STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272		8/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/01/2017

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F 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a care area assessment for behaviors which included underlying cause, risk factors, and factors to be considered in developing individualized care plan interventions for one of fifteen sampled residents (Resident #27) with comprehensive assessments. The findings included: Resident #27 was admitted to the facility 1/16/15 and last readmitted on 7/1/17. Cumulative diagnoses included: insomnia, depression, anxiety and unspecified mood disorder. An Annual Minimum Data Set (MDS) dated 6/27/17 indicated Resident #27 was moderately impaired in cognition. Mood-feeling down, depressed 7-11 days, trouble with sleep 7-11 days, feeling tired/ little energy 7-11 day and rejection of care occurred 1-3 days. Medications administered during the seven day look back period included 7 days of antianxiety and antidepressant medication and 6 days of hypnotic medication. A review of the Care Area Assessment (CAA) for behaviors dated 7/11/17 revealed the CAA was blank. There was no information regarding the underlying cause, risk factors factors to be	F 272	F272- Comprehensive Assessments 1.Corrective action will be accomplished for those residents found to have been affected by the deficient practice : a. The Care Area Assessment(CAA) for behaviors on resident #27 was completed by the MDS nurse on 7/12/17 with behaviors being updated and addressed as outlined in the RAI manual b. The MDs for resident # 27 was not due to be transmitted until 8/7/17 at which time it was done by the MDS nurse. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by: Any resident has the potential to be effected by the same practice. a. All previous comprehensive Minimum Data Sets (MDSs) dated back to 7/1/17 were reviewed by the Director of Nursing (DON) on 7/17/17 to ensure CAAs were completed. b. The audit revealed no CAAs found to be incomplete. c. All admission, annual, and significant change comprehensive MDSs completed by the MDS nurse will be audited by the DON on a QA form to ensure CAAs are	

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F 272	Continued From page 2 considered in developing individualized care plan interventions or if behaviors would be care planned. On 7/12/17 at 2:20 PM, an interview was conducted with the MDS nurse. She reviewed the CAA for behaviors and said she was responsible for the completion of the CAA for behaviors. She said she thought it had been completed and her expectation was for the CAA for behavior should have been completed. She did not know why it was blank. On 7/12/17 at 3:45 PM, an interview was conducted with the Director of Nursing. She said the MDS nurse was responsible for the completion of the CAA for behaviors and she expected the CAA for behaviors to be completed.	F 272	completed. 3. Measures put into place to ensure that the deficient practice will not occur are: a. Admission, annual, and significant change MDSs will be documented on a QA form to ensure CAAs are completed by the MDS nurse and will be audited weekly x I month, biweekly x 2 months, monthly x 6 months by the DON. 4. The facility will monitor its performance to make sure solutions are sustained by: a. QAs completed by the MDS nurse and DON audits will be reviewed in Monthly QA meeting b. The weekly reviews outlined above will be discussed monthly at the QA meeting. All QA results will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes to the QAs need to be done prior to the quarterly meeting	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request	F 280		8/10/17

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revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that

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F 280	Continued From page 4 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interviews, staff interviews and observations, the facility failed to update and revise the care plan interventions for 2 of 6 residents reviewed for decreased vision, care refusal, safety and fall prevention (Resident # 1) and the care plan in the area of falls and Restorative ambulation program (Resident # 30).	F 280	F280- Right to Participate Planning Care-Revise Care Plan 1.1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice : a. The MDS nurse updated the care plan on resident # 1 to include removal of night light, Hospice safety plan agreement,	

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F 280	Continued From page 5 The findings included: 1.a. Resident #1 was admitted to the facility on 06/06/2017 with diagnoses that included Congestive Heart Failure (CHF), Chronic Obstructive Respiratory Disease (COPD), Diabetes Mellitus Type 2 (DM2), anxiety, depression and Post Traumatic Stress Disorder (PTSD) and insomnia. An admission Minimum Data Set (MDS) dated 06/18/2017, revealed that Resident #1 was cognitively intact, able to see large print and wore corrective lenses. Resident # 1 rejected care for 1 to 3 days and required limited staff assist for transfers and toileting and supervision for walking. Resident # 1 had a fall prior to admission and wore oxygen and was admitted with a stage 2 pressure ulcer . A review of the comprehensive Care Area Assessment (CAA) dated 06/18/2017 revealed that Resident #1 wore glasses and could read the newspaper, watch television and feed himself while wearing eye glasses. A review of Resident # 1's care plans initiated on 06/26/2017 revealed that Resident # 1 had decreased vision and had to wear glasses with a goal to continue to enjoy watching television and reading through the next review with an intervention to leave a night light on at night. A review of a physician (MD) progress note dated 07/11/2017 revealed in part that Resident # 1 had eye glasses in place. An observation of Resident # 1 on 07/13/2017 at 7:12 AM revealed Resident #1 asleep in bed with	F 280	refusing meds and nebs, and for the need of plastic silverware. All unused interventions were taken off of the care plan The care plan for resident #30 was updated to reflect the removal of the intervention of hand held assistance from restorative for ambulation, and removal of wording (not cognitively able to call for help). b. Dietary Manager educated dietary staff on 7/13/17 on reading tray cards before serving, to ensure card reflects appropriate silverware is on tray. c. DON educated all nursing staff including weekend and PRN staff on 7/13/17 to check behind dietary in reading the tray card to ensure appropriate silverware is on tray. d. All new dietary and nursing employees will receive training in orientation on reading tray cards for accuracy. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by: Any resident has the potential to be effected by the same practice. a. Care plans were reviewed for all residents by the DON on 7/17/17 and found to be complete and accurate. b. All care plans will be audited by the DON weekly x I month, biweekly x 2 months, monthly x 6 months on a QA form to ensure that correct coding and care planning of assistive devices has been completed. a. All therapy discharges will be	

