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	345442	A. BUILDING _____ B. WING _____	09/14/2017

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FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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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 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.	F 280		10/13/17

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

Electronically Signed | 10/05/2017

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F 280	Continued From page 1 483.21 (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 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.	F 280		

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F 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise the plan of care for behaviors for one of five residents reviewed for unnecessary medications (Resident #11) and for nutrition for two of four residents reviewed for nutrition (Resident #9 and #73). The findings included: 1. Resident #11 was admitted to the facility on 1/5/15 with diagnoses that included dementia, delusional disorder, and depression. The quarterly Minimum Data Set (MDS) assessment dated 7/1/17 indicated Resident #11 ' s cognition was moderately impaired. He was assessed with no delusions, no hallucinations, no behaviors, and no rejection of care. Resident #11 was not on any psychotropic medications. The plan of care for Resident #11 included the problem area of Behavior/Mood initiated on 12/23/16 and most recently reviewed on 7/26/17. He was indicated to have impaired or inappropriate behaviors, signs/symptoms of behavioral and psychological symptoms of dementia, and resistance to care. Resident #11 was noted with cognitive loss, insufficient safety awareness, noncompliance with care or treatment, expressions of sorrow, refusing care, ineffective impulse control, cursing, crying, and accusatory remarks. The interventions included, in part, redirect inappropriate behaviors and wait and reattempt when refusing care or treatment. A nursing note dated 9/3/17 written by Nurse #3 at 7:20 AM indicated Resident #11 had delusional behaviors. Resident #11 reportedly stated to a	F 280	1. On 10/2/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents' care plans for behaviors/mood and nutrition/hydration are reviewed and revised with changes in residents' condition to provide behavioral and nutritional care to meet the goals and needs of the resident. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #11, it was determined that the facility failed to implement a new intervention to address a new behavior to meet the care plan goal for the patient. On 9/29/17, the Social Worker updated Resident #11 behavior/mood care plan to include a new intervention to appropriately address residents' behaviors and meet the residents' behavioral care goals. On 9/29/17 Resident #11's care plan was updated with new interventions including Family removed knives from residents possession, plastic knives will replace metal knives on meal trays, psychological evaluation and treatment, and psychiatric evaluation and treatment.	

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F 280	Continued From page 3 Nursing Assistant (NA) that he needed a broomstick to protect himself because of all of the fighting. Nurse #3 indicated she attempted to redirect Resident #11 and assured him that he was safe at the facility. A nursing note dated 9/3/17 written by Nurse #3 at 8:00 AM indicated, "[Nurse #3] to dining room ...noticed that [Resident #11] had an opened knife stuck down in front of his pants between his stomach and the elastic on his jogging pants." Resident #11 was instructed by the nurse that he was not permitted to have the knife and the knife was removed from his possession. Resident #11 was noted with delusional beliefs as he reportedly asked Nurse #3 how he was going to protect himself from all the men going around. Nurse #3 assured Resident #11 that he was safe and informed him that his knife was going to be locked up. The Director of Nursing (DON) was reportedly informed of Resident #11 ' s behaviors. A nursing note dated 9/3/17 written by Nurse #3 at 1:03 PM indicated a message was left with the mental health provider reporting Resident #11 ' s behaviors. A nursing note dated 9/3/17 written by Nurse #3 at 1:29 PM indicated Resident #11 ' s Responsible Party (RP) was contacted by phone and updated on Resident #11 ' s possession of the knife this morning and that the knife was now locked in the medication cart. Resident #11 ' s plan of care related to Behavior/Mood was updated on 9/5/17 by the Social Worker (SW). The update included the problem of Resident #11 noted to have had weapons on him to protect himself. The goals	F 280	Through Root Cause Analysis and based on the findings for Resident #9 and #73, it was determined that nursing failed to communicate diet and supplement changes to the dietary department which resulted in the failure to update the residents' nutrition/hydration care plan. On date 9/29/17, the Dietary Manager updated Resident #73 nutrition/hydration care plan to include current puree diet and supplements per RD (Registered Dietitian) recommendations and physician orders. 2. On 10/4/17, the MDS (minimum data set)nurse and Social Worker completed a QA (quality assurance) monitoring of 57 current facility residents' behavior/mood care plans to ensure that residents have appropriate interventions in place to address their behavioral care needs. No discrepancies were identified. On 10/4/17, the MDS nurse, Director of Clinical Services and Dietary Manager completed a QA monitoring of 57 current facility residents' nutrition/hydration care plans to ensure that residents' diet orders and current supplement recommendations/orders from 7/1/17-9/30/17 are included to address their nutritional needs. Any identified discrepancies were updated as appropriate. 3. On 10/2/17, the Regional Director of Clinical Services provided education to the Interdisciplinary Team (IDT) on	

