STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		9/21/17

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment

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

Electronically Signed | 09/15/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to notify the physician of a weight gain for 1 of 3 residents reviewed for reporting weights to the physician (Resident #94). The findings included: Resident # 94 was admitted to the facility 05/08/17 with diagnoses which included pneumonia, lymphedema (swelling related to fluid accumulation), and congestive heart failure (CHF). A care plan dated 05/08/17 described Resident #94 as at risk for weight fluctuation. The care plan goal specified the resident would avoid significant weight change through the next 90 day review. Interventions included "weights as ordered (daily weights for CHF)." Review of Resident #94's medical record revealed a physician's order dated 05/12/17. The order specified daily weights, notify physician if weight gain greater than 3# (pounds) in 24 hours or 5# in 1 week. Continued medical record review revealed a weight for 08/18/17 was recorded as 204.7#. A	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #94 had a weight gain and the staff nurse failed to notify the physician of the weight gain. The Physician was made aware of the weight gain. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All patients in house	

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F 157	Continued From page 2 weight obtained 08/20/17 was recorded as 210.5#, and weights for 8/21/17 was 212.9#, no weight was recorded 8/22/17, and a weight for 8/23/17 was 210.9# An interview was conducted with Nurse #4 on 08/23/17 at 3:55 PM. Nurse #4 explained night shift obtained daily weights at the same time early in the morning. Nurse #4 reviewed the weights and confirmed there had been a steady weight gain for Resident #94. The nurse acknowledged the physician's order specified to notify the physician or a greater than 3# weight gain in 24 hours or a greater than 5 # weight gain in one week. Nurse #4 was unable to find any evidence the physician had been notified. An interview was conducted with Nurse #3 on 08/24/17 at 6:11 AM. The nurse stated she was working when Resident #94 was weighed 08/21/17, 08/22/17, and 08/23/17. Nurse #3 stated if she notified the physician of the resident's weight gain, she would have done it electronically. The nurse was unable to find any evidence she reported any weight gain. A continued interview with Nurse #3 on 08/24/17 at 6:48 AM revealed when she documented weights, she could see the 3 previous weights in the computer. Therefore was unable to see weight gain over the period of a week. An interview was conducted with the facility Medical Director (MD) on 08/24/17 at 11:04 AM. The MD stated she was not notified of any recent weight gain for Resident #94. The MD explained the resident was sent to the hospital once since her admission to the facility related to a 10# weight gain. This resident weighed 245# at admission due to fluid overload. The MD stated	F 157	were audited for orders specifically to notify the physician of weight gains or losses and ensure that the physician was notified and the order was followed for notification. Utilizing the order listing report to identify patients with orders for daily weights. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: 1) Nurses educated and new hire nurses in orientation will be educated on the following procedure to ensure physician and physician extenders are notified of weight changes and/or symptoms associated with Congestive Heart Failure or Chronic Obstructive Pulmonary Disease and physician orders in general. 2) Monday through Friday Unit Manager and Unit Coordinator and weekends the Weekend Supervisor or Designee will run a Order Listing Report for Daily Weights, which is utilized for residents with Congestive Heart Failure and Chronic Obstructive Pulmonary Disease and ensure that the previous days weights were obtained as ordered. Any missed weights or reporting will result in re-education or corrective action for the Certified Nursing Assistant and the Charge Nurse that were responsible to obtain and report the weights or changes in symptoms to the physician as ordered by the Unit Manager, Unit Coordinator or Director of Nursing. This will be done daily for a period of 4 weeks, then Monday Wednesday for 1 month and 1x each week for a period of one month.	

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F 157	Continued From page 3 monitoring this resident's weight was very important. The MD added she would like to be notified if there was a greater than 3# weight gain in a 24 hour period or greater than a 5# weight gain in a week. At this time, the MD stated she did not feel the resident was harmed but needed to be monitored for further weight gain. An interview was conducted with the Director of Nursing (DON) on 08/24/17 at 4:55 PM. The DON stated the nurse should look at the weights as she recorded them and complete the expectation of the MD.	F 157	3) Monday through Friday Unit Manager and Unit Coordinator and weekends the Weekend Supervisor or Designee will run a 24 hour Shift Summary to review for documentation of symptoms and notification of physician or physician extender for Heart Failure and Chronic Obstructive Pulmonary Disease patients as indicated. This will be done daily for a period of 4 weeks, then Monday Wednesday for 1 month and 1x each week for a period of one month. 4) The 1) Order Listing Report and 2) 24 hour Shift Summary will be given to the Director of Nursing to ensure that plan of correction is followed. This will be done, daily Monday through Friday and Weekend Supervisor will place in Director of Nursing□s box from the weekend. The audits will be discussed, at the Weekly Risk Meeting and revisions made to plan as needed. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented, Audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly for a period of 3 months for review and revision as needed.	
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	F 241		9/21/17

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F 241	Continued From page 4 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 1 of 2 dining observations on the 300 unit, staff interviews and medical record review, the facility failed to provide a dignified dining experience for 2 cognitively impaired residents who watched other residents eating their lunch at the same table while Resident #161 and #182 waited on staff for assistance with eating. The findings included: 1 a. Resident #161 was admitted to the facility on 2/20/17. Diagnoses included Alzheimer's dementia, dysphagia, hemiplegia, and anxiety, among others. An annual Minimum Data Set assessment dated 5/20/17, assessed Resident #161 with severely impaired cognition and required extensive staff assistance of 1 person with eating. Resident #161 was observed in the 300 unit dining room on 8/21/17 at 12:36 PM, with 12 other residents and 3 staff. Residents began receiving their lunch meals on 8/21/17 at 12:40 PM. The lunch meal was placed in front of Resident #161 on 8/21/17 at 1:05 PM, covered and remained covered until 1:36 PM (31 minutes). During this observation 3 other residents, who were also seated at the same table, either ate their lunch or received assistance from staff with eating, while Resident #161 watched. On 8/21/17 at 1:36 PM, nurse aide (NA) #6 reheated Resident #161's lunch and assisted the resident with eating.	F 241	How the corrective action will be accomplished for the resident(s) affected. Resident #161 and #182 were setting at a table with other patients eating at the table where they required assistance. Resident #161 and Resident #182 will be served and assisted with feeding at the same time as other residents at their table. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Rounds were completed on the residents that were on the 300 unit at the time deficient practice was identified to ensure that no other residents were found to be left in a situation that would be neglectful or undignified. Measures in place to ensure practices will not occur. All staff will be in-serviced by DON/SDC on meal service and assistive feeding practices to ensure no resident is left without their meal or awaiting assistive service at the same time as other residents are eating. An additional staff member will be assigned to the 300 dining room for each meal service to ensure adequate staffing for adherence to a dignified dining experience. Dignity means that in their interaction with residents, staff carries out activities that assist the resident maintain and enhance his/her self-esteem and self-worth. Patients sitting at the same table must be	