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F 280	Continued From page 6 no night light in use and no other lights on in the room of Resident #1. On 07/13/2017 at 7:45 AM an observation of Resident # 1 in the dining room revealed eye glasses in place. On 07/13/2017 an MD note revealed to use plastic utensils on trays. An interview was conducted on 07/13/2017 at 12:00 PM with the MDS Nurse revealed that Resident #1 had decreased vision ad wore eye glasses but that there was never a nightlight in the room but staff should have left the bathroom light on during the night. The MDS nurse revealed that the intervention of a night light should have been deleted. On 07/13/2017 at 3:18 PM an interview was conducted with the Director of Nurses (DON) and revealed it was her expectation that all care plan interventions be updated and meet resident specific needs to complete a clear picture of the specific resident care. Care plan interventions should be changed as needed to be appropriate for each resident. Care plan interventions that were not resident specific should be deleted. 1.b. Resident #1 was admitted to the facility on 06/06/2017 with diagnoses that included Congestive Heart Failure (CHF), Chronic Obstructive Respiratory Disease (COPD), Diabetes Mellitus Type 2 (DM2), anxiety, depression and Post Traumatic Stress Disorder (PTSD) and insomnia. An admission Minimum Data Set (MDS) dated 06/18/2017, revealed that Resident #1 was cognitively intact, able to see large print and wore	F 280	reviewed and initialed by the MDs nurse. This will be recorded on a QA form and audited by the DON weekly x I month, biweekly x 2 months, monthly x 6 months. b. The DON will be responsible for overseeing each resident□s restorative program for appropriate approaches. She will initial all restorative referrals upon receipt and will ensure that restorative programs are updated accordingly. She will record these changes and updates on a QA form and this will be audited by the Administrator for compliance weekly x I month, biweekly x 2 months, monthly x 6 months. 3. Measures put into place to ensure that the deficient practice will not occur are: a. All therapy discharges will be reviewed and initialed by the MDs nurse and the DON. This will be recorded on a QA form and audited by the Administrator weekly x I month, biweekly x 2 months, monthly x 6 months. b. The DON will be responsible for overseeing each resident□s restorative program for appropriate approaches. She will initial all restorative referrals upon receipt and will ensure that restorative programs are updated accordingly. She will record these changes and updates on a QA form and this will be audited by the Administrator for compliance weekly x I month, biweekly x 2 months, monthly x 6 months. 4. The facility will monitor its performance to make sure solutions are sustained by: a. 1oo % of all care plans will be	

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F 280	Continued From page 7 corrective lenses. Resident # 1 rejected care for 1 to 3 days and required limited staff assist for transfers and toileting and supervision for walking. Resident # 1 had a fall prior to admission and wore oxygen and was admitted with a stage 2 pressure ulcer. A review of the comprehensive Care Area Assessment (CAA) dated 06/18/2017 revealed that Resident #1 refused nebulizer treatments and medications at times. A review of Resident # 1's care plans initiated on 06/30 /2017 revealed that Resident # 1 had refused medications and treatment at times and required a psychiatric referral for thoughts of causing self - harm; the goal was that Resident # 1 would verbalize feelings of anger and frustration in an acceptable manner with an intervention to place plastic utensils on meal trays until further notice. An interview conducted with NA #2 on 07/13/2017 at 7:14 AM revealed that she was not aware that Resident # 1 needed plastic utensils and that the nurse would have reported to the NAs any use of plastic utensils. On 07/13/2017 at 7:45 AM an observation of Resident # 1 in the dining room revealed regular utensils in place, not plastic utensils as noted on the diet card for Resident # 1. On 07/13/2017 a review of a physician progress note dated 07/13/2017 revealed an MD note revealed to use plastic utensils on trays. An interview conducted with the MDS Nurse MDS Interview on07/13/2017 at 12:00PM revealed that Resident #1 should have plastic utensils in use	F 280	reviewed weekly x 1 month; 75% biweekly x 2 months; 50 % monthly x 6 months and 10 % each month after that ongoing. b. All QAs and audits will be reviewed in the monthly QA meeting. c. The QA reviews outlined above will be discussed monthly at the QA meeting. All QA results will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes to the QAs need to be done prior to the quarterly meeting	

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for all meals as care planned and that all staff should be aware of the intervention on the care plan because each nurse had access to the care plan through the electronic medical record and the care plan book.

On 07/13/2017 at 3:18 PM an interview was conducted with the DON and revealed it was her expectation that all care plan interventions be updated and meet resident specific needs to complete a clear picture of the specific resident care. Care plan interventions should be changed as needed to be appropriate for each resident. Care plan interventions that were not resident specific should be deleted. The DON revealed that Resident #1 always had plastic utensils and was not certain why plastic utensils had not been used the morning of 07/13/2017, but she would definitely look into the reason that the care plan had not been followed.

1.c. Resident #1 was admitted to the facility on 06/06/2017 with diagnoses that included Congestive Heart Failure (CHF), Chronic Obstructive Respiratory Disease (COPD), Diabetes Mellitus Type 2 (DM2), anxiety, depression and Post Traumatic Stress Disorder (PTSD) and insomnia.

An admission Minimum Data Set (MDS) dated 06/18/2017, revealed that Resident #1 was cognitively intact, able to see large print and wore corrective lenses. Resident # 1 rejected care for 1 to 3 days and required limited staff assist for transfers and toileting and supervision for walking. Resident # 1 had a fall prior to admission and wore oxygen and was admitted with a stage 2 pressure ulcer.

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A review of the comprehensive Care Area Assessment (CAA) dated 06/18/2017 revealed that Resident #1 was at risk for falls due to weakness, shortness of breath and incontinence.

Review of a care plan initiated on 06/26/2017 revealed that Resident # 1 was at risk for falls and fall related injury and would follow safety guidelines and use call bell for assist for transfers and toileting through the next review with interventions that included in part to maintain a personal body alarm (PBA) at all times to alert staff of any attempts to transfer or ambulate without assist, low bed with mats as ordered to prevent injury, sensor mat beside bed and chair sensor in chair related to frequent falls and attempts to get up unassisted and longer side rails for resident safety.

An observation of Resident # 1 on 07/12/2017 at 6:00 PM revealed resident # 1 sitting in his wheel chair in his room with no chair alarm or bed alarm observed in place.

An observation of Resident # 1 on 07/13/2017 at 7:12 AM revealed Resident #1 asleep in bed with no bed alarm observed, no alarm in the wheel chair and one quarter length side rail elevated on the left side of the bed and the right side of the bed against the wall.

On 07/13/2017 at 7:14 AM an interview conducted with NA #2 revealed that she was not aware that Resident # 1 ever had a bed alarm or a chair alarm because the nurse had never reported to her to use them.

An interview conducted with NA #4 on 07/13/2017 at 7:14 AM revealed that she was not aware that

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Resident # 1had ever used a bed or chair alarm and if he did that the nurse would have reported to the NAs that they were needed.

