. Review of daily assignment sheet dated 06/13/17 revealed that Nursing Assistant (NA) #7 and NA #8 were taking care of Resident #47 on 06/13/17 on the day shift.	F 224	Director of Nursing provided 1:1 education on answering call lights to NA#7, and NA #8 on July 17, 2017. Director of Nursing /Staff Development Coordinator re-educated all staff on answering call lights within reasonable time frame. The education included the expectation of everyone answering call lights. Director of Nursing / Staff Development Coordinator re-educated nursing staff on attempting to identify toileting patterns for residents that are continent, but require staff assistance to use a bedpan and/or urinal. Nursing staff was re-educated to anticipate and provide assistance according to the identified patterns. The education included the importance of assisting residents to maintain dignity and be free from incontinent episodes as possible. Director of Nursing / Assistant Director of Nursing / Unit Manager / Designee will audit five (5) residents requiring assistance with toileting weekly for twelve (12) weeks to assure call lights were answered and needs were met in a timely manner. The results will be presented by the Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure	

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F 224	Continued From page 11 An observation and interview was conducted with Resident #47 on 06/28/17 at 11:54 AM. Resident #47 confirmed she had filed the grievance on 06/13/17 about lack of staff and not answering her call light. Resident #47 stated that on 06/13/17 during the day she had turned her call light on because she needed the bed pan to have a bowel movement. She stated she waited over an hour and no one showed up. Resident #47 stated she was so uncomfortable and could not hold it any longer and she had to defecate and urinate on herself. Resident #47 stated she could not recall who was working that day but she tried hard to not use the call light but this day she needed to have a bowel movement and does not like defecating on herself. Resident #47 was observed to have a small clock on her bedside table and one wall clock that hung on the wall to the left of her bed. An interview with NA #7 was conducted on 06/28/17 at 2:32 PM. NA #7 confirmed she was working the day shift on 06/13/17 and recalled Resident #47 had a bowel movement and she had to be cleaned up which was unusual for Resident #47 because she generally went in the bed pan. NA #7 stated she did not realize that Resident #47 had been waiting over an hour to be cleaned up but since there was just 2 NAs on the hall that day, waiting that long was not unusual. An interview with NA #8 was conducted on 06/28/17 at 2:48 PM. NA #8 confirmed that she had worked the day shift on 06/13/17 on Resident #47's unit. She added that she provided care to Resident #47 that day but was not aware of the incident where she had to wait over an hour. NA #8 stated that with 2 NAs on the hall waiting a long time like that was not unusual.	F 224	continued compliance.	

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BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 12 An interview with the ADON was conducted on 06/29/17 at 4:37 PM. The ADON stated she did not believe that Resident #47 waited over an hour for her call light to be answered because she did not believe that Resident #47 "would pay that close attention to the clock." She added that she believed the problem was that "the residents believed there was not enough staff" and the staff had to learn to anticipate the needs of the resident to be more efficient with their time. The ADON added that waiting an hour or longer for care was unacceptable. An interview was conducted with the Director of Nursing (DON) on 06/30/17 at 2:58 PM. The DON stated her expectation was that call lights were answered in a reasonable time from and an hour is not acceptable and the fact that Resident #47 had to defecate and urinate on herself was also unacceptable.	F 224		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (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. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to treat a resident in a dignified manner when a resident and staff member engaged in a verbal altercation that involved the use of profanity (Resident #41). The facility failed to answer a	F 241	On June 29,2017 Director of Nursing provided 1:1 education to nursing assistant #1 related to the allegation of profanity being used during an altercation with resident #41.The education included treating residents with dignity, respect and	8/15/17

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F 241	Continued From page 13 resident's call light and provide incontinent care (Resident #47) and failed to provide privacy for a resident's bathroom (Resident #29) for 3 of 4 sampled residents. The findings included: Resident #41 was admitted to the facility on 6/28/11 and readmitted on 10/5/15 with diagnoses that included heart failure, anxiety, depression and others. The most recent MDS dated 06/09/17 specified the resident refused the cognition interview and no behaviors were noted during the assessment reference date. A care plan updated 06/29/17 identified Resident #41 had the potential to be verbally aggressive with staff. The care plan included an intervention to allow time for resident to express self and feelings towards a situation. On 06/27/17 at 10:30 AM Resident #41 was interviewed and reported that some staff did not treat him with dignity and respect. The Resident provided an example that occurred 6 months ago when NA #1 cussed him after he cussed her. The Resident was asked for more information and he explained that one night at least 6 months ago, NA#1 was coming into the room to provide care to the roommate which aggravated Resident #41. During one of the times NA #1 came in to answer the roommate's call light, the roommate expressed he was cold and the NA noted that Resident #41 had the window open during a winter month. This incident occurred during the	F 241	maintaining professionalism at all times. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator provided education to staff on dignity, respect and resident rights. The education included not reacting to the actions of our residents and refraining from the use of profanity. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Administrator or Designee will conduct five (5) random resident interviews weekly for twelve (12) weeks to assure compliance. The Director of Nursing, Assist Director of Nursing, Staff Development Coordinator re-educated staff on answering call lights, with emphasis on the importance of everyone answering call lights. The Director Of Nursing , Assistant Director of Nursing ,Unit Manager or Designee will conduct ten (10) call light response audits weekly for twelve (12) weeks to assure compliance. The Director of Nursing, Assistant Director of Nursing , Staff Development Coordinator re-educated nursing staff on providing incontinence care as needed. The education included treating all residents with dignity and respect. When identifying toileting patterns for residents, provide assistance as needed to maintain the resident's dignity. The Director of Nursing, Assistant Director of Nursing, Unit Manager or Designee will audit ten (10) residents weekly for twelve (12) weeks to validate incontinence care is provided timely and with dignity.	