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F 241	Continued From page 5 During an interview on 8/24/17 at 12:01 PM, NA #4 stated that more help was needed during dining to assist residents with their meals. NA #4 further stated "It happens all the time that we can't get to everyone at the same time." NA #4 also stated that "I have told administration that we need more help to feed residents, it's not right to have residents sitting at the table not eating while other residents have their food and are eating, I don't like that." During an interview on 8/24/17 at 12:20 PM, NA #5 stated "It is very difficult to assist all the residents on this unit with meals." NA #5 further stated that at least 10 residents on the unit required some level of assistance with their meal. NA #5 stated that she always fed 2 residents at the same time while the other residents who also needed assistance had their meal covered in front of them waiting for staff assistance. NA #5 also stated that "Sometimes they wait so long their food gets cold, nobody likes to eat cold food." During an interview with Nurse #4 on 8/24/17 at 12:25 PM, Nurse #4 stated that the NAs had previously mentioned to him that they have a hard time getting all the residents fed. Nurse #4 further stated "Breakfast is the worst because they are trying to get everyone up, cleaned up and fed, I am passing out meds during breakfast and I am usually not available to help then, but during the lunch meal I usually only have a hand full of meds to pass, so I am available to help them when they ask." An interview with the Unit Manager (UM) #1 occurred on 8/24/17 at 12:35 PM. UM #1 stated	F 241	fed at the same time and there cannot be patients sitting at the table that require assistance watching others eat and not being assisted with feeding. This will be taught to all new employees and re-education provided monthly during CNA and Licensed Nurse meetings for three (3) months. Staff will notify Administrator or DON of any evidence of patient dignity being compromised. Random meal rounds will be performed by Department Heads that are assigned by Administrator or DON. The audits will be done daily Monday-Friday for a period of one month, then Monday, Wednesday and Friday for a period of 2 weeks and then bi-weekly for one month. These audits will be reviewed daily at the morning clinical meeting by the Director of Nursing, Administrator and Dining Services Manager. How the facility plans to monitor and ensure correction is achieved and sustained. The administrator will be responsible to ensure that the plan of correction is implemented, Audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly for a period of 3 months for review and revision as needed.	

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F 241	Continued From page 6	F 241		

that NAs had not brought to her attention concerns related to assisting residents with their meals, but stated "I have observed how difficult it is." UM #1 further stated that at least 10 residents on the 300 unit required some level of assistance with meals and that "breakfast is the most difficult" because the NAs are getting residents up, bathed/dressed and fed.

The Director of Nursing (DON) was interviewed on 8/24/17 at 3:43 PM. The DON stated "We should not have residents waiting with their food in front of them, we have enough staff we could send more staff to that unit to help feed, I was not aware of this, but we will address this right away."

The Administrator was interviewed on 8/24/17 at 4:04 PM. The Administrator stated that the 300 unit had more residents who required assistance with eating than the 100 and 200 units. The Administrator also stated that in the past, when it was brought to her attention that additional staff assistance was needed on the 300 unit to help residents with their meals, she instructed staff from the other units to go and assist. The Administrator further stated that it was still her expectation for staff from the 100 and 200 units to assist with dining on the 300 unit when needed.

NA #6 was interviewed on 8/24/17 at 5:46 PM via telephone. NA #6 stated that "Everyday it is hard to feed all the residents on the 300 unit at the same time." NA #6 further stated that the meal service process was so time consuming, that by the time residents received help with their meal, "it's cold." NA #6 also stated that 10 residents on the 300 unit required some staff assistance with eating and that the staff fed 2 residents at a time while the other residents who needed help waited

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with their covered tray in front of them.

1b. Resident #182 was admitted to the facility on 7/8/16. Diagnoses included dementia and failure to thrive, among others.

An annual Minimum Data Set assessment dated 6/27/17 assessed Resident #182 with severely impaired cognition and required total assistance of 1 staff person for eating.

Resident #182 was observed in the 300 unit dining room on 8/21/17 at 12:36 PM, with 12 other residents and 3 staff. Residents began receiving their meals on 8/21/17 at 12:40 PM. The lunch meal was placed in front of Resident #182 on 8/21/17 at 1:05 PM, covered and remained covered until 1:18 PM (15 minutes). During this observation 3 other residents, who were also seated at the same table either ate their lunch or received assistance from staff with eating, while Resident #182 watched. At 1:18 PM, nurse aide (NA) #4 fed Resident #182 lunch.

During an interview on 8/24/17 at 12:01 PM, NA #4 stated that more help was needed during dining to assist residents with their meals. NA #4 further stated "It happens all the time that we can't get to everyone at the same time." NA #4 also stated that "I have told administration that we need more help to feed residents, it's not right to have residents sitting at the table not eating while other residents have their food and are eating, I don't like that."

During an interview on 8/24/17 at 12:20 PM, NA #5 stated "It is very difficult to assist all the residents on this unit with meals." NA #5 further stated that at least 10 residents on the unit

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required some level of assistance with their meal. NA #5 stated that she always fed 2 residents at the same time while the other residents who also needed assistance had their meal covered in front of them waiting for staff assistance. NA #5 also stated that "Sometimes they wait so long their food gets cold, nobody likes to eat cold food."

During an interview with Nurse #4 on 8/24/17 at 12:25 PM, Nurse #4 stated that the NAs had previously mentioned to him that they have a hard time getting all the residents fed. Nurse #4 further stated "Breakfast is the worst because they are trying to get everyone up, cleaned up and fed, I am passing out meds during breakfast and I am usually not available to help then, but during the lunch meal I usually only have a hand full of meds to pass so I am available to help them when they ask."

An interview with the Unit Manager (UM) #1 occurred on 8/24/17 at 12:35 PM. UM #1 stated that NAs had not brought to her attention concerns related to assisting residents with their meals, but stated "I have observed how difficult it is." UM #1 further stated that at least 10 residents on the 300 unit required some level of assistance with meals and that "breakfast is the most difficult" because the NAs are getting residents up, bathed/dressed and fed.

The Director of Nursing (DON) was interviewed on 8/24/17 at 3:43 PM. The DON stated "We should not have residents waiting with their food in front of them, we have enough staff we could send more staff to that unit to help feed, I was not aware of this, but we will address this right away."

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F 241	Continued From page 9 The Administrator was interviewed on 8/24/17 at 4:04 PM. The Administrator stated that the 300 unit had more residents who required assistance with eating than the 100 and 200 units. The Administrator also stated that in the past, when it was brought to her attention that additional staff assistance was needed on the 300 unit to help residents with their meals, she instructed staff from the other units to go and assist. The Administrator further stated that it was still her expectation for staff from the 100 and 200 units to assist with dining on the 300 unit when needed. NA #6 was interviewed on 8/24/17 at 5:46 PM via telephone. NA #6 stated that "Everyday it is hard to feed all the residents on the 300 unit at the same time." NA #6 further stated that the meal service process was so time consuming, that by the time residents received help with their meal, "it's cold." NA #6 also stated that 10 residents on the 300 unit required some staff assistance with eating and that the staff fed 2 residents at a time while the other residents who needed help waited with their covered tray in front of them.	F 241		
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.	F 272		9/21/17

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F 272	Continued From page 10 (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 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 interviews, the facility failed to address underlying causes and factors contributing to risk for weight loss in a	F 272	F272 How corrective action will be accomplished for each resident found to	