An interview conducted with the MDS Nurse MDS Interview on07/13/2017 at 12:00PM revealed that Resident #1 never had a bed or chair alarm because the facility did not use PBAs and that the interventions were automatically pulled to the care plan for falls and fall risks automatically by the electronic medical record system, but that these interventions should have been reviewed and deleted as well as the intervention for longer side rails and mats on the floor next to the bed. The MDS Nurse was unable to explain why the interventions remained on the care plan for Resident #1 but that she would delete those interventions.

On 07/13/2017 at 3:18 PM an interview was conducted with the DON and revealed it was her expectation that all care plan interventions be updated and meet resident specific needs to complete a clear picture of the specific resident care. Care plan interventions should be changed as needed to be appropriate for each resident. Care plan interventions that were not resident specific should be deleted. The DON revealed that Resident #1 always had plastic utensils and was not certain why plastic utensils had not been used the morning of 07/13/2017, but she would investigate why the care plans were incorrect and have them updated as soon as possible.

2. a. Resident #30 was admitted to the facility on 7/1/16. Cumulative diagnoses included cerebrovascular accident (CVA) with left sided

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paresis (weakness) and difficulty walking.

An Admission Minimum Data Set (MDS) assessment dated 7/13/16 indicated Resident #30 was cognitively intact.

A care plan dated 4/5/17 stated Resident #30 was at risk for falls and fall related injury due to left sided paresis related to CVA. Resident #30 used a walker/cane when ambulating but there were times when he did not use the walker or the cane. He also used a wheelchair at times. Approaches included, in part, answer any unusual noises as resident was not cognitively able to call for help.

An Annual Minimum Data Set (MDS) dated 5/26/17 indicated Resident #30 was cognitively intact. Resident #30 was independent with transfers and ambulation in the room and hall. Balance was not steady but he was able to stabilize without staff assistance. During the assessment period, falls was documented that Resident #30 had two or more falls with no injury sustained from the falls since the last assessment.

On 7/13/17 at 1:57 PM, an interview was conducted with the MDS nurse. She stated she felt the intervention for the approach that said to answer any unusual noises promptly as resident was not cognitively able to call for help was appropriate due to the fact that Resident #30 had periods of confusion when he was first admitted to the facility. She said Resident #30 kept his door closed and, when she knocked, he sometimes did not want anyone to come in. The MDS nurse said she and other staff had explained to him that they needed to check on him to make sure he was all right

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

(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 280	Continued From page 12	F 280		

On 7/13/17 at 2:41 PM, an interview was conducted with the Director of Nursing who stated she expected the care plan to reflect an accurate picture of the resident. She stated resident #30 was cognitively intact and that staff would check on any unusual noises for any resident at any time. She stated the wording "not cognitively able to call for help" was not accurate.

2. b. Resident #30 was admitted to the facility on 7/1/16. Cumulative diagnoses included cerebrovascular accident (CVA) with left sided paresis (weakness) and difficulty walking.

An Annual Minimum Data Set (MDS) dated 5/26/17 indicated Resident #30 was cognitively intact. Resident #30 was independent with transfers and ambulation in the room and hall. Balance was not steady but he was able to stabilize without staff assistance. During the assessment period, falls was documented that Resident #30 had two or more falls with no injury sustained from the falls since the last assessment.

A care plan dated 6/19/17 stated Resident #30 received restorative ambulation and assisted range of motion to bilateral lower extremities. Approaches included, in part, Use hand held assistance with ambulation as directed by physical therapy.

A review of the Occupational therapy discharge summary (undated) indicated Resident #30 was to begin the restorative nursing program on 6/19/17. There was no indication that hand held assistance with ambulation was to be used.

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F 280	Continued From page 13 On 7/13/17 at 2:11 PM, an interview was held with Nursing Assistant (NA) #3. She said she was one of the restorative aides and had worked with Resident #30 in the restorative program. NA #3 reviewed the care plan for restorative ambulation and assisted range of motion dated 6/19/17 and stated Resident #30 was independent with a walker on even surfaces and contact guard assist on uneven surfaces (only to walk outside with restorative aide). She stated she did not use hand held assistance for Resident #30 and had not been directed to do so by therapy. On 7/13/17 at 2:38 PM, an interview was conducted with the Director of Nursing who stated she expected the care plan to be accurate and give an accurate picture of the resident. She reviewed the restorative nursing plan of care and the instructions from therapy and stated the use of hand held assistance should not have been included in the care plan.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to develop a care plan for impaired vision for 2 of 3 residents reviewed (Resident #34 and 43).	F 282	F282-Services by Qualified persons/per care plan 1.1. Corrective action will be accomplished	8/10/17

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F 282	Continued From page 14 Findings included: 1. Resident #34 was admitted to the facility on 2/15/2017 with diagnoses to include muscle weakness, difficulty walking, and seizure disorder. The admission Minimum Data Set (MDS) dated 2/22/2017 assessed the resident to be moderately cognitively impaired. The section B1000 Vision assessed her to have impaired vision (sees large print, but not regular print in newspapers/books). The Care Area Assessment (CAA) completed in the admission MDS noted vision care area triggered. The most recent quarterly MDS dated 5/17/2017 assessed the resident to be moderately cognitively impaired. The section B1000 Vision assessed her to have impaired vision (sees large print, but not regular print in newspapers/books). A review of the care plans for Resident #34 revealed no care plans addressing impaired vision. The resident had a care plan in place "activities" with interventions to encourage word search, create cards and read on her own. The Social Worker (SW) was interviewed on 7/13/2017 at 11:21 AM. She reported she was responsible for assessing residents for section B of the MDS (hearing, speech and vision). She reported to test vision, she would hand a resident a piece of paper with print and ask them to read. If they resident had difficulty, she scored them according to their ability. She reported that she was not certain why she had not referred Resident #34 to an eye doctor. Resident #34 was interviewed on 7/13/2017 at 1:11 PM. She reported she was able to see the	F 282	for those residents found to have been affected by the deficient practice : a. Care plans were updated to include vision changes for residents #34 and 43 Resident # 34 was asked if she would go to an outside appointment to have her eyes examined and she refused, stating that she preferred to wait for the facility optometrist who is scheduled to come to the facility in November. She has been added to that list Resident # 43 had an eye appointment scheduled for 8/7/17 and was transported to that appointment. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by: Any resident has the potential to be effected by the same practice. a. Care plans have been audited to identify any resident with changes in their vision b. No other residents have been identified as having changes in vision or that need vision appointments. 3. Measures put into place to ensure that the deficient practice will not occur are: a. The SW will notify the Clinical Services Coordinator (CSC)after each identified change in vision for residents, by documenting the need for follow-up appointments on the resident appointment request form. b. The Clinical Services Coordinator (CSC) will be responsible for ensuring that appointments are made for residents with vision changes c. Copies of the Resident appointment request form will be brought to the	