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F 280	Continued From page 4 were also updated and included, "[Resident #11] will have less episodes of keeping weapons on him." There were no revisions made to the interventions section of this plan of care. An interview was conducted on 9/14/17 at 2:54 PM with the SW. The nursing notes dated 9/3/17 that indicated Resident #11 was found in the dining room with a knife tucked into the resident ' s waistband of his pants was reviewed with the SW. She stated this incident had occurred over the weekend and was discussed in the morning clinical meeting on 9/5/17. She reported the Director of Nursing (DON), Unit Manager (UM), Minimum Data Set (MDS) Coordinator, Activities Director, Therapy Manager, and Dietary Manager were all in attendance at the clinical meeting. The SW stated on 9/3/17 Resident #11 had been found with butter knife that she thought he had obtained from the kitchen. She indicated the staff for the 9/3/17 incident reported Resident #11 stated he wanted to protect himself. The interview with the SW continued. She stated it was the responsibility of the all staff who attended the clinical meeting to develop new interventions for care plans, but she was responsible for updating the behavioral care plans. She reported she updated the plan of care for Resident #11 following the clinical meeting on 9/5/17. The plan of care related to Behavior/Mood for Resident #11 was reviewed with the SW. The updated problem of Resident #11 having had weapons on him to protect himself was reviewed with the SW. The updated goal of Resident #11 having less episodes of keeping weapons on him was reviewed with the SW. The unrevised interventions to this plan of care for Resident #11 was reviewed with the SW.	F 280	Consulate policies and procedures of reviewing and revising the residents' plan of care when a resident exhibits a new behavior, has a change in diet or RD (registered dietitian) recommendations and/or physicians' orders to address nutritional needs of the resident. Education included the roles and responsibilities of the Social Worker on documenting behavior/mood care plan changes and the Dietary Manager on documenting nutrition/hydration care plan changes. The IDT members are inclusive of, but not limited to, the Executive Director, Director of Clinical Services, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. Newly hired IDT members will be educated by the Director of Clinical Services upon hire. Licensed nurse will document resident behaviors using behavior monitoring sheets, 24 HR report, or nurse's notes. The IDT to review residents' with new behaviors during Daily Clinical Meeting and as needed to determine an appropriate plan of care, including a new intervention to address the new behavior and meet the patients' care needs. The Social Worker, or MDS coordinator in the absence of the social worker, is responsible for updating the behavior/mood care plan with any revisions as appropriate. The Director of Clinical Service to review residents with new behaviors during weekly Behavior Risk meetings to monitor compliance with updates to the residents' behavior/mood	

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F 280	Continued From page 5 She verified no new interventions were added to the care plan for Resident #11 ' s behavior of having weapons in his possession. An interview as conducted was conducted with the DON on 9/14/17 at 3:05 PM. The nursing notes dated 9/3/17 that indicated Resident #11 was found in the dining room with a knife tucked into the resident ' s waistband of his pants was reviewed with the DON. She stated the incident occurred on the weekend and Nurse #3 had informed her of the incident by phone. She revealed it was not a butter knife that Resident #11 had in his possession. She reported she was unsure of the type of knife it was, but it was not a knife Resident #11 had obtained from the facility. The DON stated Nurse #3 had removed the knife and locked in the medication cart for safety. She reported Nurse #3 searched Resident #11 ' s room to ensure there were no other weapons. The DON indicated she instructed Nurse #3 to contact Resident #11 ' s family to inform them of the incident and to find out how Resident #11 had obtained the knife. She reported Nurse #3 had sent messages to the mental health provider and the physician using a secured text messaging system. The DON stated Nurse #3 was instructed to observe Resident #11 more frequently that day and for his knife to be removed from his meal trays that day. She indicated this was for one day only. A phone interview was conducted with Nurse #3 on 9/14/17 at 3:10 PM. She stated she had been working at the facility for over three years. She confirmed she was working on 9/3/17 when Resident #11 was found in the dining room with a knife tucked into the resident ' s waistband of his pants. Nurse #3 reviewed the events that	F 280	care plan as appropriate. Licensed nurse will write physician order and send communication form to dietary manager. The IDT to review residents' with new nutrition/hydration changes during Daily Clinical Meeting to determine an appropriate plan of care, including a new intervention to address the nutrition/hydration changes and meet the patients' care needs. The Dietary manager, or MDS coordinator in the absence of the dietary manager, is responsible for updating the nutrition/hydration care plan with any revisions as appropriate. The Director of Clinical Service to review residents with new nutrition/hydration orders during weekly weight meetings to monitor compliance with updates to the residents' nutrition/hydration care plan as appropriate. 4. The Director of Clinical Services to complete quality assurance monitoring of 5 random residents to ensure residents with new behaviors have a new intervention updated on the residents' behavior/mood care plan and residents nutrition/hydration care plans have accurate diet type and supplements as recommended and/or ordered. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI)	