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F 241	Continued From page 14 night shift. The NA went to the window next to Resident #41's bed to close the window; and he stated he yelled at her to get out of his room and never come back. Resident #41 stated he cussed NA #1 and she cussed me back. Resident #41 could not recall what NA #1 said. The resident reported that NA #1 was never to come back into his room again. Resident #41 stated he did not report the incident because he was a "private" person and he didn't need to report it because other staff "who heard it" reported it for him. He identified the "other staff" as NA #2 and NA #5. Resident #41 could not remember what words or statements were said and he could not provide a date or month the incident occurred. On 06/28/17 at 12:32 PM Nurse #1 was interviewed and reported that NA #1 was not allowed to work with Resident #41 and that NA #1 "stayed away" from Resident #41. The nurse stated that Resident #41 reported to her that NA #1 had said "ugly things." The nurse reported she went immediately to the former Director of Nursing and was told the situation had already been handled. Nurse #1 guessed the incident occurred either December 2016 or January 2017. On 06/28/17 at 4:03 PM NA #5 was interviewed and stated she was with NA #2 when Resident #41 told them that NA #1 had "cussed him." NA #5 could not recall when this had occurred because it had been so long ago. NA #5 also stated Resident #41 did not tell them what the NA had said. NA #5 stated she and NA #2 reported the incident to Nurse #1.	F 241	A bathroom door will be installed to provide privacy for resident #29. The Maintenance Director will interview any residents with curtains up at the entrance of their bathroom doors. The Maintenance Director will replace curtains with doors for any residents preferring a door. The Maintenance Director will audit the rooms with curtains to validate the resident's preference weekly for 12 weeks. The resident interviews and call light results will be presented by the Director of Nursing and the curtain audits will be presented by the Maintenance Director monthly for three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 241	Continued From page 15 On 06/29/17 at 9:17 AM NA #1 reported to the SA she wanted to go over her telephone interview to "be clear" of what she had reported on 06/28/17 during a telephone interview. The NA recalled the night when she was providing care to Resident #41's roommate. The NA stated she went to close the window since the roommate complained of being cold and it was in the middle of a winter night. The NA added, Resident #41 started yelling at her using profanity and she left the room. The NA denied that she ever used profanity when speaking to the resident. On 06/30/17 at 1:48 PM the Director of Nursing (DON) was interviewed and explained she had been the DON since 05/01/17 and was not made aware of an incident between Resident #41 and NA #1 until 06/29/17. The DON reported that the use of profanity was not tolerated. The DON also reported that the account of what was said was second or third hand information. The DON added that she spoke with Resident #41 and he was not able to tell her what NA #1 said to him. The DON also spoke with NA #1 and the NA denied using profanity. The DON added that in this incident she could not be certain of what NA #1 said to Resident #41. On 06/30/17 at 2:12 PM Resident #41 was interviewed in his room and stated, "I'm fine and this is my home." Resident #41 went on to explain that he was not afraid in the facility. 2. Resident #47 was admitted to the facility on 01/20/16 with diagnoses that included atrial fibrillation, hypertension, diabetes mellitus, gastroparesis and others.	F 241		

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Review of the most recent quarterly minimum data set (MDS) dated 04/11/17 revealed that Resident #47 was cognitively intact for daily decision making and had no behaviors. The MDS further revealed that Resident #47 required extensive assistance of 2 staff members for toileting and was frequently incontinent of bowel and bladder. The MDS further revealed that Resident #47 had impaired vision and wore corrective lenses.

Review of a concern form dated 06/13/17 from Resident #47 read in part, She stated that on 06/13/17 she turned her call light on and no one came to assist her and she ended up "going on herself" and then still had to wait to be cleaned up. The resolution of the concern form dated 06/16/17 read in part, Administrator spoke with resident regarding her concern and told Resident #47 staff would be in-serviced to answer call lights more timely. The Unit Coordinator (UC) and the Assistant Director of Nursing (ADON) would have a morning huddle and customer service training.

An observation and interview was conducted with Resident #47 on 06/28/17 at 11:54 AM. Resident #47 confirmed she had filed the grievance on 06/13/17 about lack of staff and not answering her call light. Resident #47 stated that on 06/13/17 during the day she had turned her call light on because she needed the bed pan to have a bowel movement. She stated she waited over an hour and no one showed up. Resident #47 stated she was so uncomfortable and could not hold it any longer and she had to defecate and urinate on herself which made her feel awful. She added that if she would have just urinated

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she would not have felt so bad but she hated defecating on herself. Resident #47 stated she could not recall who was working that day but she tried hard to avoid using the call light unless she really needed to. Resident #47 was noted to have a small clock on her bedside table and wall clock on the wall to the left of her bed.

An interview with NA #7 was conducted on 06/28/17 at 2:32 PM. NA #7 confirmed she was working the day shift on 06/13/17 and recalled Resident #47 had a bowel movement and she had to be cleaned up which was unusual for Resident #47 because she generally used the bed pan. NA #7 stated she did not realize that Resident #47 had been waiting over an hour to be cleaned up but since there were just 2 NAs on the hall that day, waiting that long was not unusual.

An interview with NA #8 was conducted on 06/28/17 at 2:48 PM. NA #8 confirmed that she had worked the day shift on 06/13/17 on Resident #47 ' s unit. She added that she provided care to Resident #47 that day but was not aware of the incident where she had to wait over an hour. NA #8 stated that with 2 NAs working on the hall waiting a long time like that was not unusual.

An interview with the ADON was conducted on 06/29/17 at 4:37 PM. The ADON stated she did not believe that Resident #47 waited over an hour for her call light to be answered because she did not believe that Resident #47 "would pay that close attention to the clock." She added that she believed the problem was that "the residents believed there was not enough staff" and the staff had to learn to anticipate the needs of the resident to be more efficient with their time. The ADON added that waiting an hour or longer for

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care was unacceptable.

An interview was conducted with the Director of Nursing (DON) on 06/30/17 at 2:58 PM. The DON stated her expectation was that call lights were answered in a reasonable time frame and an hour was not acceptable. She added the fact that Resident #47 had to defecate and urinate on herself was also unacceptable.

3. Resident #29 was admitted to the facility on 09/05/15 and readmitted on 09/21/16 with diagnoses that included heart failure, hypertension, diabetes mellitus and anxiety disorder. The annual Minimum Data Set (MDS) dated 06/15/17 revealed that Resident #29 had an assessment of moderately impaired cognition. The MDS also revealed that Resident #29 had no behaviors, was occasionally incontinent of urine and stool and received insulin injections, antipsychotic, antidepressant and antianxiety medications daily.

A review of the Care Area Assessment (CAA) dated 06/15/17 for Resident #29 revealed she required limited assistance of 1 with most activities of daily living (ADL) including transfer to her wheelchair. Her mobility was in her wheelchair and she was able to transfer independently from her wheelchair to the commode.

A review of her care plan dated 06/15/17 revealed that she was care planned for ADL with the goal for her to remain at current level of participation through the next review period. The interventions included in part that her pathway to the bathroom would remain clear and free of clutter.

An observation of Resident #29 on 06/27/17 at

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8:16 am revealed resident lying in bed with the head of bed elevated and resident lying sideways in the bed holding her stomach and complaining of pain. Stated she was waiting on the nurse to bring her some medication for her stomach.

An observation of Resident #29 on 6/27/17 at 10:48 am revealed her up in her wheelchair and stated she was feeling much better after she ate breakfast. It was noted that the bathroom for the resident and her roommate did not have a door on it but rather a half curtain over the doorway. During an interview with Resident #29's roommate, the resident had to go to the bathroom and her roommate had to move so Resident #29 could get to the bathroom in her wheelchair. While interviewing the roommate, Resident #29 could be heard through the curtain straining and grunting on the toilet. While sitting on the bed of the roommate, Resident #29 was visible on the toilet in the bathroom through the curtain.

An observation of Resident #29 on 06/28/17 at 8:50 am revealed her sitting up on the side of the bed with her hair up in a wrap, eating her breakfast.