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F 282	Continued From page 15 TV at the end of her bed without difficulty, but she was unable to see to read. The SW was interviewed again on 7/13/2017 at 4:44 PM. She reported that she didn ' t feel there was a change or decline in Resident #34 ' s vision from the admission MDS to the quarterly MDS. The Director of Nursing (DON) was interviewed on 7/13/2017 at 5:07 PM. She reported it was her expectation that SW communicate with the nursing staff to notify of resident changes and/or the need for referrals for outside services. The DON concluded she felt there was a breakdown in communication between the disciplines. 2. Resident #43 was admitted to the facility on 12/28/2016 and readmitted on 2/16/2017 with diagnoses to include chronic obstructive pulmonary disease, muscle weakness and difficulty walking. The most recent significant change MDS dated 6/30/2017, Section B1000 Vision assessed the resident to have impaired vision (sees large print, but not regular print in newspapers/books. A review of the Care Area Assessment (CAA) completed in the significant change MDS noted vision care area triggered. The admission MDS dated 1/9/2017 was reviewed and the section B1000 Vision assessed him to have adequate vision "sees fine detail". A review of the care plans for Resident #43 revealed no care plans addressing impaired vision. Resident #43 was interviewed on 7/12/2017 at 9:23 AM. A pair of reading glasses were on his bed, and when asked about the readers,	F 282	morning meetings for review 4. The facility will monitor its performance to make sure solutions are sustained by: a. The resident appointment request form will be reviewed daily in the morning meetings for 1 month; weekly x 1 month; biweekly x 1 month and monthly thereafter b. The QA reviews outlined above will be discussed monthly at the QA meeting. All QA results Will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes to the QAs need to be done prior to the quarterly meeting	

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F 282	Continued From page 16	F 282		

Resident #43 stated, "They don ' t do much for me."

Nursing assistant (NA) #6 was interviewed on 7/12/2017 at 9:28 AM and he reported the resident was able to see food on his tray without problems.

NA #7 was interviewed on 7/12/2017 at 9:44 AM and she reported she was the certified medication aide for Resident #43. She further reported the resident was not able to see his pills, but would count them by touching them.

The Social Worker (SW) was interviewed on 7/13/2017 at 11:21 AM. She reported she was responsible for assessing residents for section B of the MDS (hearing, speech and vision). She reported to test vision, she would hand a resident a piece of paper with print and ask them to read. If they resident had difficulty, she scored them according to their ability. She reported that she was not certain why she had not referred Resident #43 to an eye doctor. She reported that she felt she did not refer Resident #43 because he was a Hospice patient and she did not think Hospice covered eye exams.

The SW was interviewed again on 7/13/2017 at 4:44 PM. She reported that she didn ' t feel there was a change or decline in Resident #43 ' s vision. She reported that Resident #43 had difficulty seeing the paper she had him read, and it took him a long time to read the paper.

The Director of Nursing (DON) was interviewed on 7/13/2017 at 5:07 PM. She reported it was her expectation that SW communicate with the

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F 282	Continued From page 17 nursing staff to notify of resident changes and/or the need for referrals for outside services. The DON concluded she felt there was a breakdown in communication between the disciplines.	F 282		
F 313 SS=D	483.25(a)(1)(2) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to arrange for a consultation for vision care for 2 of 3 residents reviewed (Resident #34 and 43). Findings included: 1. Resident #34 was admitted to the facility on 2/15/2017 with diagnoses to include muscle weakness, difficulty walking, and seizure disorder. The admission Minimum Data Set (MDS) dated 2/22/2017 assessed the resident to be moderately cognitively impaired. The section B1000 Vision assessed her to have impaired vision (sees large print, but not regular print in newspapers/books). The Care Area Assessment	F 313	F313- Treatment/Devices to Maintain Hearing/Vision 1. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice : a. On 8/2/17 the Clinical Services Coordinator (CSC) went to speak to resident # 34 about scheduling an eye appointment. The resident told her that she did not want to go out of facility to an eye doctor. She explained to her that it would be a few months before the eye doctor would be on site and she said that was fine, she did not feel she was having	8/10/17

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F 313	Continued From page 18 (CAA) completed in the admission MDS noted vision care area triggered. The most recent quarterly MDS dated 5/17/2017 assessed the resident to be moderately cognitively impaired. The section B1000 Vision assessed her to have impaired vision (sees large print, but not regular print in newspapers/books). A review of the care plans for Resident #34 revealed no care plans addressing impaired vision. The Social Worker (SW) was interviewed on 7/13/2017 at 11:21 AM. She reported she was responsible for assessing residents for section B of the MDS (hearing, speech and vision). She reported to test vision, she would hand a resident a piece of paper with print and ask them to read. If they resident had difficulty, she scored them according to their ability. She reported that she was not certain why she had not referred Resident #34 to an eye doctor. Resident #34 was interviewed on 7/13/2017 at 1:11 PM. She reported she was able to see the TV at the end of her bed without difficulty, but she was unable to see to read. She denied seeing an eye doctor since admission to the facility. The MDS nurse was interviewed on 7/13/2017 at 1:57 PM. She reported Resident #34 had not been examined by an eye doctor. The SW was interviewed again on 7/13/2017 at 4:44 PM. She reported that she didn ' t feel there was a change or decline in Resident #34 ' s vision. The Director of Nursing (DON) was interviewed	F 313	any vision problems at this time. The eye doctor will be in the facitly for his regularly scheduled visit in November and he will be calling to confirm actual day as time gets closer and she has been placed on the list for that visit. b. An Eye appointment was made for resident #43 on 8/3/17 by the CSC and was scheduled for 8/7/17. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by: Any resident has the potential to be effected by the same practice. a. Every resident was reviewed on 7/26/17 for visual acuity by the Social Worker and Clinical Services Coordinator. b. Every resident who was cognitively able to be accurately assessed for vision was asked if they were able to see the headlines, subtitles, and fine print in the newspaper. c. Residents with cognitive issues and unable to be accurately assessed for vision will be seen yearly or as deemed more often by an Optometrist, or Ophthalmologist. d. Every resident□s vision will be assessed on admission, quarterly, annually or with any significant change assessment or as needed by the Social Worker as required of the MDS process. e. Residents identified as having changes in vision have been offered a choice of having an outside appointment made for them now, or to be placed on the list to be seen by the eye doctor who is scheduled to come to the facility in November.	