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F 280	Continued From page 6 occurred on 9/3/17 with Resident #11. She reported she went into the dining room and noticed something under Resident #11 ' s shirt. She stated she pulled up his shirt and saw a knife tucked into the waistband of his pants. She described the knife as a hunting knife that could be folded to close the blade into the handle. She stated the knife was in the open position with the blade fully out of the handle. She reported the blade was approximately 4 inches long. Nurse #3 stated she asked Resident #11 what he was going to do with the knife and he said, "the men are running around cutting up people around here". She stated she asked Resident #11 where he had gotten the knife from and he said it was his "deer skinning knife". She indicated she had ensured Resident #11 that he was safe, but that he was not permitted to have a weapon on him. She stated she took the knife from Resident #11 and locked it in the medication cart. She reported she also searched Resident #11 ' s room and located two other "kitchen knives", one smaller "little knife", and a pair of pliers. She stated she removed these items from Resident #11 ' s room and locked them in the medication cart. Nurse #3 indicated she messaged the mental health provider and physician on the paging system, she notified the DON by phone, and she contacted Resident #11 ' s family member. She stated the mental health provider responded that Resident #11 would be seen the next time they were in the building and she was unable to recall what the physician responded. Resident #11 ' s family member came to the facility later that afternoon to retrieve the knives and pliers. The family member had not known how Resident #11 obtained the items. The phone interview with Nurse #3 continued.	F 280	Committee to maintain compliance. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. 5. The Executive Director is responsible for the implementation and execution of this plan.	

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She stated Resident #11 was delusional at times, but this was the first incident of him having any type of weapons. She reported she thought the NAs had monitored him every 15 minutes for the remainder of that day (9/3/17), but she not sure of that information. She indicated Resident #11 routinely spent most of his time in the hallways or near the nurse ' s station so he was easily observed on a normal basis. Nurse #3 reported Resident #11 had not said anything about the knife after the incident. She indicated since that day (9/3/17) there were no new interventions implemented for Resident #11.

An interview was conducted with NA # 3 on 9/14/17 at 3:49 PM. She stated she had worked at the facility for over a year and she was familiar with Resident #11. She confirmed she was working on 9/3/17 when Resident #11 was found in the dining room with a knife tucked into the resident ' s waistband of his pants. NA #3 stated that morning (9/3/17), Resident #11 was more confused than usual, he was talking about the war, and was crying excessively. She reported Nurse #3 informed her of the knife being found on Resident #11. She indicated after the incident she had checked on Resident #11 once per hour for the remainder of her shift. She reported Resident #11 routinely spent most of his time in the hallways, the dining room, or near the nurse ' s station and was easily observed. She stated he had calmed down throughout the day with no additional incidents. NA #3 reported she thought Resident #11 was also given plastic silverware at his meals for the remainder of that day. She indicated since that day (9/3/17) there were no new interventions implemented for Resident #11.

An interview was conducted with Nurse #2 on

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9/14/17 at 4:15 PM. She indicated she had worked at the facility for about 3 to 4 months and she was familiar with Resident #11. She indicated she was aware of the 9/3/17 when Resident #11 was found in the dining room with a knife tucked into the resident ' s waistband of his pants. She confirmed there were no new interventions implemented after the 9/3/17 incident.

A follow up interview was conducted with the DON on 9/14/17 at 4:45 PM. She indicated it was her expectation for care plans to be reviewed and revised as needed.

2. Resident #9 was initially admitted to the facility on 8/22/08 and most recently readmitted on 2/7/15 with multiple diagnoses that included dementia.

The annual Minimum Data Set (MDS) dated 10/17/16 indicated Resident #9 ' s cognition was severely impaired. She required the extensive assistance of one staff for eating. Resident #9 was on a mechanically altered diet, she had no swallowing concerns, and was assessed with no significant weight loss.

The Care Area Assessment (CAA) related to Nutrition for the 10/27/16 MDS indicated Resident #9 ' s diet texture was mechanical soft.

A physician ' s order dated 6/14/17 indicated a downgrade to Resident #9 ' s diet texture from mechanical soft to pureed.

A diet order and communication form dated 6/16/17 indicated Resident #9 ' s diet texture was

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changed to pureed.

The plan of care for Resident #9 included the focus category of Nutrition/Hydration. This plan of care was initiated on 10/14/16 and was most recently reviewed on 7/13/17. The interventions included, in part, a mechanical soft diet for Resident #9.

An interview was conducted with Nursing Assistant (NA) #2 on 9/14/17 at 10:22 AM. She stated she was familiar with Resident #9. She reported Resident #9 was on a pureed diet.

An interview was conducted with the Director of Nursing (DON) on 9/14/17 at 10:35 AM. She reported the Dietary Manager (DM) was responsible for reviewing and revising care plans related to nutrition.

An interview was conducted with the DM on 9/14/17 at 11:10 AM. She stated she began working at the facility on 7/17/17. She indicated she was responsible for reviewing and revising care plans related to nutrition. The physician ' s order dated 6/14/17 and the diet order and communication form dated 6/16/17 that indicated Resident #9 ' s diet texture was changed from mechanical soft to pureed was reviewed with the DM. The care plan related to Nutrition for Resident #9 that indicated she was on a mechanical soft diet was reviewed with the DM. The DM stated she had not worked at the facility at the time of the diet change (6/16/17) or at the time the care plan was most recently reviewed (7/13/17). She indicated this care plan revision had been the responsibility of the facility ' s previous DM.