An interview with Resident #29 on 06/29/17 at 7:55 am revealed her lying in bed with the head of the bed elevated and stated she was not feeling well this morning. Resident #29 stated there had been a curtain over the bathroom door since she had been in the room. She stated she did not like to go to the bathroom when someone was in the room but stated if she had to go she had no choice but to go to the bathroom with visitors or staff in the room. Resident #29 stated she would rather have a door to the bathroom than a curtain because the curtain did not provide any privacy

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F 241	Continued From page 20 while in the bathroom. An interview with the Director of Nursing (DON) on 06/30/17 at 2:54 pm revealed she was aware there were rooms in the building with curtains over the doorway to the bathroom instead of doors. She stated that she thought Resident #29 was care planned for the curtain instead of a door to the bathroom but the Maintenance Director would know more about the curtain. An interview with the Maintenance Director and Administrator on 06/30/17 at 3:43 pm revealed the Maintenance Director was aware of the curtain over the bathroom door and stated they had provided the curtain to allow more room for all the residents in the room to move freely to and from the bathroom. The Maintenance Director also stated it made it easier for the residents in the room to get in and out of the bathroom in their wheelchairs. He stated putting a door on the bathroom would reduce the amount of room that the 3rd bed resident had and would not allow her to maneuver on one side of her bed in her wheelchair. He stated he would put a door back on the bathroom but doing so may result in only being able to have 2 instead of 3 residents in the room. The Maintenance Director stated that he was not aware Resident #29 was not comfortable going to the bathroom with just a curtain over the door.	F 241		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination	F 278		8/15/17

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F 278	Continued From page 21 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 1 of 2 residents reviewed for diagnoses (Resident #135) related to Preadmission Screening and Resident Review Level II status. Findings included:	F 278	Corrections were submitted to reflect the diagnosis of anxiety and depression for resident #135 most recent two previous comprehensive data sets (MDS). All residents with anxiety diagnosis were reviewed by the MDS Coordinator to assure the MDS indicated the diagnosis on the current MDS.	

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F 278	Continued From page 22 Resident #135 was admitted to the facility on 01/18/17 with a Level II Preadmission Screening and Resident Review (PASRR) determination. The Nurse Practitioner's notes dated 01/20/17 specified the resident's diagnoses included anxiety and depression. The comprehensive admission Minimum Data Set (MDS) dated 01/25/17 specified the resident's PASRR status and that she had received antidepressant and antianxiety medication during the assessment period, but it did not include anxiety and depression among the listed diagnoses. The quarterly MDS dated 04/24/17, included depression but did not include the diagnosis of anxiety even though she had received antianxiety medication 4 of the 7 days of the assessment period. On 06/30/17 at 2:56 PM an interview was conducted with MDS Coordinators #1 and #2. MDS Coordinator #2 stated she had coded the section for Active Diagnoses on Resident #135's assessments. MDS Coordinator #2 stated she usually reviewed all sections of the clinical record for diagnoses but had overlooked the Nurse Practitioner's note on 01/20/17. The MDS Coordinator stated she would submit a correction for the error of the missed diagnoses on the two assessments. During an interview on 06/30/17 at 4:26 PM, the Director of Nursing (DON) stated it was her expectation that Resident #135's assessments would have been accurately coded to reflect active diagnoses.	F 278	The Director of Nursing re-educated both MDS coordinators on accurate MDS coding to include all relevant diagnosis. Director of Nursing, MDS Coordinators, Assistant Director of Nursing, Designee will audit five (5) completed MDS weekly for twelve (12) weeks to assure accuracy of coding to include active diagnosis. The results will be presented by the Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 281	Continued From page 23	F 281		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, nurse practitioner, consultant pharmacist, and staff interviews the facility failed to transcribe a physician order as written into the electronic medical record for 1 of 5 residents sampled for unnecessary medications (Resident #79). The findings included: Resident #79 was admitted to the facility on 07/01/13. Resident #79's diagnoses included dementia, anxiety, cognitive communication deficit, diabetes mellitus and others. Review of Resident #79's most recent quarterly minimum data set (MDS) dated 04/01/17 revealed that she was severely cognitively impaired for daily decision making. The MDS further revealed that Resident #79 required extensive assistance with activities of daily living and received 3 days of antianxiety medication during the reference period. Review of physician order dated 04/11/17 read in part, discontinue Ativan (antianxiety medication) 0.5 milligrams (mg). Ativan 0.5 mg give ½ tab (0.25 mg) by mouth every other day as needed	F 281	On June 30, 2017 the nurse practitioner discontinued all orders for Ativan on resident #79. The Director of Nursing re-educated the Unit Manager on processing physician orders completely and with accuracy. The Director of Nursing, Staff Development re-educated licensed nurses on processing physician orders. Director of Nursing, Assistant Director of Nursing, Unit Managers will audit ten(10)resident records weekly to assure physician orders are processed correctly. The results will be presented by the Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	8/15/17

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for anxiety. Signed by the Nurse Practitioner (NP) and was signed off by the Unit Coordinator (UC).

Review of the Medication Administration Record (MAR) dated 04/01/17 through 04/30/17 revealed that Ativan 0.5 mg by mouth had been discontinued on 04/11/17. No other Ativan order was noted on the MAR.

Review of the MAR dated 05/01/17 through 05/31/17 revealed no order for Ativan.

Review of the MAR dated 06/01/17 through 06/30/17 revealed no order for Ativan.

An interview was conducted on 06/30/17 at 10:39 AM with the NP. The NP stated that Resident #79 had been very stable and not required any "as needed" antianxiety medication and had no side effects from the transcription error. She added that Resident #79 was also followed by psychiatric services and was seen on 06/20/17 with no recommendations noted. The NP stated that if Resident #79 would have required anything "as needed" for anxiety the staff would have contacted her for an order.

An interview was conducted with the Director of Nursing (DON) on 06/30/17 at 10:45 AM. The DON stated that the order for Ativan 0.25 mg by mouth every other day as needed for anxiety should have been transcribed into the electronic medical record. She explained that since she came to the facility in May 2017 the UC rounded with doctors and processed the orders obtained. Then the next morning the facility would print out the order listing report and double check the orders obtained in the previous 24 hour period. The DON stated that they have caught

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F 281	Continued From page 25 transcription errors before they reached the residents by doing it this way. An interview was conducted with the UC on 06/30/17 at 10:50 AM. The UC stated that she could not recall this specific order but was aware the NP had been working on dose reduction for Resident #79. The UC stated to the best of her recollection she got called away from the desk and just missed entering the Ativan 0.25 mg order into the electronic medical record. An interview with the Consultant Pharmacist was conducted on 06/30/17 at 3:06 PM. He stated that he was filling in at the building in April and May of 2017 and he did not recall Resident #79 at all. The consultant pharmacist stated that when he reviewed charts he was looking for any drug interactions, unnecessary medications, documentation issues etc. He added that for new admissions he verified the orders to the medical record to make sure they were correct. The consultant pharmacist added that a lot of times the orders were not present in the medical record because the staff directly entered them into the electronic medical record so it was possible that he would not have caught this error if the order was not present in the medical record.	F 281		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		8/15/17