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F 313	Continued From page 19 on 7/13/2017 at 5:07 PM. She reported it was her expectation that SW communicate with the nursing staff to notify of resident changes and/or the need for referrals for outside services. The DON concluded she felt there was a breakdown in communication between the disciplines. 2. Resident #43 was admitted to the facility on 12/28/2016 and readmitted on 2/16/2017 with diagnoses to include chronic obstructive pulmonary disease, muscle weakness and difficulty walking. The most recent significant change MDS dated 6/30/2017, Section B1000 Vision assessed the resident to have impaired vision (sees large print, but not regular print in newspapers/books. A review of the Care Area Assessment (CAA) completed in the significant change MDS noted vision care area triggered. The admission MDS dated 1/9/2017 was reviewed and the section B1000 Vision assessed him to have adequate vision "sees fine detail". A review of the care plans for Resident #43 revealed no care plans addressing impaired vision. Resident #43 was interviewed on 7/12/2017 at 9:23 AM. A pair of reading glasses were on his bed, and when asked about the readers, Resident #43 stated, "They don ' t do much for me." He denied seeing an eye doctor since admission to the facility. Nursing assistant (NA) #6 was interviewed on 7/12/2017 at 9:28 AM and he reported the resident was able to see food on his tray without problems. NA #7 was interviewed on 7/12/2017 at 9:44 AM	F 313	3. Measures put into place to ensure that the deficient practice will not occur are: a. The Social Worker will notify the Clinical Services Coordinator after each identified change in vision for residents, by documenting the need for follow-up appointments on the resident appointment request form. b. The Clinical Services Coordinator will be responsible for ensuring that appointments are made for residents with vision changes. c. Copies of the Resident appointment request form will be brought to the morning meetings for review 4. The facility will monitor its performance to make sure solutions are sustained by: a. The resident appointment request form will be reviewed daily in the morning meeting b. The QA reviews outlined above will be discussed monthly at the QA meeting. All QA results will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes to the QAs need to be done prior to the quarterly meeting	

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F 313	Continued From page 20 and she reported she was the certified medication aide for Resident #43. She further reported the resident was not able to see his pills, but would count them by touching them. The Social Worker (SW) was interviewed on 7/13/2017 at 11:21 AM. She reported she was responsible for assessing residents for section B of the MDS (hearing, speech and vision). She reported to test vision, she would hand a resident a piece of paper with print and ask them to read. If they resident had difficulty, she scored them according to their ability. She reported that she was not certain why she had not referred Resident #43 to an eye doctor. She reported that she felt she did not refer Resident #43 because he was a Hospice patient and she did not think Hospice covered eye exams. The MDS nurse was interviewed on 7/13/2017 at 1:57 PM. She reported Resident # 43 had not been examined by an eye doctor. The SW was interviewed again on 7/13/2017 at 4:44 PM. She reported that she didn ' t feel there was a change or decline in Resident #43 ' s vision. She reported that Resident #43 had difficulty seeing the paper she had him read, and it took him a long time to read the paper. The Director of Nursing (DON) was interviewed on 7/13/2017 at 5:07 PM. She reported it was her expectation that SW communicate with the nursing staff to notify of resident changes and/or the need for referrals for outside services. The DON concluded she felt there was a breakdown in communication between the disciplines.	F 313		
F 323	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323		8/10/17

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F 323 SS=E	Continued From page 21 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interviews with staff and residents and record review, the facility failed to maintain water temperatures at or less than 116 degrees Fahrenheit (F) in fourteen (14) of sixteen (16) resident's bathrooms (101, 104, 103/105, 106/108, 107/109, 201/203, 202/204,205, 206,218, 301/303, 302/304, 305/307 and 306/308) and in one of two shower rooms (West). The findings included:	F 323	F323- Free of Accident Hazards/Supervision/Devices 1. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. On July 11, the maintenance supervisor drained the holding tank and removed the mixing valve for inspection.	

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F 323	Continued From page 22 A review of the Manufacturer's instructions revealed "Temp Control valve control mechanism must be kept clean and free from deposits and any foreign matter build-up that will be present in many water systems. Inspect within 30 days of initial installation of operation. If inspection determines that your water system causes deposits and foreign matter buildup monthly, then valve should be cleaned monthly." An observation on 7/10/17 at 3:00 PM during stage 1 interview revealed the hot water coming from the faucet in the bathroom shared by rooms 103/105 was 120 degrees F. The temperature was obtained by using a thermometer that was calibrated to 32 degrees in ice water. An observation on 7/10/17 at 3:13 PM during stage 1 interview revealed the hot water coming from the faucet in the bathroom shared by rooms 102/104 was 120 degrees F. Resident # 2 stated he did not have any complaints about the water being too hot. An observation on 7/10/17 at 3:45 PM was conducted with the following was noted: Bathroom shared by 103/105-water from the faucet was 120 degrees F. Bathroom shared by 107/109-water from the faucet was 120 degrees F Bathroom shared by 201/203-water from the faucet was 120 degrees F. Bathroom shared by 202/204-water from the faucet was 120 degrees F. Bathroom shared by 206/208-water from the faucet was 120 degrees F. Bathroom shared by 102/104-water from the faucet was 120 degrees. F	F 323	He noted that debris had collected in the mixing valve and was preventing it from working properly. He cleaned the valve and replaced it on the holding tank. Once the tank was filled, he checked the temperature of the water to ensure that it was within the allowable range and that the mixing valve was functioning properly. There were no further issues at this time. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by: Any resident has the potential to be effected by the same practice. a. On July 12, the maintenance supervisor installed a manufacturer recommended thermometer on the holding tank that will allow him to check the temperature of the water in the tank b. The Maintenance supervisor began a daily QA of temperatures in the residents rooms for allowable state approved temperatures 3. Measures put into place to ensure that the deficient practice will not occur are: a. The water temperatures in the holding tank and all resident□s rooms will be checked daily by the maintenance supervisor to ensure it is within allowable range and will be documented on a preventive maintenance form that will be reviewed by the Administrator for compliance. b. The mixing valve will be checked on a monthly basis and documented on a QA form by the maintenance supervisor to ensure that no debris has collected in it and be cleaned out. This will be audited	