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A second interview was conducted with the DON on 9/14/17 at 11:15 AM. The physician ' s order dated 6/14/17 and the diet order and communication form dated 6/16/17 that indicated Resident #9 ' s diet texture was changed from mechanical soft to pureed was reviewed with the DON. The care plan related to Nutrition for Resident #9 that indicated she was on a mechanical soft diet was reviewed with the DON. She verified this care plan revision had been the responsibility of the facility ' s previous DM as the current DM began working at the facility on 7/17/17. She stated her expectation was for care plans to be reviewed and revised as needed.

3. a. Resident #73 was admitted to the facility on 4/25/17 and readmitted on 8/9/17. Cumulative diagnoses included dysphagia (difficulty swallowing) and gastroesophageal reflux disease. An Admission Minimum Data (MDS) dated 5/2/17 indicated resident #73 was cognitively intact. Supervision was required with eating. Weight was documented as 147 pounds.
A Care Area Assessment (CAA) for nutrition dated 5/1/17 stated Resident #73 was alert with some episodes of confusion. She received a regular mechanical soft no added salt diet and thin liquids. Resident #73 liked to receive her meals in the dining room where she could feed herself without supervision. The CAA was triggered due to therapeutic diet as well as elevated BMI (body mass index) and mechanically altered diet. Proceed to care plan.

A Quarterly MDS dated 7/23/17 indicated Resident #73 was cognitively intact. She required limited assistance with eating. Weight was documented as 130 pounds with no weight loss

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or gain.

A review of the physician orders for August 2017 revealed an order for Med Pass 2.0 (supplement) 60 cubic centimeters (2 ounces) three times a day for nutritional support.

A review of the August Medication Administration Record (MAR) indicated Resident #73 received Med Pass 2.0 60 cc (cubic centimeters) 2 ounces three times daily from 8/1/17 through 8/5/17.

A care plan was initiated on 5/12/17 and last reviewed 8/9/17 for nutrition due to poor intake and eating less than 25% of meals. Goals stated Resident #73 would maintain adequate nutritional status as evidenced by maintaining weight with no signs or symptoms of malnutrition. Interventions included the following: Weights per facility protocol. Snacks-no specific snacks were specified. Assign seating at meal time. Provide and serve diet (no diet specified). There was no intervention for the use of supplements on the care plan.

A Registered Dietician (RD) note dated 9/5/17 stated, in part, Resident #73 had a 12.81% weight loss over 3 months. Current weight was 121.2 pounds. Weight had continued to trend down x last 3 months. Weight was currently monitored weekly. Resident #73 ' s weight change was related to a readmission on 7/6/17 and 8/9/17. Weight on readmission 7/7/17 was approximately 125 pounds. Prior to discharge, her weight was 139 pounds. Readmission weight on 8/9/17 was approximately 129.5 pounds. Resident #73 was discharged to hospital prior to frozen treat starting with lunch meal and med pass 2.0 60 cc three times daily was not restarted on readmission

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8/9/17. Diet was now mechanical soft. Continue to monitor weight pattern weekly until stabilized. Recommend restart of med pass 2.0 60 cc three times daily and add a frozen treat to lunch meal every day.

A physician order dated 9/7/17 stated Med Pass 2.0 60 cc. three times daily. There was also an order for frozen treat (supplement) on her lunch tray daily.

On 9/14/17 at 10:18 AM, an interview was conducted with the MDS Coordinator who stated the Food Service Director was responsible for initiating and updating the nutrition care plan.

On 9/14/17 at 11:18 AM, an interview was conducted with the Food Service Director who stated she was responsible for the care plans for nutrition. She stated if there were changes to the nutrition care plan between care plan meetings, she would make those changes at the time they occurred. She stated the Med Pass 2.0 and the frozen treats should have been added to the care plan.

On 9/14/17 at 11:29 AM, an interview was conducted with the Director of Nursing who stated she expected the care plan to be followed and reviewed and revised as needed.

3. b. Resident #73 was admitted to the facility on 4/25/17 and readmitted on 8/9/17. Cumulative diagnoses included dysphagia (difficulty swallowing) and gastroesophageal reflux disease. An Admission Minimum Data (MDS) dated 5/2/17 indicated resident #73 was cognitively intact. Supervision was required with eating. Weight was documented as 147 pounds.

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A Care Area Assessment (CAA) for nutrition dated 5/1/17 stated Resident #73 was alert with some episodes of confusion. She received a regular mechanical soft no added salt diet and thin liquids. Resident #73 liked to receive her meals in the dining room where she could feed herself without supervision. The CAA was triggered due to therapeutic diet as well as elevated BMI (body mass index) and mechanically altered diet. Proceed to care plan.

A Quarterly MDS dated 7/23/17 indicated Resident #73 was cognitively intact. She required limited assistance with eating. Weight was documented as 130 pounds with no weight loss or gain.