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F 309	Continued From page 26 well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and nurse practitioner interviews, the facility failed to assess a resident for pain, administer pain medication as ordered by the physician and as requested by the resident for pain control for 1 of 5 residents reviewed for medication administration. (Resident #141) The findings included:	F 309	On June 30, 2017, resident #141 was assessed by the Nurse Practitioner and pain medications were adjusted. On July 5, 2017, resident #141's pain care plan was updated by MDS coordinator. On July 26, 2017, Director of Nursing completed an update pain assessment on resident #141. MDS Coordinator will review residents with care area assessment (CAA)for pain and update	

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F 309	Continued From page 27 Resident #141 was admitted to the facility on 03/13/17 with diagnoses that included atrial fibrillation, hypertension, diabetes mellitus and arthritis. A review of Resident # 141's physician orders revealed an order for Oxycodone 20 milligrams (mg) by mouth every 4 hours as needed (prn) for pain. The original date of the order was 03/16/17. The admission Minimum Data Set (MDS) dated 03/23/17 revealed that Resident #141 had intact cognition. The MDS also revealed that Resident #141 had no behaviors, was always continent of urine and stool and received scheduled and prn (as needed) pain medication for occasional pain at a level of 6 out of a scale of 1-10. The Care Area Assessment (CAA) dated 03/27/17 for Resident #141 did not trigger for pain at the time of the admission assessment and there was no care plan for pain. An observation of Resident #141 on 06/27/17 at 11:11 am revealed he was sitting in his wheelchair and watching TV. He was dressed neatly and rubbing his knees and complained of pain due to arthritis at a level 7 out of 10. The resident stated his pain medication was not lasting until the next dose. Resident #141 stated that he was going to tell the nurse when she brought his next dose of pain medication. An interview with Resident #141 on 06/27/17 at 11:32 am revealed he had waited last night for approximately 1 hour and 45 minutes for pain medication for pain at a level of 7. He stated he put his call light on some time around 4:30 pm to 5:00 pm (could not remember exact time) and the	F 309	care plans. Director of Nursing, Staff Development Coordinator re-educated licensed nurses and certified medication aides on pain, pain management and administering routine and as needed(prn) pain mediations as ordered. The education included the importance of maintaining consistent pain control rather than attempting to get pain under control. The use of as needed (prn) medications for breakthrough pain and notifying the physician of uncontrolled pain was also included in the education. Education was provided on care planning residents need for pain management. Director of Nursing, Assistant Director Nursing, Unit Manager, Designee will audit five(5)residents weekly for twelve(12) weeks to assure pain was assessed and medication was administered as requested following physician orders. The results will be presented by the Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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nurse aide (NA) came in (could not remember who came in) and he told her he needed something for pain. The resident stated the NA came back into his room and told him that she had told the medication aide. Resident #141 stated it was after 6:00 pm before Certified Medication Aide #1 (CMA) brought his pain medication to him and by that time his pain level was at a 9 out of 10. Resident #141 stated CMA #1 told him no one told her he needed something for pain.

A review of the June Medication Administration Record (MAR) revealed Resident #141 received Oxycodone 20 milligrams (mg) by mouth on 06/26/17 at 6:23 pm but could have received his medication as early as 5:03 pm according to the MAR.

A review of a nursing progress note dated 06/26/17 at 6:21 pm revealed Nurse #4 had assessed Resident #141 for pain at a level of 7 out of 10. A review of a nursing progress note on 06/27/17 at 6:23 pm revealed Resident #141 was given his pain medication by CMA #1 at 6:23 pm.

An interview with nurse aides #11 and #12 on 06/27/17 at 6:08 pm revealed they did not remember answering his call light last evening (06/26/17 around 4:30 to 5:00 pm) when he requested pain medication. They both stated they knew he had asked for it because they saw CMA #1 bring it to him.

An interview with CMA #1 on 06/27/17 at 6:20 pm revealed she had not been told by any of the NAs that Resident #141 had requested pain medication last evening. She stated she and Nurse #4 had been on another hall working with a

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resident and then she went to Resident #141's hall to give medications. CMA #1 stated she went into Resident #141's room and asked if he wanted something for pain with his afternoon meds and stated Resident #141 said, "Did they not tell you I wanted something for pain? I asked for something an hour and a half ago." CMA #1 stated she told Resident #141 no one had told her he had requested something for pain but she would get it and give it to him. CMA #1 stated after a while Resident #141 came out of his room and apologized for being short with her about his pain medication. CMA #1 stated she understood his frustration and did not like for anyone to be in pain.

An interview with the NA who was assigned to care for Resident #141 during first shift, NA #13, on 06/28/17 at 2:20 pm revealed Resident #141 had not asked her about pain medication on 06/26/17 during first shift. She stated if he had asked her for pain medication she would have told the medication aide.

An interview with the Nurse Practitioner (NP) on 06/30/17 revealed the resident had refused an order for longer acting morphine and stated that he wanted to remain on Oxycodone. The NP stated she was going to try him on Oxycontin ER (extended release) 20 mg twice daily and continue him on Oxycodone 20 mg every 4-6 hours as needed (prn) for breakthrough pain. The NP stated that she was not sure if this would work but they were going to try it at least for a few days to see if Resident #141 would get better pain relief.

An interview with the Director of Nursing on 06/30/17 at 2:54 pm revealed her expectation

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F 309	Continued From page 30 was for all residents to receive pain medication as needed and ordered to relieve their pain.	F 309		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to keep a residents' fingernails cleaned and trimmed for 3 of 6 dependent residents (Resident #s 84, 45 and #135). The findings included: 1. Resident #84 was admitted to the facility 03/18/17 diagnosed with a rectal fistula, colostomy, dementia without behavioral disturbances, anxiety and others. The most recent quarterly minimum Data Set (MDS) dated 06/21/17 specified the resident had short and long term memory impairment, did not reject care but had behaviors not directed towards others 1 to 3 days such as hitting, scratching or rummaging. The MDS also specified the resident required extensive 2 person assistance with activities of daily living (ADL) and person hygiene. A care plan updated on 04/07/17 was developed for Resident #84 to meet the resident' s ADL needs. An intervention specified staff were to	F 312	On June 29, 2017, Director of Nursing validated that resident #84's fingernails were cleaned and trimmed. On June 28, 2017, the Director of Nursing validated resident #45's fingernails were cleaned and trimmed by the Certified Medication Aide. On June 30, 2017, the Assistant Director of Nursing soaked, cleaned and filed resident #135's fingernails. On July 6, 2017 resident #135 fingernails were trimmed by the Podiatrist. All residents nails were reviewed by the Director of Nursing , Assistant Director of Nursing, Unit Manager on July 5, 2017 and nail care provided as indicated. Director of Nursing, Staff Development Coordinator provided education to resident care specialist on bathing/showering and routine nail care during the bath and as needed for debris under the nails. The Director of Nursing, Assistant Director of Nursing, Designee will audit ten(10)residents weekly for twelve(12)	8/15/17