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An observation on 7/10/17 was conducted of all the bathrooms in the resident rooms. Temperatures were taken with a calibrated thermometer and were obtained from the water faucet. The water faucets were hot to touch. The following was noted

Time	Room number	location	water temperature
4:02 PM	106/108	sink	122 degrees F
4:05 PM	101	sink	122 degrees F
4:08 PM	201/203	sink	120 degrees F
4:09 PM	202/204	sink	122 degrees F
4:10 PM	205	sink	124 degrees F
4:16 PM	West wing shower room	sink	120 degrees F
4:21 PM	301/303	sink	122 degrees F.
4:23 PM	305/307	sink	122 degrees F
4:26 PM	306/308	sink	120 degrees F
4:28 PM	302/304	sink	120 degrees F

On 7/10/17 at 4:55 PM, an interview was conducted with Nurse Aide (NA) #4. She stated she assisted with providing showers on the evening shift. She said the hot water was a normal temperature to her and, in general, no resident had complained that the water was too hot.

On 7/10/17 at 4:59 PM, an interview was conducted with Med Aide #5 who stated she worked day shift and helped with showers. She stated every resident was different when it came to water temperatures and the water was

by the Regional Facility Services Maintenance Supervisor monthly ongoing.
c. Any area of concern will be reported to the Regional Facility Services Maintenance Supervisor immediately.
4. The facility will monitor its performance to make sure solutions are sustained by:
a. Water temperatures will be monitored daily by the maintenance supervisor on a preventive maintenance form and reported to the Administrator on a daily basis x 4 weeks; weekly x 1 month; biweekly x 1 month and weekly thereafter or more often if need.
b. The Regional Facility Services Maintenance Supervisor will audit the preventive maintenance form completed by the maintenance supervisor for recorded temperatures weekly x 4 weeks; biweekly x 1 month and monthly thereafter .
c. Water temperatures will be reviewed by the Safety committee weekly x 4 weeks; biweekly x 1 month; monthly x 6 months to the Monthly QA committee for compliance.
d. The QA reviews outlined above will be discussed monthly at the QA meeting. All QA results
will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes to the QAs need to be done prior to the quarterly meeting

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	345140	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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adjusted to their liking. She said she had not noticed it being too hot.

On 7/10/17 at 5:16 PM, an interview was conducted with Level II NA #2 who stated she assisted with baths and showers. She said she had seen the water hot in the shower room but not to the point it was "steamy". She had not noted any water too hot in the resident's bathrooms.

On 7/10/17 at 5:02 PM, an observation of water temperatures in the resident rooms and shower rooms was conducted with the Maintenance Director. He stated he checked the water temperatures every Monday morning. Most of the time, he checked every room because he then knew he had accurate information. The Maintenance Director stated the average water temperature ranged between 107-108 degrees F. He said the East wing of the building was farther away from the water heaters. The West wing area was closer to the water heaters and the water temperature usually ran between 110-115 degrees F. The Maintenance Director had a digital electronic thermometer. He attempted to calibrate the thermometer but it would not calibrate below 36.6 degrees F. He stated he did not routinely calibrate the thermometer before checking the water temperatures. He checked the water temperature by holding another calibrated thermometer directly in the center of the water flow so that the water actually fell on the middle of the stem and tip of the probe was in the stream of the water. The following was noted:

Time	Room number	location	Water Temperature
5:10 PM	109/107	sink	120 degrees F
5:12 PM	106/108	sink	110 degrees F

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5:14 PM	102/104	sink	124 degrees F
5:16 PM	103/105	sink	110 degrees F
5:18 PM	101	sink	124 degrees F
5:20 PM	200	sink	116 degrees F
5:22 PM	201/203	sink	122 degrees F
5:24 PM	202/204	sink	120 degrees F
5:26 PM	205	sink	120 degrees F
5:28 PM	206/208	sink	122 degrees F
5:30 PM	209/207	sink	112 degrees F
5:32 PM	302/304	sink	120 degrees F
5:34 PM	301/303	sink	120 degrees F
5:36 PM	306/308	sink	118 degrees F
5:38 PM	307/305	sink	120 degrees F
5: 41 PM	309	sink	112 degrees F
5:50 PM	West wing shower room sink 112 degrees F.		

On 7/10/17 at 6:01 PM, a review of the water temperature logs for May 2017, June 2017 and July 2017 was conducted. The temperatures were checked in twelve resident bathrooms and averaged 107-108 degrees F. The Maintenance Director stated he was taught to get the water temperature to 107-108 degrees F and leave it there. He said he did not know what the regulations stated about water temperatures.

On 7/10/17 at 6:15 PM, an observation of the mixing valve was conducted with the Maintenance Director. He stated the mixing valve had been replaced about 2 years ago. He said there was not a thermostat for the mixing valve and no temperature gauge was noted on the mixing valve. The Maintenance Director stated he did not routinely check the mixing valve and moved the knob higher or lower if he checked the water and it did not seem hot enough. He indicated there was no routine maintenance done for the mixing valve and he did not know if routine

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maintenance was supposed to be done. The Maintenance Director stated he last adjusted it in March when he turned it back a little bit.

On 7/11/17 at 10:10AM, an interview was conducted with the Maintenance Coordinator who stated the water being used for resident care should not be over 116 degrees F. He stated the water coming straight off the boiler to the kitchen and laundry was set at 140-150 degrees F and there were not separate lines going to the kitchen and laundry areas. He was unsure if there should be routine maintenance done for the mixing valve.

On 7/11/17 at 10:15 AM, an observation of the water tanks and mixing valve was conducted with the Maintenance Director and the Maintenance Coordinator. There were two holding tanks where the water was stored before going to the laundry and kitchen areas. The tanks also fed water to the mixing valve before it went to the resident shower rooms and bathrooms. There were no separate lines for the kitchen/ laundry. The temperature on the gauge located on the holding tanks indicated the water temperature was 145 degrees F. The Maintenance Coordinator stated there was no way of knowing the temperature of the water coming out of the mixing valve to the resident bathrooms and showers without checking each one with a thermometer. He stated he would try and adjust the mixing valve, check to see if it needed to be replaced immediately. He stated he would obtain manufacturer's instructions to see if routine maintenance was needed for the mixing valve.