A care plan was initiated on 5/12/17 and last reviewed 8/9/17 for nutrition due to poor intake and eating less than 25% of meals. Goals stated Resident #73 would maintain adequate nutritional status as evidenced by maintaining weight with no signs or symptoms of malnutrition. Interventions included the following: Weights per facility protocol. Snacks-no specific snacks were specified. Assign seating at meal time. Provide and serve diet (no diet specified). There was no intervention for the use of supplements on the care plan. Weekly weights were not indicated on the care plan.

On 9/14/17 at 10:18 AM, an interview was conducted with the MDS Coordinator who stated the Food Service Director was responsible for initiating and updating the nutrition care plan.

On 9/14/17 at 11:18 AM, an interview was conducted with the Food Service Director who stated she was responsible for the care plans for

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nutrition. She stated if there were changes to the nutrition care plan between care plan meetings, she would make those changes at the time they occurred. She stated weekly weights should have been added to the care plan.

On 9/14/17 at 11:29 AM, an interview was conducted with the Director of Nursing who stated she expected the care plan to be followed and reviewed and revised as needed.

3. c. Resident #73 was admitted to the facility on 4/25/17 and readmitted on 8/9/17. Cumulative diagnoses included dysphagia (difficulty swallowing) and gastroesophageal reflux disease.

An Admission Minimum Data (MDS) dated 5/2/17 indicated resident #73 was cognitively intact. Supervision was required with eating. Weight was documented as 147 pounds.
A Care Area Assessment (CAA) for nutrition dated 5/1/17 stated Resident #73 was alert with some episodes of confusion. She received a regular mechanical soft no added salt diet and thin liquids. Resident #73 liked to receive her meals in the dining room where she could feed herself without supervision. The CAA was triggered due to therapeutic diet as well as elevated BMI (body mass index) and mechanically altered diet. Proceed to care plan.

A Quarterly MDS dated 7/23/17 indicated Resident #73 was cognitively intact. She required limited assistance with eating. Weight was documented as 130 pounds with no weight loss or gain.

A care plan was initiated on 5/12/17 and last reviewed 8/9/17 for nutrition due to poor intake

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F 280	Continued From page 15 and eating less than 25% of meals. Goals stated Resident #73 would maintain adequate nutritional status as evidenced by maintaining weight with no signs or symptoms of malnutrition. Interventions included, in part, to assess for a restorative dining program (undated). A review of the medical record revealed there was no documentation that an assessment was completed for a restorative dining program. On 9/14/17 at 8:48 AM, an interview was conducted with the Speech therapist. She stated, if a resident needed an assessment completed for a restorative dining program, nursing would complete a form requesting therapy for a restorative dining assessment and what would be needed for the resident to be safe with dining. She said she did not remember assessing Resident #73 for restorative dining and, to her knowledge, resident #73 was never assessed for restorative dining. On 9/14/17 at 10:18 AM, an interview was conducted with the MDS Coordinator who stated the Dietary Manager who had completed the nutrition care plan on 5/12/17 was no longer employed at the facility. She said she was unaware that the restorative dining assessment had not been done. On 9/14/17 at 11:29 AM, an interview was conducted with the Director of Nursing who stated she expected the care plan to be followed and reviewed and revised as needed.	F 280		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		10/13/17

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F 323	Continued From page 16 (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 observations, record reviews, and interviews with resident, family, staff, psychologist, and mental health nurse practitioner, the facility failed to ensure a resident ' s safety when an immobile resident was improperly positioned in a geriatric (geri) chair when transferred by one staff using a mechanical lift. The improper positioning resulted in the geri chair tipping backward, the resident sliding out of the chair onto the floor and sustaining a golf ball sized hematoma to the back of her head for 1 of 4 residents (Resident #2) reviewed for accidents.	F 323	1. On 10/2/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure immobile residents requiring two-person assistance and use of a mechanical lift with transfers are carried out per the residents' plan of care to prevent accidents. QAPI committee members in attendance included the Executive Director (QAPI	

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F 323	Continued From page 17 The findings included: Resident #2 was initially admitted to the facility on 9/27/10 and most recently readmitted on 7/31/17 with multiple diagnoses that included history of stroke, seizure disorder, contracture of unspecified joint, and dementia. The annual Minimum Data Set (MDS) dated 7/21/17 indicated Resident #2 ' s cognition was severely impaired. She was assessed with no behaviors and no rejection of care. Resident #2 was coded as dependent on two or more staff with transfers and dependent on one staff with locomotion on/off the unit, dressing, toileting, personal hygiene, and bathing. She was coded as requiring the extensive assistance of two or more staff with bed mobility. Resident #2 was not steady on her feet and was only able to stabilize with staff assistance for surface to surface transfers. The following activities were listed as not occurring for Resident #2 during the 7 day MDS look back period: moving from seated to standing position, walking, turning around, and moving on and off the toilet. Resident #2 had impairment on both sides of the upper and lower extremities and she utilized a wheelchair. She was indicated to always be incontinent of bowel and bladder. She had no falls noted. The Care Area Assessment (CAA) related to falls for the 7/21/17 annual MDS assessment indicated Resident #2 required extensive to dependent assistance with most Activities of Daily Living (ADLs). She was assessed as requiring [Brand Name] mechanical lift for transfers. Resident #2 had no recent falls, but was noted at an increased risk due to the assistance she	F 323	Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #2, it was determined that the facility failed to ensure that a nursing assistant followed the plan of care related to providing two-person assist with a mechanical lift during resident transfer for an immobile resident resulting in improper positioning and a fall with injury from her Geri chair. Resident #2 continues to be transferred with two-person assistance and use of mechanical lift per plan of care to prevent accidents with no further incidents. 2. On 10/11/17, the Director of Clinical Services and licensed nurse supervisors completed a QA (quality assurance) monitoring of immobile residents requiring two-person assistance and use of mechanical lift with transfers by reviewing residents' plan of care and Kardex for accuracy and by visual observations during all 3 shifts (7a-3p, 3p-11p and 11p-7a) with transfers per plan of care to prevent accidents. No further discrepancies were identified. 3. Beginning 10/2/17 and completed 10/11/17, the Director of Clinical Services and RN supervisor designee provided competency based education to all nurse aides and licensed nurses, including PRN and weekend staff, on following the residents' plan of care for immobile	