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F 272	Continued From page 11 nutrition Care Area Assessment for 1 of 3 residents reviewed for nutrition (Resident #131). The findings included: Resident #131 was admitted to the facility 07/31/17 with diagnoses of seizures and stroke with left sided weakness. The admission Minimum Data Set (MDS) dated 07/20/17 indicated Resident #131's cognition was intact. The MDS assessment described the resident with limited range of motion on one side of the upper body and required extensive staff assistance for all activities of daily living except eating which required staff supervision. A review of a Care Area Assessment (CAA) for nutrition contained documentation describing the resident as alert, oriented, and verbal. The documentation specified the resident received a regular diet, fed himself, and had a good appetite. The weight was documented as 220 pounds. The documentation concluded with "will continue to monitor." A checklist following this documentation contained check marks by partial or total loss of arm movement, hemiparesis (weakness on one side of the body), and inability to perform ADLs (activities of daily living) without significant physical assistance. Documentation following this checklist specified "see nursing documentation dated 7/13-7/20 for supportive documentation." A review of nursing documentation from 7/13/17 through 7/20/17 made no reference to the resident's diagnoses or strengths and weaknesses.	F 272	have been affected by the deficient practice - CAA referenced review nursing documentation rather than indicating that the patient had no difficulty feeding himself when hemiparesis/paraplegia was checked. A progress note was completed 9/20/17 with a corrected nutrition CAA for resident #131. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: A corrected nutritional CAA was completed and scanned into the Medical Record by 9/21/17 for all currently admitted patients who triggered for the nutrition CAA on their last comprehensive MDS, which includes a revised/corrected analysis of findings and updated source descriptions. Measures to be put in place or systemic changes made to ensure practice will not re-occur: The Dining Services Manager and MDS Coordinators were educated on proper completion of nutrition CAA by the Corporate MDS Support, on 9/20/17. The Corporate Dietitian will include a review of CAA documentation as part of her weekly facility visits and include this on her weekly visit report to Administration. The audit sheets will be reviewed in weekly morning clinical stand up meeting with Director of Nursing, Administrator and Dining Services Manager. The Corporate Dietitian will audit nutrition CAA documentation at each weekly visit to observe 100% of CAAs completed since	

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F 272	Continued From page 12 An interview was conducted with MDS Coordinator #1 and MDS Coordinator #2 on 08/24/17 at 2:33 PM. MDS Coordinator #1 stated the Dietary Manager was responsible for completing nutrition CAAs. MDS Coordinator #1 read the nurses' notes for the designated dates and did not see any information that explained the resident's diagnoses or what made him at risk for weight loss. Both MDS Coordinators agreed the CAA was incomplete and did not address the underlying causes and contributing factors that could lead to weight loss. An interview was conducted with the Dietary Manager (DM) on 08/24/17 at 3:15 PM. The DM explained when he wrote see nursing documentation he meant anything the nurses might have documented anywhere in the medical record relating to the care of Resident #131 . The DM was unaware when referring to information in the medical record, he needed to be specific when referring to documentation to complete a CAA.	F 272	previous weekly visit x 4 weeks, then monthly x 2 months, then quarterly x 1 quarter to ensure deficient practice does not recur. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented, Audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly for a period of 3 months for review and revision as needed.	
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 review and staff and physician interviews, the facility failed to follow physician	F 281	How corrective action will be accomplished for each resident found to	9/21/17

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F 281	Continued From page 13 orders related for reporting weight gain and failed to follow facility protocol for reporting weight loss for 2 of 3 residents reviewed for nutrition (Residents #94 and #131). The findings included: 1. Resident # 94 was admitted to the facility 05/08/17 with diagnoses which included pneumonia, lymphedema (swelling related to fluid accumulation), and congestive heart failure (CHF). A care plan dated 05/08/17 described Resident #94 as at risk for weight fluctuation. The care plan goal specified the resident would avoid significant weight change through the next 90 day review. Interventions included "weights as ordered (daily weights for CHF)". Review of Resident #94's medical record revealed a physician's order dated 05/12/17. The order specified to obtain daily weights and notify the physician if weight gain greater than 3# (pounds) in 24 hours or 5# in 1 week. An annual Minimum Data Set (MDS) dated 06/03/17 indicated Resident #94's cognition was intact and was totally dependent on staff for dressing and locomotion throughout the facility. Continued medical record review revealed a weight for 08/18/17 was recorded as 204.7#. A weight obtained 08/20/17 was recorded as 210.5#, and weights for 8/21/17 was 212.9#, no weight was recorded 8/22/17, and a weight for 8/23/17 was 210.9# An interview was conducted with Nurse #4 on	F 281	have been affected by the deficient practice: Resident #94 had a weight gain and #131 had a weight loss and the staff nurse failed to notify the physician of the weight gain/loss, for patient #216 Daily weights were not obtain and reported so dietician could make recommendations. Physician was made aware of the weight gain and loss at the time of realization that notification had not occurred during the survey process and Dietician also made aware of the missed weights. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All patients in house were audited for orders specifically to notify the physician of weight gains or losses and ensured that physician and Registered Dietician were notified if appropriated and the order was followed for notification. Utilizing order listing report to identify patients with orders for daily weights. Measures to be put in place or systemic changes made to ensure practice will not re-occur: 1) Nurses educated and new hire nurses in orientation will be educated on the following procedure to ensure physician and physician extenders are notified of weight changes and/or symptoms associated with Congestive Heart Failure or Chronic Obstructive Pulmonary Disease and physician orders in general. 2) Monday through Friday Unit Manager and Unit Coordinator and weekends the	

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F 281	Continued From page 14 08/23/17 at 3:55 PM. Nurse #4 explained night shift obtained daily weights at the same time early in the morning. Nurse #4 reviewed the weights and confirmed there had been a weight gain for Resident #94. The nurse acknowledged the physician's order specified to notify the physician or a greater than 3# weight gain in 24 hours or a greater than 5 # weight gain in one week. Nurse #4 was unable to find any evidence the physician had been notified. An interview was conducted with Nurse #3 on 08/24/17 at 6:11 AM. The nurse stated she was working when Resident #94 was weighed 08/21/17, 08/22/17, and 08/23/17. Nurse #3 stated if she notified the physician of the resident's weight gain, she would have done it electronically. The nurse was unable to find any evidence she reported any weight gain. A continued interview with Nurse #3 on 08/24/17 at 6:48 AM revealed when she documented weights, she could see the 3 previous weights in the computer. Therefore was unable to see weight gain over the period of a week. An interview with Nurse Aide (NA) #3 on 08/24/17 at 6:36 AM revealed she weighed Resident #94 every day from 08/21/17 through today, 08/24/17. NA #3 stated she always weighed this resident by assisting the resident to stand on the scale in her room at the same time every morning. The NA added she provided the nurse with the weight results every day this week. An interview was conducted with the facility Medical Director (MD) on 08/24/17 at 11:04 AM. The MD stated Resident #94 was sent to the hospital once since her admission to the facility related to a 10# weight gain. This resident	F 281	Weekend Supervisor or Designee will run a Order Listing Report for Daily Weights, which is utilized for residents with Congestive Heart Failure and Chronic Obstructive Pulmonary Disease and ensure that the previous days weights were obtained as ordered. Any missed weights or reporting will result in re-education or corrective action for the Certified Nursing Assistant and the Charge Nurse that were responsible to obtain and report the weights or changes in symptoms to the physician as ordered by the Unit Manager, Unit Coordinator or Director of Nursing. This will be done daily for a period of 4 weeks, then Monday Wednesday for 1 month and 1x each week for a period of one month. 3) Monday through Friday Unit Manager and Unit Coordinator and weekends the Weekend Supervisor or Designee will run a 24 hour Shift Summary to review for documentation of symptoms and notification of physician or physician extender for Heart Failure and Chronic Obstructive Pulmonary Disease patients as indicated. This will be done daily for a period of 4 weeks, then Monday Wednesday for 1 month and 1x each week for a period of one month. 4) Weekly the Unit Manager and Unit Coordinator will run the weight variance report and prepare for the weekly weight meeting. During the weekly weight meeting the IDT (DON, Dietary Manager, Unit Manager and Unit Coordinator and RD if present) will meet and discuss significant weight losses and weight gains and documentation in medical completed	