On 7/11/17 at 10:20 AM, the Administrator was made aware of the hot water temperatures and

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F 323	Continued From page 27 stated she relied on the maintenance people to take care of the maintenance of the water and did have the Maintenance Director keep a log of the water temperatures. On 7/11/17 at 1:59 PM, an interview was conducted with the Administrator and the Maintenance Coordinator. The Maintenance Coordinator stated he had readjusted the mixing valve and the temperatures were rechecked and were within 104 degrees F to 111 degrees F. The Administrator stated they had been doing temperature checks weekly and the temp checks were within normal limits. If there had been elevated temperatures, they would have been aware there was a problem with the mixing valve. The Maintenance Coordinator stated there was "trash" in the mixing valve that caused the problem. On 7/11/17 at 3:46 PM, an interview was conducted with the Maintenance Director and the Maintenance Coordinator. The Maintenance Director stated he was trained by the Coordinator who told him the temperature should be between 101 degrees F -116 degrees F and water temperature checks should be completed at least monthly but he did water temperature checks weekly.	F 323		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 356		8/10/17

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(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)

(C) Certified nurse aides.

(iv) Resident census.

(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) Facility data retention requirements. The facility must maintain the posted daily nurse

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F 356	Continued From page 29 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post an accurate facility census and nursing staffing report of total hours worked for licensed and unlicensed staff for 14 out of 15 days reviewed for the daily staffing posting. Findings included: Upon entrance to the facility on 7/10/2017 the Administrator reported the current census of 41 residents. The Administrator reported one resident was at assisted living level. During the initial tour of the facility on 7/10/2017 at 11:00 AM, the facility staffing posting reported 41 residents. The actual census was 40 that date. The daily reporting was filled out for all three shifts with total number of hours worked completed for first, second and third shifts. A review of the staffing and daily schedule revealed the census was incorrect by including the assisted living resident with the skilled nursing census on the following dates: 6/28/2017, 6/29/2017, 7/1/2017, 7/2/2017, 7/3/2017, 7/4/2017, 7/5/2017, 7/6/2017, 7/7/2017, 7/8/2017, 7/9/2017, 7/10/2017, 7/11/2017, and 7/12/2017. A review of the staffing and daily schedule revealed the total number of hours worked by Registered Nurse (RN) were incorrect on 6/28/2017, 6/30/2017, 7/3/2017, 7/5/2017, 7/6/2017, 7/7/2017, 7/10/2017, and 7/12/2017. A review of the staffing and daily schedule	F 356	F356- Posted Nurse Staffing Information 1.1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice : a. The daily staff hours report was corrected immediately by the Director of Nursing on 7/14/17. b. The facility scheduler was educated by the Director of Nursing on 7/14/17 on how to record the hours for staffing based on separating the certified bed census numbers and assisted living census number s on the posted daily staff hours, and calculating actual nurse hours worked every shift. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice by: Any resident has the potential to be effected by the same practice. a. The DON or the Administrator will record on a QA form that she has reviewed the daily staff hours form and that it is correct for the census and the actual hours worked by nurses M-F weekly x I month, biweekly x 2 months, monthly x 6 months The weekend supervisor is responsible for ensuring the correct staffing numbers are on the report on the weekend and will record results on the QA form weekly x I month, biweekly x 2 months, monthly x 6 months b. The DON will report on the QA form in	

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F 356	Continued From page 30 revealed the total number of hours worked by Licensed Practical Nurse (LPN) were incorrect on 6/29/2017, 6/30/2017, 7/4/2017, 7/6/2017, and 7/11/2017. A review of the staffing and daily schedule revealed the total number of hours worked by nursing assistants (NA) was incorrect by including the time worked with the assisted living resident on the following dates: 6/28/2017, 6/29/2017, 7/1/2017, 7/2/2017, 7/3/2017, 7/4/2017, 7/5/2017, 7/6/2017, 7/7/2017, 7/8/2017, 7/9/2017, 7/10/2017, 7/11/2017, and 7/12/2017. An interview was conducted with NA #3 on 7/13/2017 at 8:54 AM. She reported she was responsible for filling out the report of the nursing staff report of total hours worked for licensed and unlicensed staff for each day. She went on to explain she had been instructed to list the total number of residents in the facility for the daily census. She then described the process to list the RN nurse manager and the LPN clinical services coordinator as licensed personnel for both first and second shift, but the nurse manager and clinical services coordinator did not work past 5-6:00 PM when they were scheduled. She reported she was not aware the assisted living resident should not be included in the total census and was not aware she would have to adjust the total hours of the NA assigned to his care. The Administrator and the Corporate Vice President (VP) were interviewed on 7/13/2017 at 9:17 AM. The Administrator and VP were not aware the assisted living level resident was not to be included in the total census for the building, or that care provided for the assisted living level	F 356	the administrative morning meeting for accuracy of the census and actual hours worked for nursing staff weekly x I month, biweekly x 2 months, monthly x 6 months. 3. Measures put into place to ensure that the deficient practice will not occur are: a. The DON or the Administrator will record on a QA form that she has reviewed the daily staff hours form and that it is correct for the census and the actual hours worked by nurses M-F The weekend supervisor is responsible for ensuring the correct staffing numbers are on the report on the weekend and will record results on the QA form b. The DON will report on the QA form in the administrative morning meeting for accuracy of the census and actual hours worked for nursing staff including the QA form completed by the weekend supervisor 4. The facility will monitor its performance to make sure solutions are sustained by: a. QAs will be done weekly x I month, biweekly x 2 months, monthly x 6 months b. The QA reviews outlined above will be discussed monthly at the QA meeting. All QA results will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes to the QAs need to be done prior to the quarterly meeting	

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F 356	Continued From page 31 resident could not be included in the total hours worked. The Administrator and VP both stated their expectations were the census was accurately posted, as well as the posting of licensed and unlicensed staff was updated with accurate information at the end of the shift.	F 356		
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	F 520		8/10/17