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F 323	Continued From page 18 needed. The fall risk evaluation dated 7/31/17 indicated Resident #2 was at risk for falls. She was assessed as disoriented, chair bound, poor vision status, and unable to stand. The plan of care for Resident #2 related to ADLs, initiated on 8/4/17, indicated she had an ADL self-care performance deficit, limited range of motion, limited mobility, and activity intolerance. The ADL interventions for Resident #2 included, in part, 1-2+ assistance with bed mobility, transfer assistance, and a mechanical lift for transfers. The plan of care for Resident #2 related to safety initiated on 8/4/17, indicated she had the potential for injury, poor safety awareness, poor communication, history of seizures, and decreased mobility. The safety interventions for Resident #2 included, in part, a mechanical lift for transfers. The SBAR (Situation, Background, Appearance, Review and notify) Communication Form dated 8/15/17 and completed by Nurse #1 indicated an unwitnessed fall occurred at 11:05 AM. A skin evaluation revealed Resident #2 sustained a golf ball sized hematoma to the back of her head. A pain evaluation indicated Resident #2 had chronic pain in her shoulders, arms, and hands. A neurological evaluation assessed Resident #2 with no changes. The Nurse Practitioner (NP) was notified on 8/15/17 at 11:14 AM. The NP recommendations were to monitor and notify of him of any neurological changes for Resident #2. The form indicated, "[Nursing Assistant #1] reported to [Nurse #1] that Resident #2 was in a geri chair and geri chair fell back and [Resident	F 323	residents requiring two-person assistance with a mechanical lift during transfers to prevent accidents. Education also included the proper positioning requirements of immobile residents into a Geri chair with the aide of two persons to ensure resident safety. Newly hired nurse aides and licensed nurses will be educated upon hire. Continuing education will be provided on a semi annual basis. Nursing aides and licensed nurses to transfer immobile residents by providing two-person assistance and use of mechanical lift to aide in the proper positioning and prevention of accidents. 4. The Director of Clinical Services or LPN supervisor to complete quality assurance monitoring of three (3) immobile residents, randomly across all shifts and weekends, by physical observation of transfers to ensure two-person assistance with use of mechanical lift for proper positioning and prevention of accidents. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee to evaluate the	

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F 323	Continued From page 19 #2] fell out." The daily skilled nurse ' s note dated 8/15/17 and written by Nurse #1 at 12:00 PM indicated Nursing Assistant (NA) #1 reported Resident #2 had a fall at 11:05 AM. The note indicated NA #1 stated the geri chair fell back and Resident #2 fell from the chair. Resident #2 sustained a hematoma to the back of her head. Neurological checks were initiated, the physician was notified, and the family was notified. Resident #2 was assessed for pain with no abnormal signs or symptoms of pain. The geri chair was checked for proper functioning and it was noted to be working properly. The "Fall Root Cause Investigation Report" dated 8/15/17 and completed by Nurse #1 indicated Resident #2 required two staff for assistance with transfers and a mechanical lift was to be utilized. The staff summary statement indicated Resident #2 was observed on the floor by Nurse #1. NA #2 reported Resident #2 was in her geri chair in the resident ' s room. NA #2 went into the resident ' s bathroom (located inside of the resident ' s room) and while inside of the bathroom she heard a noise. She re-entered Resident #2 ' s room and saw that Resident #2 had fallen from the geri chair. The resolution/intervention for minimizing future occurrences was staff re-education due to geri chair position/mechanical lift. A form titled, "Five Whys Tool for Root Cause Analysis", not dated and not signed, indicated the following for Resident #2: - Problem Statement: "Resident fell on floor" - Why: "She had unwitnessed fall" - Why: "She slid from geri chair" - Why: "Positioned improperly in geri chair"	F 323	effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. 5. The Executive Director is responsible for the implementation and execution of this plan.	