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F 281	Continued From page 15 weighed 245# at admission due to fluid overload. The MD stated monitoring this resident's weight was very important. She expected her orders to be followed. The physician added she was not notified of any recent weight gain for Resident #94. An interview was conducted with the Director of Nursing (DON) on 08/24/17 at 6:04 PM. The DON stated it was the nurse's responsibility to follow the physician's orders. All the nurse had to do was click a button and all the resident's weights could be seen. 2. Resident #131 was admitted to the facility 07/13/17 with diagnoses which included stroke with muscle weakness. A care plan dated 07/14/17 described Resident #131 as at risk for weight fluctuation related to an acute condition and recent hospitalization. The care plan goal specified the resident would avoid significant weight change through the next 90 day review period. Interventions included provide diet as ordered and monitor intake and record each meal. An admission Minimum Data Set (MDS) dated 07/20/17 indicated Resident #131's cognition was intact and required extensive staff assistance for all activities of daily living except for eating. Supervision was required for eating. The MDS described the resident with limited range of motion on 1 side of the upper body. A nutrition care area assessment described Resident #131 as alert, oriented and verbal. The resident was able to feed himself and weighed 220# (pounds). The DM further documented he would continue to monitor Resident #131.	F 281	with notification of MD and RP. DON will e-mail the Dietician with patients discussed during Weight Meeting if RD□s signature is not on attendance sheet. The completed Nutrition Risk form will be given to the Director Nursing during the weekly Weight Meeting to ensure compliance. This will be done weekly for a period of 3 months. 5) The 1) Order Listing Report, 2) 24 hour Shift Summary and 3) List of patients discussed and copy of email if applicable will be given to the Administrator to monitor compliance with this plan. This will be done, daily Monday through Friday and Weekend Supervisor will place in Director of Nursing□s box from the weekend for 1) Order Listing Report, 2) 24 hour Shift Summary and 3) List of patients discussed and copy of email if applicable will be given to the Administrator will be provided weekly too monitor compliance with this plan. The audits will be discussed, at the Weekly Risk Meeting and revisions made to plan as needed. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented, Audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly for a period of 3 months for review and revision as needed.	

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A review of Resident #131's medical record revealed a weight of 220# recorded on 07/24/17 by Nurse Aide (NA) #2. "Wheelchair" was observed written by the 220#. An additional weight dated 08/14/17 specified the weight was obtained by NA #1 and was recorded as 202.3# with "Standing" written by the recorded weight.

Continued review of Resident #131's medical record revealed a note written by the Registered Dietician (RD) on 08/21/17 at 8:55 PM. The note specified Resident #131 triggered for questionable significant weight loss since admission. The most recent weight of 202.3# was in line with the hospital weight listed at 200#. The note further specified the weight of 220# was obtained via wheelchair and appeared to have been entered/obtained in error. Will continue to monitor intake and weight trends.

An interview was conducted with NA #2 at 6:09 PM on 08/23/17. NA #2 stated she weighed Resident #131 on 07/24/17. She explained when a resident was weighed in a wheelchair, the wheelchair was weighed without the resident and that weight was subtracted from the weight of the resident in the wheelchair. NA #2 stated that was the procedure she followed when weighing Resident #131 on 07/24/17 and 220# was the resident's actual weight. The NA added she gave the weight she obtained to the nurse on duty at that time.

An interview was conducted with NA #1 at 8:07 AM on 08/23/17. NA #1 stated she weighed Resident #131 on 08/14/17. The NA explained the resident was standing when she obtained the weight. NA #1 stated according to the procedure

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she was to follow when weighing a resident, she was supposed to reposition the resident and weight again if there was a 5# difference from the previous weight. She added she was unable to see the previous weight in the computer and was unaware of Resident #131's previous weight of 220#. The NA further stated she reported the weight she obtained to the nurse. NA #1 was unable to recall the nurse that was working on 08/14/17.

An interview was conducted with the RD on 08/23/17 at 10:51 AM. The RD stated he was in the facility weekly. He explained the Director of Nursing (DON) usually notified him of residents at risk for weight loss. The RD added the last facility weight meeting was 07/27/17. The RD stated he ran a weight report on 08/21/17 and discovered Resident #131's weight discrepancy of an 18# difference from July to August. In an additional interview on 08/24/17 at 11:02 AM the RD confirmed he did not find out about the 8% weight loss until he ran the weight report on 08/21/17.

An interview was conducted with the DON on 08/24/17 at 12:07 PM. The DON described the procedure the facility was to utilize to keep up with weight loss. He stated the NAs obtained the weight and reported to the nurse. The nurse should look to see if there was a change since the previous weight. If there was a change, the weight should be checked for accuracy by re-weighing the resident. The nurse should report the weight discrepancy to the Unit Manager. At that point, the weight should be brought up in the morning meeting and the RD, Physician, and Dietary Manager would be notified. The DON added he expected this

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F 281	Continued From page 18 procedure to be followed. An interview with Unit Manager #2 on 08/24/17 at 4:31 PM revealed she was the Unit Manager for the 200 hall where Resident #131 resided when first admitted. She stated she ran a report to check weights. She was unable to recall noting weight loss for Resident #131. An additional interview with Unit Manager #2 on 08/24/17 at 4:49 PM revealed she was unable to confirm which nurse worked on the evening of 08/14/17 when the last weight for Resident #131 was obtained and was unable to confirm on what hall the resident resided when the second weight was obtained.	F 281		
F 309 SS=D	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 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:	F 309		9/21/17