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F 312	Continued From page 31 provide assistance as needed for completion of ADL. On 06/26/17 at 4:12 PM an observation of Resident #84 was made of her sitting in her wheelchair in the hallway. During the observation, Resident #84 was licking her right middle finger. Closer observations revealed the resident's fingernails were trim but had black debris underneath the nails on both hands. Review of the shower schedule revealed Resident #84 was assigned showers on Tuesday and Fridays during the evening shift. On 06/29/17 at 11:51 AM observations were made of Resident #84's right fingernails. Her fingernails had black debris underneath the nails. On 06/29/17 at 12:51 PM nurse aide (NA) #2 was interviewed and stated Resident #84 required two staff for assistance with personal hygiene and they had not had time to clean the Resident's fingernails yet that day during the shift. The NA explained that fingernails were typically trimmed and cleaned on shower days but also as needed. NA #2 also explained that Resident #84 often "played" in her colostomy bag due to dementia and needed frequent nail care. The agency nurse aide assigned to give Resident #84 a shower on 06/27/17 was unable to be reached for an interview. Review of documentation revealed the agency	F 312	weeks to validate fingernails are trimmed. The results will be presented by the Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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nurse aide initialed she had given Resident #84 a shower on 06/27/17 during the evening shift.

On 06/29/17 at 11:10 AM the Director of Nursing (DON) was interviewed and reported that fingernails were scheduled to be trimmed and cleaned by nurse aides on shower days but she expected staff to attend to nails care as often as needed.

On 06/30/17 at 9:07 AM observations were made of Resident #84 in the hallway. Her fingernails had black debris under the nails.

2. Resident #45 was admitted to the facility on 12/08/13 with diagnoses that included cerebral vascular accident, convulsions, anxiety, muscle wasting and dementia with aggressive behaviors, among others. The most recent quarterly Minimum Data Set (MDS) dated 04/20/17 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making and the resident had physical behaviors directed towards others 1 to 3 days that included hitting or kicking. The MDS also specified the resident required two person assistance with activities of daily living (ADL) and was dependent on staff for personal hygiene. The resident had impaired range of motion on one side of his upper and lower body.

A care plan updated on 04/27/17 for Resident #45 addressed his self-care deficit and identified the resident was totally dependent on staff for

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personal hygiene.

On 06/28/17 at 9:52 AM observations were made of Resident #45's hands with the Occupational Therapist (OT). The OT demonstrated Resident #45's fingers to his right hand were able to open from a clinched position. When the Resident's fingers were extended, the fingernails were noted to be at least ¼ inch past the fingertip. The left hand was observed and the nails were also noted to be at least ¼ inch in length past the finger tip. The OT also observed the fingernails and reported they were longer than they should be. Observations made with the OT of the Resident's palm revealed the skin was dry and intact.

On 06/28/17 at 9:55 AM nurse aide (NA) #3 was interviewed and reported she was assigned to Resident #45. The NA explained that it took two staff to provide care. The NA also stated the resident at times could be combative. NA #3 reported nails were trimmed on shower days and as needed. NA #3 was unaware when the Resident's nails were last trimmed because he was showered on 2nd shift (3:00 PM to 11:00 PM.) The NA also stated she had not observed Resident #45's fingernails yet that day.

On 06/28/17 at 10:03 AM the Director of Nursing (DON) was interviewed and reported that nails were to be trimmed on shower days and as needed by nurse aides. She added that if a resident was resistive with care or refused care, the nurse aide was to notify the nurse. The DON provided the shower schedule for Resident #45 that revealed the resident was showered every

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Wednesday and Saturday on evening shift. The shower documentation for Resident #45 indicated he had received a shower on 06/24/17 and was next scheduled to be showered on 06/28/17 in the evening.

On 06/28/17 at 10:10 AM nurse aide (NA) #4 was interviewed and reported she was assigned to Resident #45 on 06/24/17 and had provided his shower, shaved him but had not been able to trim his nails. NA #4 explained that she saw the nails were "pretty bad" and intended to get assistance from another NA but failed to do so. She also stated she did not notify the nurse that she was unable to complete personal hygiene for Resident #45.

On 06/29/17 at 11:10 AM the DON was interviewed and stated NA #4 should have taken the time to trim Resident #45's nails when she became aware they were long.

3. Resident #135 was admitted to the facility on 01/18/17 with diagnoses including blindness, some paralysis, and a history of meningitis.

The quarterly Minimum Data Set (MDS) dated 04/24/17 indicated the resident required total assistance with personal hygiene. Rejection of care was not noted as a behavior and the resident was coded as cognitively intact.

The Care Plan, most recently updated on 04/24/17 specified Resident #135 required extensive to total assistance with activities of daily living (ADL).

Review of the shower schedule in the nurse aide

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(NA) notebook revealed Resident #135 was scheduled for showers on Wednesdays and Saturdays.

On 06/27/17 at 10:27 AM, Resident #135 was observed in her wheelchair in the dayroom area. The thumb and first two fingers of each hand revealed nails that were long and thick.

On Wednesday, 06/28/17 at 8:41 AM, Resident #135 was observed in bed. The thumb nail and nails of the first two fingers of each hand appeared to be thick and extended at least ¼ inch beyond the tip of each digit.

The resident was in the dining room on 06/29/17 at 8:42 AM, and a staff member was feeding her breakfast. The nails of Resident #135's fingers were in the same condition as the previous day.

Nursing Assistants (NAs) #2, #9 and #10 indicated the three of them were providing care for the residents on Resident #135's hall when they were interviewed on 06/29/17 at 9:42 AM. NA #2 said the residents on this hall required a lot of care and because of staffing, the NAs didn't have much time to do extras like nails and shaving. NA #10 indicated they tried to get as many as possible done but that nail care should be done on bath days.

On 06/30/17 at 9:20 AM, Resident #135 was asked about the condition of her nails. The resident stated she would like her nails trimmed but since coming here in January, her family member was the only one who had trimmed her nails.