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F 323	Continued From page 20 - Why: "Top or bottom too far up in chair" - Why: "Positioned in chair with use of lift" - Root Cause: "Geri chair positioning" The "Report of Resident Fall" form dated 8/15/17 indicated Resident #2 fell at 11:05 AM. The description of the incident indicated, "[Resident #2] found on floor behind geri chair." The report indicated Resident #2 slid out of the chair and was found on the floor in her room by NA #1. Resident #2 sustained a hematoma to the back of her head. New interventions that were indicated to be implemented as a result of the fall investigation were one on one re-education on geri chair/ [Brand Name mechanical] lift, group nursing re-education on proper placement of residents, and competency/skills checklists. An inservice training record with the subject of "Mechanical Lift Competency and Skills Checklist" was documented as provided by the Unit Manager (UM) to NA #1 on 8/15/17 at 3:00 PM. The daily skilled nurse ' s note dated 8/15/17 written for the 3:00 PM to 11:00 PM shift indicated Resident #2 ' s vitals were assessed with no concerns, she had no changes in cognitive status, and no signs or symptoms of distress. Neurological checks continued with no concerns identified. The physician was updated and no new orders were obtained for Resident #2. The note indicated a family member of Resident #2 arrived at the facility and requested for her to be sent to the Emergency Room (ER) for evaluation. The physician was notified and Emergency Medical Services (EMS) were contacted to transport Resident #2 to the ER. Resident #2 was noted to have been evaluated at the ER and	F 323		

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returned to the facility with no new orders.

An NP progress note dated 8/16/17 indicated Resident #2 was seen at the facility for a follow up to her ER visit from 8/15/17. Resident #2 was noted to have fallen backwards in her geri chair and hit her head on the floor. Neurological checks were done both prior to the ER visit and after the ER visit all of which were noted to be baseline for Resident #2. A Computed Tomography (CT) scan of Resident #2 ' s head was conducted at the ER and was reviewed with no acute abnormalities. Resident #2 ' s hematoma to the back of her head was assessed and was almost completely resolved within one day.

The Fall Committee Minutes dated 8/16/17 indicated Resident #2 had a fall on 8/15/17. The plan of care changes related to Resident #2 ' s fall were indicated as staff education related to [Brand Name mechanical] lift policy/procedure and the geri chair.

Resident #2 ' s plan of care related to safety was updated on 8/16/17. Resident #2 was noted with a fall on 8/15/17. The intervention added was staff re-education on proper use of a mechanical lift and geri chair.

An inservice training record with the subject of "[Brand Name] mechanical Lift" was documented as provided by the UM to 18 staff (14 NAs and 4 nurses) on 8/16/17 at 7:00 AM. The training was noted to include reading materials and skills checklist.

A list of the nursing staff (licensed and unlicensed) employed at the facility on 8/15/17

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was reviewed. It indicated there were 37 nursing staff members (22 NAs and 15 nurses) employed at the facility on 8/15/17.

An observation was conducted of Resident #2 on 9/11/17 at 12:05 PM. Resident #2 was seated in a geri chair in the dining room. Staff provided total assistance to Resident #2 with eating. Resident #2 was noted with no movement in the geri chair during this observation.

A family interview was conducted for Resident #2 on 9/11/17 at 3:45 PM. The family member reported Resident #2 had fallen out of her geri chair about a month ago. She stated Resident #2 had hit her head on the floor and had a "knot" on her head. She reported she spoke with Nurse #1 on 8/15/17 and was informed Resident #2 had slipped and fell out of the geri chair when NA #1 had gone into the resident ' s bathroom. The family member reported the facility had not sent Resident #2 to the hospital so she had requested for her to be sent to the ER for evaluation on the afternoon of 8/15/17. She indicated Resident #2 was not admitted to the hospital and returned to the facility several hours after she had gone to the ER. Resident #2 ' s family member expressed concern about how the resident slipped out of the geri chair when she was immobile and was dependent on staff for assistance.

An observation was conducted of Resident #2 on 9/12/17 at 7:50 AM. Resident #2 was lying in bed in her room. She was alert, but was unable to answer questions due to impaired cognition. Resident #2 was noted with no movement during this observation.

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An interview was conducted with Nurse #1 on 9/13/17 at 10:45 AM. She indicated she was familiar with Resident #2 and she worked with her regularly. She verified she was working on 8/15/17 when Resident #2 had a fall from her geri chair that resulted in a hematoma to the back of her head. Nurse #1 stated she was at the nurse ' s station when NA #1 came up to her and said Resident #2 had fallen. She revealed she was surprised Resident #2 had fallen because the resident was not mobile, she was dependent on 2 staff and a mechanical lift for transfers, and she had no recent falls. Nurse #1 stated she went to Resident #2 ' s room with the Director of Nursing (DON) and UM. She indicated when she got to the room she observed Resident #2 lying on the ground behind the geri chair. She reported Resident #2 ' s entire body was on the floor and the mechanical lift sling was on the ground beneath her. Nurse #1 indicated NA #1 said she had transferred Resident #2 from the mechanical lift to the geri chair without issue and she had then stepped into Resident #2 ' s bathroom when she heard the resident fall. Nurse #1 stated she thought Resident #2 had been positioned either too far forward or too far back in the geri chair which had caused the chair to tip. She reiterated that Resident #2 was immobile and was unable to move her body around in the chair independently.