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F 309	Continued From page 19 (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 record reviews and staff interviews the facility failed to assess a resident with weight gain and swelling in both lower legs for 1 of 2 residents sampled to provide services to maintain well-being (Resident #216). Findings included: Resident #216 was admitted to the facility on 05/02/17 with diagnoses which included heart disease, chronic obstructive pulmonary disease and shortness of breath. A review of the admission Minimum Data Set (MDS) dated 05/09/17 revealed Resident #216 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #216 was totally dependent on staff for eating and had a feeding tube. A review of a hospital discharge summary dated 05/02/17 revealed Resident #216 had chronic obstructive pulmonary disease, heart disease and	F 309	How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #94 had a weight gain and the staff nurse failed to notify the physician of the weight gain. The Physician was made aware of the weight gain. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All patients in house were audited for orders specifically to notify the physician of weight gains or losses and ensure that the physician was notified and the order was followed for notification. Utilizing the order listing report to identify patients with orders for daily weights. Measures to be put in place or systemic changes made to ensure practice will not	

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F 309	Continued From page 20 hyponatremia (low sodium levels) and should be weighed daily. A review of an admission weight dated 05/02/17 revealed Resident #216 weighed 123.2 pounds. A review of a care plan dated 05/03/17 with a problem statement revealed in part Resident #216 was at risk for weight fluctuation related to recent hospitalization and feeding tube dependence and the goal indicated Resident #216 would avoid significant weight change through next review. The interventions were listed to provide bolus tube feeding regimen, provide water flushes and supplements as ordered and obtain weekly weights. A review of physician's orders dated 05/03/17 indicated feedings by a tube in the stomach 5 times a day for hydration and 100 milliliters (ml) water flush before and after tube feeding 5 times daily and resident was ordered nothing by mouth. A review of a Registered Dietician's note dated 05/03/17 revealed Resident #216 was admitted with a diet of nothing by mouth with tube feeding dependence and weight was 123.2 pounds and continue to monitor tube feeding tolerance and weight trends. A review of physician's orders dated 05/08/17 indicated to check weight daily and notify physician or Nurse Practitioner if weight gain was greater than 3 pounds in 24 hours or greater than 5 pounds in 1 week. A review of weights documented in the electronic medical record revealed there were no daily weights recorded on the following dates:	F 309	re-occur: 1) Nurses educated and new hire nurses in orientation will be educated on the following procedure to ensure physician and physician extenders are notified of weight changes and/or symptoms associated with Congestive Heart Failure or Chronic Obstructive Pulmonary Disease and physician orders in general. 2) Monday through Friday Unit Manager and Unit Coordinator and weekends the Weekend Supervisor or Designee will run a Order Listing Report for Daily Weights, which is utilized for residents with Congestive Heart Failure and Chronic Obstructive Pulmonary Disease and ensure that the previous days weights were obtained as ordered. Any missed weights or reporting will result in re-education or corrective action for the Certified Nursing Assistant and the Charge Nurse that were responsible to obtain and report the weights or changes in symptoms to the physician as ordered by the Unit Manager, Unit Coordinator or Director of Nursing. This will be done daily for a period of 4 weeks, then Monday Wednesday for 1 month and 1x each week for a period of one month. 3) Monday through Friday Unit Manager and Unit Coordinator and weekends the Weekend Supervisor or Designee will run a 24 hour Shift Summary to review for documentation of symptoms and notification of physician or physician extender for Heart Failure and Chronic Obstructive Pulmonary Disease patients as indicated. This will be done daily for a period of 4 weeks, then Monday	

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F 309	Continued From page 21 05/09/17 05/17/17 05/26/17 05/29/17 A review of weights documented in the electronic medical record revealed there were no weights recorded on the following dates: 06/06/17 06/07/17 A review of a Nurse Practitioner's Progress Note dated 06/12/17 indicated Resident #216 had increased swelling in both of his lower legs according to family. The notes further indicated a trace amount of swelling was noted but family reported the swelling was worse yesterday on 06/11/17 and Resident #216 was short of breath. The notes revealed Resident #216 was encouraged to elevate both of his lower legs intermittently. A review of nurse's progress notes dated 06/12/17 revealed there was no nursing assessment of Resident #216 and no documentation regarding increased swelling in his lower legs or assessment of lung sounds. A review of a Registered Dietician note dated 06/20/17 indicated Resident #216 had significant weight gain noted over the past month and the Nurse Practitioner note on 06/12/17 indicated bilateral lower leg swelling and the weight gain was likely fluid related and continue to monitor tube feeding tolerance and weight trends. A review of a Nurse Practitioner progress note dated 06/22/17 indicated Resident #216 had increased oral secretions and his weight on	F 309	Wednesday for 1 month and 1x each week for a period of one month. 4) The 1) Order Listing Report and 2) 24 hour Shift Summary will be given to the Director of Nursing to ensure that plan of correction is followed. This will be done, daily Monday through Friday and Weekend Supervisor will place in Director of Nursing□s box from the weekend. The audits will be discussed, at the Weekly Risk Meeting and revisions made to plan as needed. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented, Audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly for a period of 3 months for review and revision as needed.	

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06/20/17 was 140.6 pounds. The notes further indicated Resident #216's weight today on 06/22/17 was 146.9 pounds with a 6.3 pound weight gain in 2 days. The notes revealed family was taking Resident #216 to the hospital.

During an interview on 08/24/17 at 6:33 AM with Nurse #3 she stated she recalled Resident #216 received tube feedings. She explained after review of Resident #216's medical record he had an increase in weights and nurses were expected to assess residents if they had any changes in their condition. She further stated she did not recall doing an assessment related to symptoms for his weight increase and if she had done them she would have documented them.

During an interview on 08/24/17 at 11:40 AM the Nurse Practitioner stated it was her expectation for nurses to monitor residents who had daily weights and she expected for them to assess residents for increased swelling or shortness of breath. She further stated Resident #216 had an increase in his weights and he should have been monitored for any symptoms related to his increased weight. She explained she felt the system for nursing assessments needed to be improved and that would be of help to her and the physician in obtaining information regarding changes in resident conditions. She stated she was aware the Nurse Aides (NAs) obtained the weights on residents but she was concerned as to whether nurses monitored them.

During an interview on 08/24/17 at 12:48 PM with Resident #216's Physician who was also the facility Medical Director she confirmed Resident #216 had previous hospitalizations for low sodium levels. She stated it was her expectation for

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F 309	Continued From page 23 nurses to assess residents and check weights according to physician's orders. She further stated she expected for physician's orders to be followed and for nurses to assess and document their findings. During a phone interview on 08/24/17 at 2:29 PM with Nurse #1 who had provided care to Resident #216 she stated if a resident had changes in a their condition, they were supposed to assess the resident and check their vital signs. She confirmed she had not reviewed Resident #216's weights and had not assessed him for symptoms such as swelling in his lower legs related to his weights. During a telephone interview on 08/24/17 at 5:14 PM Nurse #7 verified she no longer worked at the facility but had provided care to Resident #216 when she had worked at the facility. She explained if a resident had a change in condition nurses were supposed to assess the resident. She stated she remembered he could not eat or drink anything by mouth and he had a lot of phlegm in the beginning and he kept a cup close by to spit in. She explained she had not looked at his weights when she had provided care to him. During an interview on 08/24/17 at 5:46 PM with the Director of Nursing he stated it was his expectation for nurses to review resident weights and to assess residents. He stated it was his expectation for nurses to follow physician's orders and to assess residents for any changes in their condition and report their findings to the physician for them to evaluate the resident.	F 309		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		9/21/17