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F 520	Continued From page 32 Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QA and A) failed to implement, monitor and revise as needed the action plans developed for the recertification survey dated 08/04/2016 and the extended survey dated 01/26/2017, in order to achieve and sustain compliance. The facility had a repeat deficiency to prevent accidents and hazards (F 323). The facility had a repeat deficiency to post accurate daily staffing hour sheets (F356). The continued failure of the facility during two recertification surveys and an extended survey shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: 1. This F tag is cross referenced to F 323. 1.a. On 08/04/2016, the facility failed to secure a side rail to the bed frame for one of twenty residents. 1.b. On 07/13/2017, the facility failed to maintain water temperatures at or less than 116 degrees Fahrenheit (F) for 14 of 16 resident bathroom sinks (rooms 101,104,103/105, 106/108,	F 520	F520- QAA Committee- Members Meet Quarterly /Plans 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice : a. The facility had in place a Weekly QA monitoring system that was completed by the Maintenance supervisor to record the water temperature in resident rooms and bathing areas. This QA had not identified any water temperature outside the allowable range. Due to the fact that there has now been an identified problem, the QA process has been redefined to initiate a daily check of the water temperatures to ensure they are within the allowable range which is performed by the maintenance supervisor. b. The facility scheduler has now been educated on how to record the hours for staffing based on separating the certified bed census numbers and assisted living census number s on the posted daily staff hours, and calculating actual nursing staff worked every shift. 2. Corrective action will be accomplished	

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F 520	Continued From page 33 107/109, 201/203, 202/204, 205, 206, 218, 301/303, 302/304, 305/307 and 306/308) and 1 (West Hall) of 2 resident shower rooms. An interview conducted on 07/1/32017 at 5:12 PM with the Corporate Vice President revealed that the facility had no action plan in place to monitor that the facility monitored water temperatures for water temperature stability and that the facility had already initiated corrective actions to meet the regulations for maintaining safe water temperatures throughout the facility. 2. This F tag is cross referenced to F 356. 2.a. On 01/26/2017, the facility failed to post separate and actual RN (Registered Nurse) and LPN (Licensed Practical Nurse) hours on the posted daily staffing hour sheets for 14 of 14 days reviewed. 2.b. On 07/13/2017, the facility failed to separate certified bed census numbers and assisted living census numbers on the posted daily staff hours for 14 of 15 days reviewed and the facility failed to did not calculate actual nurse hours worked every shift on the posted daily staff hours for 8 of 15 daily posted staff sheets reviewed. An interview conducted on 07/13/2017 at 5:12 PM with the Corporate Vice President revealed that the facility had no action plan in place for to monitor that the facility followed the regulations for accuracy of information recorded on the posted daily staffing sheets.	F 520	for those residents having potential to be affected by the same deficient practice by: Any resident has the potential to be effected by the same practice. a. The water temperatures in the holding tank and all resident□s rooms will be checked daily by the maintenance supervisor to ensure it is within allowable range and will be documented on a preventive maintenance form that will be reviewed by the Administrator for compliance. b. The mixing valve will be checked on a monthly basis and documented on a QA form by the maintenance supervisor to ensure that no debris has collected in it and be cleaned out. This will be audited by the Regional Facility Services Maintenance Supervisor monthly ongoing. d. Any area of concern will be reported to the Regional Facility Services Maintenance Supervisor immediately. e. Resident rooms and bathing areas have been added to the Quality Assurance Checklist that was already in place for room condition and personal care of the residents, performed daily by the administrative staff. If they find any resident room or bathing area that has water temperatures outside the allowable range they are to notify the Administrator and maintenance supervisor immediately. This will be ongoing. f. The DON or the Administrator will record on a QA form that she has reviewed the daily staff hours form and that it is correct for the census and the actual hours worked by nurses M-F weekly x 1 month, biweekly x 2 months,	

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F 520	Continued From page 34	F 520	monthly x 6 months The weekend supervisor is responsible for ensuring the correct staffing numbers are on the report on the weekend and will record results on the QA form weekly x 1 month, biweekly x 2 months, monthly x 6 months g. The DON will report on the QA form in the administrative morning meeting for accuracy of the census and actual hours worked for nursing staff weekly x I month, biweekly x 2 months, monthly x 6 months. 3. Measures put into place to ensure that the deficient practice will not occur are: a. The water temperatures in the holding tank and all resident□s rooms will be checked daily by the maintenance supervisor to ensure it is within allowable range and will be documented on a preventive maintenance form that will be reviewed by the Administrator for compliance. b. The mixing valve will be checked on a monthly basis and documented on a QA form by the maintenance supervisor to ensure that no debris has collected in it and be cleaned out. This will be audited by the Regional Facility Services Maintenance Supervisor monthly ongoing. c. Any area of concern will be reported to the Regional Facility Services Maintenance Supervisor immediately. d. Resident rooms and bathing areas have been added to the Quality Assurance Checklist that was already in place for room condition and personal care of the residents, performed daily by the administrative staff. If they find any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 35	F 520	resident room or bathing area that has water temperatures outside the allowable range they are to notify the Administrator and maintenance supervisor immediately. This will be ongoing. e. The DON or the Administrator will record on a QA form that she has reviewed the daily staff hours form and that it is correct for the census and the actual hours worked by nurses M-F weekly x 1 month, biweekly x 2 months, monthly x 6 months The weekend supervisor is responsible for ensuring the correct staffing numbers are on the report on the weekend and will record results on the QA form weekly x I month, biweekly x 2 months, monthly x 6 months f. The DON will report on the QA form in the administrative morning meeting for accuracy of the census and actual hours worked for nursing staff weekly x I month, biweekly x 2 months, monthly x 6 months. 4. The facility will monitor its performance to make sure solutions are sustained by: a. Quality Assurance Checklist for administrative staff are reviewed daily M-F in the morning meeting, and any area out of compliance is discussed for follow-up and recorded on the 24 hour report. b. The Daily Water Temperature Record is discussed in the weekly Safety meeting X 4 weeks; bi-weekly x 2 months, monthly x 6 months c. The DON will report on the daily staff hours form in the administrative morning meeting for accuracy of the census and actual hours worked for nurses weekly x I	

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F 520	Continued From page 36	F 520	month, biweekly x 2 months, monthly x 6 months d. The mixing valve QA will be checked monthly by the maintenance supervisor and the Regional Director of Facility Services will be completed weekly x 4 weeks; bi- weekly x 2 months; monthly x 6 months; e. The QA performed by the Regional Facility Services Maintenance Supervisor will check the thermometer on the holding tank on a weekly basis x 4 weeks; bi-weekly x 2 months; monthly x 6 months; f. All QA forms will be reviewed in the monthly QAA committee and any changes or recommendations will be discussed, reviewed or re-evaluated on an ongoing basis. The QA reviews outlined above will be discussed monthly at the QA meeting. All QA results will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes to the QAs need to be done prior to the quarterly meeting	