During an interview on 06/30/17 at 9:25 AM, the

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F 312	Continued From page 36 Assistant Director of Nursing said nail care was supposed to be done on shower day. She was aware Resident #135 had a shower on 06/29/17 but didn't know why the resident's nails were so long and had not been trimmed. On 06/30 at 9:42 AM, the Director of Nursing (DON) observed Resident #135's fingernails and estimated that longer fingernails were 1/4 to 1/2 inch beyond the tip of the resident's fingers. The DON said it was her expectation that nail care would be provided on the shower days. The DON said the nursing assistants "should attempt to cut or file them and if they can't, due to the thickness [of the nail], they should tell the nurse."	F 312		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		8/15/17

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F 329	Continued From page 37 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and Physician interviews, the facility failed to complete laboratory tests for medication management per the Physician's orders for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #45). The findings included: Review of the medical record revealed Resident #45 was admitted on 12/08/13 with diagnoses including dementia with psychotic features. Review of the medical record revealed a Physician's order dated 07/23/16 for a Comprehensive Metabolic Profile (CMP) and a Complete Blood Count (CBC) to be completed every three months in January, April, July, and October. Continued review of the medical record revealed there was no Physician's order written to	F 329	On 6/30/17, the physician was made aware of missing labs on resident #45 with no additional orders given. Unit Managers conducted a facility wide audit to assure labs were scheduled as ordered. The audit included comparing the physician orders with the orders entered into the lab computer for accuracy. Director of Nursing educated licensed nurses on lab orders and lab scheduling. Director of Nursing, Assistant Director of Nursing, Unit Managers, Designee will audit ten(10) resident records weekly for twelve (12) weeks to assure labs are obtained as ordered.	

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F 329	Continued From page 38 discontinue the quarterly laboratory tests. Review of Resident #45's laboratory test results revealed there were no results for the April 2017 CMP or CBC located in the medical record. An interview with the Assistant Director of Nursing (ADON) on 06/29/17 at 4:27 PM revealed she was not able to locate the results of Resident #45's April 2017 CMP and CBC. The ADON stated she had called the hospital and they did not have the results either. During an interview on 06/29/17 at 4:35 PM the Director of Nursing (DON) stated the unit manager usually entered laboratory test orders into the computer as a Physicians order and also sends the order through the computer directly to the laboratory. The DON explained the phlebotomist came to the facility on designated days with the list of residents and what laboratory tests needed to be obtained. The DON reviewed Resident #45's Physician's orders in the computer system and stated it appeared the staff member who entered the order for the CMP and CBC on 07/23/16 did not enter enough occurrences which resulted in the laboratory tests not being obtained in April of 2017. The interview further revealed the DON expected the facility to follow the Physician's orders for laboratory tests. An interview was conducted with the Physician on 06/30/17 at 9:39 AM. The Physician stated Resident #45 had quarterly monitoring labs ordered for medication management due to the use of antipsychotic medications and he expected monitoring laboratory tests to be completed as ordered. The Physician noted there was no negative outcome to Resident #45 due to the	F 329	The results will be presented by the Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 329	Continued From page 39 April 2017 CMP and CBC not being completed.	F 329		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		8/15/17

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F 353	Continued From page 40 (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to have sufficient quantity of staff to ensure a dependent resident was provided incontinent care (Resident #47) and dependent residents received nail care (Resident #84, #45, and #135) for 4 of 4 sampled residents. The findings included: 1. Cross reference F-224: Based on observations, record reviews, and staff interviews the facility neglected to answer a call light and provide incontinent care for 1 of 2 sampled residents (Resident #47). 2. Cross reference F-312: Based on observation, staff interviews and reviews the facility failed to keep a residents fingernails cleaned and trimmed for 3 of 6 dependent residents (Resident #'s 84, 45, and 135). An interview was conducted with the Staffing	F 353	See (F224 and F312) Director of Nursing met with resident #47 and a toileting pattern was identified. Nursing staff was educated on meeting resident's toileting needs in a timely manner. On June 28, 2017 the Director of Nursing validated that resident #45's fingernails were cleaned and trimmed. On June 29, 2017, the Director of Nursing validated that resident #384's fingernails were cleaned and trimmed. On June 30, 2017, the Director of Nursing validated that resident #135 fingernails were soaked, cleaned and filed. Director of Nursing validated that resident #135 fingernails were trimmed by the Podiatrist on July 6, 2017. The Director of Nursing implemented a different shower sheet for nurse aides to sign which included fingernail care. The Director of Nursing, Assistant Director of Nursing educated the nurse assistants	

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F 353	Continued From page 41 Coordinator (SC) on 06/27/17 at 5:23 PM. The SC stated she had been in her role for 2 months and when she started in the role the facility was under interim administration. She explained that when she started in her role the facility was overstaffed. She added that when the current Administration started the census started to drop and the facility had to scale back on the number of staff on a daily basis. The SC stated that generally the facility staffed 2 nurses and 4 medication aides for the entire building and each hall had 2 nursing assistants (NAs). She added that the residents on 200 hall required the most assistance with care due to the number of total care patients that required a 2-person assist. The SC stated that the 200 hall really did need 3 NAs, but that she was instructed to keep 2 NAs on each hall by administration. She added that the Restorative Aides did help out when needed and the facility used agency staff when they needed too. The SC stated that this week she was instructed to have 3 NAs on the 200 hall because of the recertification survey taking place. An interview with NA #7 was conducted on 06/28/17 at 2:32 PM. NA #7 confirmed that she routinely worked the 200 hall. NA #7 stated that the 200 hall was "very heavy" with total care residents that required 2 person assist and it was very difficult to get everything done with only 2 NAs. She added that with 2 NAs on the hall, call bell response time was slower and sometimes residents waited up to an hour for care. An interview with NA #2 was conducted on 06/29/17 at 12:35 PM. NA #2 confirmed that she routinely worked on the 200 hall on first shift. She added that occasionally the facility placed 3 NAs on the 200 hall but generally there were only 2,	F 353	and licensed nurses on the shower form. The Director of Nursing implemented audit tools to validate compliance with fingernail care for all residents. The Director of Nursing, Assistant Director of Nursing, Unit Manager will audit and determine the acuity of resident care needs on each hall to assure staffing is appropriate to manage resident care. The Administrator and Director of Nursing will review the schedule daily with Scheduling Clerk. The Administrator, Director of Nursing, Scheduling Clerk will validate there is appropriate staffing based on resident acuity to assure resident care needs are met. Facility currently contracted with two (2) agencies to assist with staffing opportunities. The facility continues to advertise, recruit and hire staff. The results will be presented by the Administrator and Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 353	Continued From page 42	F 353		

and at meal time one of the NAs had to go to the dining room which left 1 NA on the hall. NA #2 stated that when there were 2 NAs on the hallway they had to concentrate on providing personal care and let the other things go like nail care/shaving. NA #2 state that when there were only 2 NAs on the hallway the call bell response time was greatly increased to greater than 30 minutes. She also stated that had discussed their concerns with the Administrator and he told them he would discuss it with the SC.