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F 371	Continued From page 24 (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 interview the facility failed to serve a potentially hazardous food (pureed beef) at least 135 degrees Fahrenheit (F) to prevent food borne illness, store bananas 60 - 70 degrees F per USDA recommendations to prevent the growth of bacteria and discard bananas once there were signs of spoilage and gnat activity. The findings included: 1 a. An observation of the lunch tray line on the	F 371	How the corrective action will be accomplished for the resident(s) affected - On 8/21/17 expired food items were identified (spoiled bananas) and discarded immediately by Dietary Manager. Dietary Manager & Supervisor checked all food storage areas for expired items and sanitation expectation was reviewed with Supervisor by Dietary Manager. On 8/23/17 pureed beef was served at 128.7 degrees F. Corporate Dietitian & Dietary Manager reviewed	

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F 371	Continued From page 25 300 unit occurred on 8/23/2017 at 12:23 PM. The Kitchen Supervisor (KS) was observed to conduct temperature monitoring of pureed beef prior to the start of the lunch tray line. The pureed beef was packaged in an individual plastic pouch and stored on the steam table in a 4 inch stainless steel pan stacked with other individual plastic pouches of pureed foods. The temperature of the pureed beef was observed at 132 degrees F. On 8/23/17 at 12:46 PM, the KS removed the pureed beef from the plastic pouch and plated the beef for Resident #161. The KS obtained the temperature of the pureed beef at the request of the surveyor. The pureed beef was 128.7 degrees F and then the KS placed the lunch meal, with the pureed beef, for Resident #161 on the top shelf of the steam table for delivery to the Resident. The KS was interviewed on 8/23/17 at 1:00 PM and stated that hot foods should be maintained on the steam table at a temperature of at least 160 degrees F and that the pureed beef should have been reheated. The Director of Food Service (DFS) was interviewed on 8/23/17 at 1:11 PM and stated that hot foods should be served at a temperature of at least 135 degrees F and he expected dietary staff to reheat potentially hazardous foods to at least 165 degrees F before serving. 1 b. Review of USDA recommendations for storage of bananas (https://fns-prod.azureedge.net/sites/default/files/quality_intro.pdf) revealed a recommendation to store bananas at 60 - 70 degrees F. An observation of the dry storage room occurred	F 371	proper serving temperatures (> or equal to 135 degrees F for hot foods) with Supervisor and all Dietary Staff on shift 8/23/17. How corrective action will be accomplished for those residents with the potential to be affected by the same practice Dietary department in-service started on 9/12/17 to review food storage guidelines and proper holding/serving temperatures for hot and cold foods. In-service will be completed for all dietary staff and will be completed by 9/15/17. Measure to be put in place or systemic changes made to ensure practice will not re-occur All future dietary staff hired will be given education on food storage guidelines, information on labeling and dating food, disposal of expired food items, and proper holding/serving temperatures for hot and cold foods. An audit of all storage areas (refrigerators, freezer, and dry storage) will be completed by the Dining Services Manager, Corporate RD, or designee once a week for 4 weeks, once monthly x 2 months, then quarterly for 1 quarter to ensure sanitation expectations are met and results reported to the Administrator. The Dining Services Manager, Corporate RD, or designee will complete daily temperature checks of all serving kitchens to ensure proper holding temps of > or equal to 135 degrees F for hot foods and < or equal to 41 degrees F for cold foods is maintained. To ensure acceptable performance is maintained, this audit of food holding temperatures will be conducted once a week for 4 weeks, once	

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F 371	Continued From page 26 on 8/21/17 at 10:20 AM. During the observation a box of 15 bananas was observed open to air. The bananas were observed with dark brown discolored banana peels and gnat activity. The DFS stated during the observation that it was the facility's routine practice to store fresh bananas in the dry storage room because bananas should not be refrigerated. He stated that bananas were best stored at a temperature between 55 - 70 degrees which was warmer than refrigeration. He stated the current temperature of the dry storage room was 71 degrees F and further stated, "I will go ahead and discard these since there is gnat activity."	F 371	monthly x 2 months, then quarterly for 1 quarter. The audit sheets will be reviewed in the weekly morning clinical stand-up meeting with the Dining Services Manager, DON and Administrator How facility will monitor corrective action(s) to ensure deficient practice will not re-occur The administrator will be responsible to ensure that the plan of correction is implemented, Audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly for a period of 3 months for review and revision as needed.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 441		9/21/17

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possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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F 441	Continued From page 28 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to disinfect a blood glucose meter according to manufacturer's guidelines after obtaining a finger stick blood sugar for 1 of 1 resident observation of blood glucose monitoring during medication pass (Resident #268). The facility also failed to ensure a sitter adhered to isolation precautions for 1 of 2 residents reviewed for isolation precautions (Resident #337). Findings included: 1. A review of a facility policy titled Infection Control Policies and Procedures for Clinical Equipment dated 02/01/15 indicated in part a section labeled Glucometers (blood glucose meters) to clean in accordance with manufacturer's recommendations. A review of the manufacturer's directions for use of Bleach Germicidal Disposable Wipes indicated to unfold a clean wipe and thoroughly wet surface of blood glucose meter. The directions further indicated the treated surface must remain visibly wet for a full 4 minutes and additional wipes may be used to assure continuous wet contact time. An observation during medication pass on 08/23/17 at 4:43 PM revealed Nurse #2 removed a blood glucose meter from inside a drawer on the medication cart and gathered supplies and then carried the blood glucose meter and supplies into Resident's #268's room and placed	F 441	F441 How the corrective action will be accomplished for the resident(s) affected. Nurse that did not disinfect the glucometer correctly was immediately in-serviced on the use of PDI Sani Cloth wipes to disinfect glucometers on 08/24/17. Visitor educated on the use of PPE and not sitting in the resident room unprotected and this was documented. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Nurses were in-serviced on the disinfection process using PDI Sani Cloth wipes, wiping the machine and discarding first wipe and using a second wipe and allowing the 4 minutes of contact with wipe and then allowed to air dry. Any nurses not in-serviced will not be allowed work until in-service is obtained from SDC. The following is the information that was presented: Using PDI Sani-Cloth Germicidal Disposable Wipes to disinfect the Blood Glucose Meters. Steps for disinfecting Blood Glucose Meters: 1. Use one wipe to clean meter- discard 2. Use a second wipe and wrap the meter in it. 3. Place wrapped meter in cup, let stand	

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them on a bedside table. She performed a finger stick blood sugar and carried the blood glucose meter back to the medication cart. She then opened an individual packet of a Bleach Germicidal Disposable Wipe and wiped the front, sides and back of the blood glucose meter at 4:48 PM and then wrapped a dry tissue around the meter and placed it back in the medication cart at 4:51 PM.

During an interview on 08/23/17 at 4:56 PM Nurse #2 stated she did not clean the blood glucose meter before she performed the finger stick blood sugar for Resident #268 because she had wiped it off earlier after she had checked another's resident's blood sugar. She explained it was her usual practice to wipe the front, sides and back of the blood glucose meter with the Bleach Germicidal Disposable Wipe but she did not check or verify the length of time the meter stayed wet after she wiped off the blood glucose meter. She explained she thought it took 2-4 minutes for the meter to dry and then it was ready for use.

During an interview on 08/24/17 at 5:46 PM the Director of Nursing stated it was his expectation for staff to follow the manufacturer's guidelines for cleaning blood glucose meters. He verified the manufacturer's guidelines specified for the blood glucose meter to remain wet for 4 minutes and he expected for staff to make sure the blood glucose meter remained wet for the required 4 minutes.

2. Review of Centers for Disease Control and Prevention (CDC) 2007 guidelines for isolation precautions for a person with shingles revealed the recommendation to place the patient on airborne and contact precautions for the duration

for 4 minutes
4. Remove wrapped meter from cup, discard wipe, place meter
On wash cloth to air dry.
While this meter is being disinfected utilize your second Blood Glucose Meter.

Nurses were educated that patient visitors of isolation patients would be instructed on proper use of PPE and if adherence to the use of Protective Equipment was not adhered too then the visitor would be asked to leave for the protection of themselves and public health.

Measures in place to ensure practices will not occur. During orientation all nurses will receive education in regards to disinfection of glucometer using PDI Sani Cloth wipes, wiping surfaces and wrapping in a second cloth for 4 minutes and then allowed to air dry.
Using PDI Super Sani-Cloth Germicidal Disposable Wipes to disinfect the Blood Glucose Meters.
Steps for disinfecting Blood Glucose Meters:
1. Use one wipe to clean meter- discard
2. Use a second wipe and wrap the meter in it.
3. Place wrapped meter in cup, let stand for 4 minutes
4. Remove wrapped meter from cup, discard wipe, place meter on wash cloth to air dry.
While this meter is being disinfected utilize your second Blood Glucose Meter.

SDC/Infection Control Nurse/Unit

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of the illness if the infection was disseminated in any patient, or if it was localized in an immunocompromised patient until dissemination was ruled out.

Review of CDC 2007 guidelines for isolation precautions for a person with Clostridium difficile (C. diff.) revealed the recommendation to place the patient on contact precautions for the duration of the illness.

Review of a facility policy titled Infection Control Policies and Procedures, Precautionary Measures, Isolation Precautions- General Practice, effective 11/11/16, revealed isolation precautions were initiated to protect other patients, employees and visitors from the spread of a confirmed or suspected infection or contagious disease. The policy documented that precautions would be based on studies of pathogens, knowledge of the natural history of certain diseases and studies of epidemiology. Transmission based precautions could be used for patients with known or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens. The policy further documented that the health care team and visitors would be instructed on the importance and necessity of maintaining isolation precautions before entering the patient's room.

Resident #337 was admitted to the facility on 8/14/17 with diagnoses including shingles.

Review of Resident #337's record revealed an order dated 8/14/17 for contact precautions for shingles (this order was discontinued on 8/23/17). Another order dated 8/14/17 revealed a prescription for valcyclovir (an antiviral

Manager or DON to do weekly observations on 5 residents which have Glucose Monitoring for x12 weeks, to observe for correct disinfection, then monthly x3 months.

Nurses were educated that patient visitors of isolation patients would be instructed on proper use of PPE and if adherence to the use of Protective Equipment was not adhered too then the visitor would be asked to leave for the protection of themselves and public health.
1) Isolation signs indicate that visitors should contact nurse before entering the patient room.
2) If a visitor is found in a resident room without appropriate protective equipment then they will be asked to wash hands and don protective equipment to protect themselves and the public.
3) If visitor refuses to don protective equipment then they will be restricted from visiting the patient until such time they are compliant with infection control guidelines as public safety takes priority.

Staff Development/Infection Control Nurses will do rounds on all patients on Isolation Monday through Friday, twice daily to monitor for adherence Infection Control Guidelines. This will be annotated on an audit tool and indication of whether a visitor had to be asked to not visit was required. A progress note will be placed in patient medical record of the noncompliance of visitor and restriction to visitation. This will be done weekly for a period of 3 months to monitor for

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F 441	Continued From page 31 medication) for shingles (this order was discontinued on 8/15/17). Observation on 8/21/17 at 12:51 PM revealed a yellow airborne precaution sign affixed to the door frame leading into an anteroom just outside Resident #337's room. This sign instructed visitors to wear respiratory protection, gowns and gloves when entering the room (also known as personal protective equipment, or PPE). Inside the anteroom was a receptacle full of used gowns. Outside of the door in the hallway was a cart with drawers containing PPE. Observation on 8/22/17 at 10:13 AM revealed a visitor leaving Resident #337's room and entering the anteroom with no PPE. Interview on 8/22/17 at 10:13 AM with the visitor revealed she was Resident #337's private sitter when the resident was at her home and she was in the facility to attend to her needs. She stated she only put on a gown and gloves if she was caring for her or touching her, but if she was only delivering a meal tray or visiting, she did not wear a gown or gloves. Further review of Resident #337's record revealed an order dated 8/23/17 to cleanse the right upper abdominal with shingles with bacitracin zinc ointment and apply dressing, changing it daily. Review of a laboratory report dated 8/23/17 revealed the presence of toxigenic C. diff. Review of another order dated 8/23/17 directed contact precautions for C. diff. Observation on 8/23/17 at 8:15 AM revealed a red contact precaution sign for "Special Enteric" affixed to the door frame leading into an anteroom just outside of Resident #337's room.	F 441	continued compliance. How the facility plans to monitor and ensure correction is achieved and sustained. The administrator will be responsible to ensure that the plan of correction is implemented, Audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly for a period of 3 months for review and revision as needed.	

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This sign instructed visitors to wear PPE when entering the room. Inside the anteroom was a receptacle full of used gowns. Outside of the door in the hallway was a cart with drawers containing PPE.
Observation on 8/23/17 at 11:22 AM revealed a red contact precaution sign for "Special Enteric" affixed to the door frame leading into an anteroom just outside of Resident #337's room and PPE in the cart in the hallway. The door to Resident #337's room was cracked open and Visitor #1 was seated next to the resident, who had her eyes closed. A visitor (the same observed on 8/22/17) was not wearing PPE, reading a book.

Interview on 8/23/17 at 11:24 AM with Nurse #5 revealed she was assigned to Resident #337. She stated the resident was put on isolation for shingles when she was admitted. She stated the resident's lesions were located on her right upper abdomen and were slightly weeping but barely, and the resident did scratch the lesions. She stated there was discussion about discontinuing her isolation that day and a loose dressing was placed over the lesions to prevent the resident from scratching them.