An interview was conducted with the Administrator on 06/30/17 at 1:49 PM. The Administrator stated he came to the facility on 05/09/17 and he knew he was facing some challenges and one of those was staffing. He stated that when he came to the facility a staffing agency was being used and his goal was to eventually be agency-free. The Administrator stated that he had been hiring and training new staff. He added that he felt the building was adequately staffed, if not over staffed. He explained that staffing was a daily decision based on census and patient acuity. The Administrator stated that at times they would have 2 NAs on the halls and sometimes there would be 3 NAs on the halls, but again it was a decision that was made daily. The Administrator also stated that staff had come to him and expressed concerns about staffing and that he and the Director of Nursing (DON) reviewed the hallway census and patients that resided on the halls. He added that department heads passed trays and that he had offered staff the chance to move assignments and they refused. The Administrator stated that he expected all staff to answer call lights and assist the resident if they are able to. Call lights were expected to be answered in a reasonable

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F 353	Continued From page 43 time frame and waiting an hour for care was unacceptable to him.	F 353		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to serve lunch trays under sanitary conditions for 1 of 2 lunch observations. A staff member was observed to place a dirty breakfast tray on the lunch cart and serve 3 lunch trays before the Administrator noted the dirty breakfast tray and had the unserved lunch trays re-plated.	F 371	Education was provided to Nursing Assistant #6 on the procedure for removal of soiled resident trays on July 27, 2017 by Administrator. The Dietary Manager on 6/26/17 obtained fresh food trays for two residents whose trays were on the cart with the soiled trays.	8/15/17

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F 371	Continued From page 44 The findings included: An observation of Nursing Assistant (NA) #6 was made on 06/26/17 at 12:50 PM. NA #6 was observed to walk out of room 314 and place a dirty breakfast tray on the bottom of the lunch cart that had just arrived to the unit. The Administrator and NA #6 were observed to serve lunch tray to Rooms 311, 312, and 313. The Administrator then observed the dirty breakfast tray on the lunch cart and asked the Dietary Manager (DM) to replace the remaining 2 lunch trays with new ones. An observation of the DM was made on 06/26/17 at 1:00 PM. The DM was observed to bring the remaining 2 lunch trays from the kitchen back to hall and were then served to the residents. An interview was conducted with the DM on 06/28/17 at 5:45 PM. The DM stated that NA #6 should have immediately brought the dirty breakfast tray to the kitchen. She added that when the dirty breakfast tray got placed on the lunch tray then the entire cart of lunch trays should have been brought back to the kitchen and replaced with new ones. The DM stated that the staff was aware that dirty plates are never supposed to be mixed with clean ones. An interview with the Administrator was conducted on 06/29/17 at 9:06 AM. The Administrator stated that during the lunch delivery on 06/26/17 he noted that there was a dirty tray on the bottom of the lunch cart and I immediately took the cart to the kitchen and asked the DM to make new ones, which she did. The Administrator added that NA #6 should have taken the dirty breakfast tray to the dietary department and then	F 371	The Dietary Manager in-serviced /re-educated staff that dirty trays do not go on the clean food tray carts when passing out trays in the hallways. All dirty trays are to go to the kitchen or put on the dirty tray cart. The Dietary Manager, Designee will randomly audit all hallways on different meal times three(3) times a week for four (4) weeks then two (2) times every other week for two (2) months to ensure continued compliance. The results will be presented by the Dietary Manager monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 371	Continued From page 45 washed her hands and then continue to pass out lunch trays but should not mix clean trays with dirty trays. An interview with NA #6 was conducted on 06/29/17 at 10:10 AM. She stated that the breakfast tray in room 314 did not get picked up with the other breakfast trays. She added that she should have taken the tray to the kitchen and not put the dirty tray on the clean lunch cart.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		8/15/17

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F 431	Continued From page 46 (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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a medication when left unattended at the nurses' station for 1 of 1 nurses' station and failed to remove an expired medication stored for use in 1 of 1 medication room. The findings included: 1. On 06/28/17 at 8:54 AM an observation was made of the nurses' station. The nurses' station	F 431	The Unit Manager removed the medication from the nurse's station and the expired medication was removed from the stock area on June 30, 2017. The Director of Nursing, Assistant of Director of Nursing, Unit Manager conducted a complete check of the medication room for expired medications. The Director of Nursing, Staff Development Coordinator re-educated licensed nurses and certified medication	

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F 431	Continued From page 47 was unattended. On the desk of the nurses' station was a prescription medication for liquid Augmentin (antibiotic). The bottle of medication was unsecured and unattended. Residents were seated in wheelchairs near the nurses' station during the observation. On 06/28/17 at 8:59 AM the Unit Coordinator approached the nurses' station and was interviewed about the unattended medication. The Unit Manager reported she didn't know where the bottle of prescribed medication came from and wasn't sure why it was at the nurses' station. The Unit Manager took the bottle of medication and stated it should not have been left unattended at the nurses' station. On 06/29/17 at 11:11 AM the Director of Nursing (DON) was interviewed and reported that all bottles of prescribed medication should be kept secured in either a medication cart or medication room when not in use. The DON stated that the bottle of medication belonged to a discharged resident and when she arrived to work that morning she noted the night nurse was at the nurses' station with the medication, making arrangements to return it to the pharmacy. The DON added the nurse must have left the bottle at the nurses' station. The DON stated the bottle of medication should have been secured before leaving it unattended at the nurses' station. The night nurse was unable to be reached for an interview. 2. Observations of the medication storage room	F 431	aides on medication storage. The education include monitoring mediations at all times. Medications should be supervised, locked in the medication room or secured in the medication carts at all times. Director of Nursing, Assistant Director of Nursing, Unit Manager, Designee will audit the nurse station five(5)times weekly for twelve(12)weeks to assure medications are stored properly. Director of Nursing, Staff Development re-educated the licensed nurses and certified medication aides on checking expiration dates on medications, removing expired medications and returning them to the pharmacy. Director of Nursing, Assistant Director of Nursing, Unit Manager, Designee will audit the medication room three (3) times weekly for twelve(12)weeks to assure compliance. The results will be presented by the Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 431	Continued From page 48 on 06/29/17 at 3:05 PM revealed an unopened bottle of Zinc Sulfate 220 mg (milligram) tablets available for use. The label indicated there were 100 tablets and the expiration date was 09/2016 An interview was conducted with the Director of Nursing (DON) on 06/29/17 at 3:09 PM. The DON stated either she or the Assistant DON or the Unit Manager checked the medication storage room for expired medications weekly but did not document this monitoring. The DON explained she had checked the medication storage room for expired medications on 06/27/17 and could not explain how the expired Zinc Sulfate tablets were in the stock medication cabinet available for resident use. The DON stated it must have been an oversight on her part.	F 431		
F 469 SS=E	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure that all fly reduction measures were effective to prevent fly activity for 2 of 2 residents (Resident # 39 and Resident # 83) and in 1 of 1 dining rooms. The findings included: 1a. Resident #39 was admitted to the facility on 02/25/16. His diagnoses included chronic obstructive pulmonary disease, heart failure, diabetes mellitus, hyperlipidemia and others. Review of most recent quarterly minimum data	F 469	Resident #39 and #83 have been monitored and observed with no fly activity in their rooms. Resident #18 has been monitored and observed by the Administrator in the dining room with no fly activity. The Maintenance Director will install five(5)fly light units which will be installed at each end of the four hallways and one in the from lobby. The pest control company has installed traps for outside fly activity and will continue to monitor and treat monthly or as needed. The	8/15/17