Interview on 8/23/17 at 11:24 AM with the Unit Manager #2 for Resident #337's hallway revealed there was no drainage from the resident's lesions but a small amount of drainage was noted on an abdominal pad which was closely monitored. She stated that airborne precautions sign was initially put up but this was the wrong sign, which was replaced with a contact precautions sign, which was what was ordered by the physician and was care planned. She stated family and visitors were educated on wearing PPE for residents on

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F 441	Continued From page 33 isolation and if nurses did not see them wearing this they were educated. She stated staff were aware of the resident's visitor who was a private sitter and this visitor was not performing any resident assistance with activities of daily living. She stated the resident was bed bound at this time and the Director of Nursing (DON) and she were providing coverage for infection control matters in the facility. Interview on 8/23/17 at 3:56 PM with Nurse #6 revealed Resident #337 was on contact isolation for shingles but was now on contact isolation for C. diff. She stated one did not wear a mask for isolation precautions for C. diff but otherwise, "all the other rules apply." She stated everyone who entered the resident's room was expected to gown and glove. She stated the resident was just diagnosed with C. diff and she did not care for the resident when she had shingles. Interview on 8/24/17 at 10:22 AM with the Administrator revealed she would "rather err on the side of caution" with regard to following isolation precautions and the facility put them in place if there was no definitive proof that an infection process had cleared. She stated the facility physician would make the final decision if precautions should be implemented for a resident.	F 441		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that	F 514		9/26/17

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F 514	Continued From page 34 are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to document daily weights as ordered by the physician for 1 of 3 residents who had weight gain and swelling of lower extremities who were sampled for weights (Resident #216). Findings included: Resident #216 was admitted to the facility on	F 514	F514 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #216 had symptoms of edema and there were no daily weights documented. Physician and physician extender were informed of the weight gain	

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F 514	Continued From page 35 05/02/17 with diagnoses which included heart disease, chronic obstructive pulmonary disease and shortness of breath. A review of the admission Minimum Data Set (MDS) dated 05/09/17 revealed Resident #216 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #216 was totally dependent on staff for eating and had a feeding tube. A review of a hospital discharge summary dated 05/02/17 revealed Resident #216 had chronic obstructive pulmonary disease, heart disease and hyponatremia (low sodium levels) and should be weighed daily. A review of a care plan dated 05/03/17 with a problem statement revealed in part Resident #216 was at risk for weight fluctuation related to recent hospitalization and feeding tube dependence and the goal indicated Resident #216 would avoid significant weight change through next review. The interventions were listed to provide bolus tube feeding regimen, provide water flushes and supplements as ordered and obtain weekly weights. A review of physician's orders dated 05/03/17 indicated feedings by a tube in the stomach 5 times a day for hydration and 100 milliliters (ml) water flush before and after tube feeding 5 times daily and Resident #216 was ordered nothing by mouth. A review of a Registered Dietician's note dated 05/03/17 revealed Resident #216 was admitted with a diet of nothing by mouth with tube feeding dependence and his weight was 123.2 pounds	F 514	and the associated edema loss at the time of realization that notification had not occurred, but patient was already discharged. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All patients in house were audited for orders specifically to notify the physician of weight gains or losses and 8/24/72 hour shift summary reviewed for indications of Congestive Heart Failure symptoms as of 9/12 and physician notified. Utilizing order listing report to identify patients with orders for daily weights and shift summary report. CNA□s re-educated on documenting daily weights into PCC and notifying nurses of weight variances and any indications of swelling noted during patient care. Measures to be put in place or systemic changes made to ensure practice will not re-occur: 1) Monday through Friday Unit Manager and Unit Coordinator and weekends the Weekend Supervisor or Designee will run a Order Listing Report for Daily Weights, which is utilized for residents with Congestive Heart Failure and Chronic Obstructive Pulmonary Disease and ensure that the previous days weights were obtained as ordered. Any missed weights or lack of documentation of the weights will result in re-education or corrective action for the Certified Nursing Assistant and the Charge Nurse that were responsible to obtain and report the	

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F 514	Continued From page 36 and would continue to monitor tube feeding tolerance and weight trends. A review of physician's orders dated 05/08/17 indicated to check weight daily and notify physician or Nurse Practitioner if weight gain was greater than 3 pounds in 24 hours or greater than 5 pounds in 1 week. A review of weights documented in the electronic medical record revealed there were no weights recorded on the following dates: 05/09/17 05/17/17 05/26/17 05/29/17 A review of weights documented in the electronic medical record revealed there were no weights recorded on the following dates: 06/06/17 06/07/17 A review of a Registered Dietician note dated 06/20/17 indicated Resident #216 had significant weight gain noted over the past month and the Nurse Practitioner note on 06/12/17 indicated bilateral lower leg swelling and the weight gain was likely fluid related and continue to monitor tube feeding tolerance and weight trends. A review of a Nurse Practitioner progress note dated 06/22/17 indicated Resident #216 had increased oral secretions and his weight on 06/20/17 was 140.6 pounds. The notes further indicated Resident #216's weight today on 06/22/17 was 146.9 pounds with a 6.3 pound weight gain in 2 days. The notes revealed family was taking Resident #216 to the hospital.	F 514	weights or changes in symptoms to the physician as ordered by the Unit Manager, Unit Coordinator or Director of Nursing. This will be done daily for a period of 4 weeks, then Monday Wednesday and Friday for 1 month and 1x each week for a period of one month. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented, Audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly for a period of 3 months for review and revision as needed.	

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F 514	Continued From page 37 During an interview on 08/24/17 at 6:33 AM Nurse #3 explained if a resident was ordered a daily weight the Nurse Aides (NAs) were supposed to document the daily weights in their computerized documentation system and if a resident refused a weight there was a place to comment on the reason of the refusal. After review of Resident #216's medical record Nurse #3 confirmed on the Medication Administration Record dated June 2017 there were 2 dates on 06/06/17 and 06/07/17 where the documentation of weights was blank. During an interview on 08/24/17 at 11:40 AM the Nurse Practitioner stated it was her expectation for nursing staff to follow physician's orders and if a resident was ordered daily weights she expected for them to be done and recorded in the resident's medical record. During an interview on 08/24/17 at 12:48 PM with Resident #216's physician who was also the facility Medical Director she stated it was her expectation for nurses to follow physician's orders. She further stated if a resident was ordered daily weights she expected for those to be documented in the resident's medical record so she or her Nurse Practitioner could monitor for weight changes. During an interview on 08/24/17 at 2:29 PM Nurse #1 stated she was not sure how to see if a resident's weight was recorded in a resident's electronic medical record because the NAs documented it in their electronic system but not in the one she used. She stated since she did not know where the weights were recorded she had not reviewed Resident #216's weights.	F 514		

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F 514	Continued From page 38 During a telephone interview on 08/24/17 at 4:31 PM NA #7 confirmed she remembered Resident #216. She explained residents who were ordered daily weights were done by the third shift NAs. She stated she tried to get Resident #216 up between 6:00 and 7:00 AM but she could not explain Resident #216's weights were not documented. During a telephone interview on 08/24/2017 on 4:25 PM NA #8 stated she recalled she had helped NA #7 get Resident #216's weights but had no idea why the weights were not documented every day. She stated NAs were supposed to let the nurse know if they could not get a weight or if a resident refused a weight. During an interview on 08/24/17 at 5:46 PM the Director of Nursing stated if a resident was ordered daily weights they should be obtained and placed in the resident's medical record. He explained if a resident refused weights he would have expected for NAs to report it to the nurse. He further stated he felt there was room for improvement with documentation.	F 514		