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	345080	A. BUILDING _____ B. WING _____	C 06/30/2017

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F 469	Continued From page 49 set (MDS) dated 05/19/17 revealed that Resident #39 was cognitively intact and required extensive assistance with activities of daily living. An observation and interview was conducted with Resident #39 on 06/26/17 at 12:05 PM. He was observed to be swatting flies away from his facial area throughout the interview. He stated "this time of year is bad for flies. They just won't leave me alone." b. Resident # 83 was admitted to the facility on 03/17/17. His diagnoses included end stage renal disease, hypertension, diabetes mellitus, left below knee amputation and others. Review of Resident #83's most recent quarterly minimum data set (MDS) dated 05/11/17 revealed that Resident #83 was cognitively intact and required extensive assistance with activities of daily living. An observation and interview was conducted with Resident #83 on 06/29/17 at 3:41 PM. Resident #83 was up in his wheelchair in his room. There was 2 flies buzzing around him and as he propelled himself out into the hallway the flies stayed with him. Resident #83 continued to swat the flies and stated "goodness look at those flies, I am not sure why they seem to like me." c. An observation of the main dining room on 06/27/17 at 9:40 AM revealed a fly buzzing around Resident #18 who was sitting at the table. Resident #18 was observe to swat the fly in an attempt to keep the fly off of him. The fly light in the dining room was noted to be on at the time. An interview was conducted with the Director of	F 469	Maintenance Director will in-service staff to close the entrance doors promptly when they enter and exit the facility. The Maintenance Director will audit that all fly light units are properly working weekly for three(3)months, then monthly for one year. The Maintenance Director will randomly audit main dining rooms and all hallways and residents rooms for fly activity three(3) times a week for four(4) weeks then two(2) times every week for two(2) months to ensure continued compliance. The results will be presented by the Administrator and Maintenance Director monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 469	Continued From page 50	F 469		

Maintenance (DOM) on 06/29/17 at 3:43 PM. He stated that he had seen an increase in fly activity this week, which was not unusual for the time of the year. The DOM stated that this time of year there was more traffic in and out of the building and that contributed to the increase in fly activity. He added that at the end of winter he turned the facilities fly fans on, which were located on the service hall and on the exit door of the dining room. The DOM stated that the front door of the facility did not have a fly fan. He added that the dining room and service hall also had fly lights that helped control fly activity in those areas. The DOM stated that last year he had provided a fly swat for Resident #39's room. The DOM further stated that the pest control company was coming this afternoon for routine maintenance and he would notify them of the increase in fly activity and see what they recommended

Review of receipt from Pest Control Company dated 06/29/17 read in part, technician recommendations: "sending information for 4 fly light units at the end of each hall and traps for outside."

An interview was conducted with the Administrator on 06/30/17 at 2:25 PM. The administrator stated he was not aware that flies were a problem in the facility. He added that when he came to the facility a couple of months ago there was open trash can on the front porch and he had that changed out to a self-shutting trash can and that has helped with the fly activity. The administrator added that there was 2 fly fans and 2 fly lights in the facility and he had not seen any flies. He added that whatever the pest control company recommended that they would purchase and install.

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F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520		8/15/17

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F 520	Continued From page 52 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in July 2016 and March 2017. This was for 4 recited deficiencies originally cited in July 2016 on an annual recertification survey and 2 recited deficiencies originally cited in March 2017 on a complaint investigation. The deficiencies were in the areas of dignity, MDS accuracy, assistance with activities of daily living, sufficient staffing, kitchen sanitation and drug storage. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee. (Resident #s 135, 84, 45, 41, 47). Cross refer to: F 241: Based on observations, resident and staff interviews and record review the facility failed to treat a resident in a dignified manner when a resident and staff member engaged in a verbal altercation that involved the use of profanity for 1 of 4 sampled residents (Resident #41). The facility was cited for F 241 in March 2017 for leaving a resident in a soiled brief.	F 520	The Area Staff Development Coordinator re-educated the Administrator and Management staff on implementing and maintaining an effective Quality Assurance and Performance Improvement(QAPI) Committee. The committee uses the Plan, Do, Study, Act method for QAPI, including scheduling, identification of trends or patterns, submission of data and initiation of quality improvement plans related to identified areas of opportunity. The Quality Assurance Committee consists of: Administrator Director of Nursing Dietary Manager Rehabilitation Manager Maintenance of Environmental Representative Activities Director Social Services Director Human Resource Designee Business Office Director Resident Care Management Pharmacist Consultant Director Medical Director	

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F 520	Continued From page 53 F 278: Based on record review and staff interviews the facility failed to accurately code 1 of 2 residents reviewed for diagnoses (Resident #135) related to Preadmission Screening and Resident Review Level II screening. The facility was cited in July 2016 and March 2017 for inaccurate MDS assessments. F 312: Based on observations, staff interviews and record review the facility failed to keep dependent residents' fingernails clean and trimmed for 3 of 6 sampled residents (Resident #s 84, 45 and 135). The facility was cited for F 312 in July 2016 and March 2017 for failing to provide incontinent care, showers and bed baths. F 353: Based on observations, record review and resident and staff interviews the facility failed to have sufficient quantity of staff to ensure a dependent resident received incontinent care (Resident #47) and dependent residents received nail care (Resident #s 84, 45 and 135) for 4 of 4 sampled residents. The facility was cited for F 353 in March 2017 for failing to have adequate staff to meet the needs of residents. F 371: Based on observations and staff interviews the facility failed to serve lunch trays under sanitary conditions for 1 of 2 meal observations. A staff member was observed to	F 520	Infection Preventionist All repeated citations were reviewed, corrected and monitoring tools implemented to maintain compliance. (F241, F278, F312, F353, F371, F431 and F520) The results will be presented by the Administrator and Director of Nursing monthly for the three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 520	Continued From page 54	F 520		

place a dirty breakfast tray on the lunch cart and serve 3 lunch trays before the Administrator noted the dirty breakfast tray and had the unserved lunch trays re-plated.

The facility was cited for F 371 in July 2016 for rusty floors.

F 431: Based on observations and staff interviews the facility failed to secure a medication when left unattended at the nurses' station for 1 of 1 nurses' station and failed to remove an expired medication stored for use in 1 of 1 medication room.

The facility was cited F 431 in July 2016 for leaving a medication cart unlocked and unattended.

On 06/30/17 at 4:38 PM the Administrator and Director of Nursing (DON) were interviewed regarding the Quality Assurance Program (QA). The Administrator explained he and the DON were new in their roles as of May 2017. The Administrator reported he had reviewed the previous citations but believed the facility was in compliance with the Federal regulations.