The interview with Nurse #1 continued. She stated Resident #2 had sustained a golf ball sized hematoma to the back of her head. She indicated the NP was contacted and neurological checks were initiated. She reported Resident #2 was alert, had no cognitive changes, and no abnormal pain. She clarified that Resident #2 had chronic pain issues and there were no signs or symptoms of worsened pain or distress. She stated the NP

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had not felt Resident #2 required evaluation at the ER as there were no acute changes with Resident #2 ' s status. The NP asked to be updated later that day on Resident #2 ' s condition. Nurse #1 reported Resident #2 remained at her baseline status throughout the day with no acute changes. She indicated the NP was updated on Resident #2 ' s status later that day (8/15/17) and no new orders were received. She reported Resident #2 ' s family member came to the facility sometime in the later afternoon or evening (8/15/17) and requested for Resident #2 to be sent to the ER for evaluation. She stated Resident #2 was evaluated at the ER and returned to the facility with no new orders. Nurse #1 stated she completed a nursing note, the SBAR, the Five Whys Tool, and the Fall Root Cause Investigation Report related to the 8/15/17 for Resident #2.

An interview was conducted with the DON on 9/13/17 at 11:10 AM. She verified she was present at the facility on 8/15/17 when Resident #2 had a fall from her geri chair that resulted in a hematoma to the back of her head. She reported she was called to the room by NA #1 and when she got to the room she observed Resident #2 ' s entire body lying on the ground with the mechanical lift sling underneath her. The DON stated NA #1 said "I put [Resident #2] in the wrong spot". She revealed NA #1 had utilized a mechanical lift independently to transfer Resident #2 from the bed to her geri chair. The DON confirmed NA #1 utilized the mechanical lift without another staff ' s assistance. She indicated this was the incorrect procedure as a mechanical lift transfer required two staff members. The DON reported she believed NA #1 had positioned Resident #2 too far forward or

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backward causing the geri chair to tip and the resident to slide out of the chair onto the floor. The DON indicated it was her expectation that staff followed the facility ' s procedure to have two staff members when using a mechanical lift. She additionally indicated she expected staff to ensure residents were positioned correctly when transferred.

An interview was conducted with NA #1 on 9/13/17 at 3:55 PM. She stated she had worked at the facility for close to two years. She indicated she was familiar with Resident #2 and worked with her regularly. She reported Resident #2 was not mobile, she was dependent on staff for transfers, and a mechanical lift was utilized that required two staff members. She verified she was working with Resident #2 on 8/15/17 at the time of the fall that resulted in a hematoma to the back of Resident #2 ' s head. NA #1 described the events related to the 8/15/17 fall for Resident #2. She reported she needed to transfer Resident #2 from her bed to the geri chair for her go to lunch in the dining room. She stated she had briefly looked for a staff member to help her operate the mechanical lift, no one was readily available, and it was almost time for her own lunch break so she had decided to use the mechanical lift by herself. NA #1 stated she was aware she was not supposed to use the mechanical lift by herself. She revealed she had used the mechanical lift on her own approximately three other times prior to 8/15/17. She stated she had not used the mechanical lift on her own since the 8/15/17 incident with Resident #2.

The interview with NA #1 continued. NA #1 stated she had used the mechanical lift on her

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own and transferred Resident #2 from her bed to her geri chair without issue. She indicated once Resident #2 was placed in the geri chair and the mechanical lift sling was unhooked, she had noticed there was more weight on the top end of the geri chair (the head of the chair) because Resident #2 was positioned too far back/up in the geri chair. NA #1 reported she "scooted" Resident #2 further down in the chair and into a more balanced position. She stated at that time she believed Resident #2 was in a safe position and she went into the resident ' s bathroom (located inside of the resident ' s room) to gather supplies. She reported she was in the bathroom with the door open, but with Resident #2 out of her eye sight for about one to two minutes when she heard a "bang". NA #1 stated she immediately came out of the bathroom and saw that the geri chair had tipped backwards and Resident #2 had slid back and her head hit the ground. She reported she had yelled for assistance from Resident #2 ' s room and Nurse #1, the DON, and the UM all came to the room to assist Resident #2. NA #1 indicated following the incident she provided a verbal statement to Nurse #1 about the incident. She additionally stated the nursing staff had a meeting on mechanical lifts, geri chairs, and positioning. She reported the staff were instructed to never use the mechanical lift without 2 staff members. She indicated the staff had not been required to complete any demonstrations of how to properly use the mechanical lift to position a resident in the geri chair. NA #1 stated, "I knew what to do I just didn ' t do it."

A follow up interview was conducted with the DON on 9/13/17 at 4:30 PM. She indicated inservices on the mechanical lift, geri chair

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F 323	Continued From page 27 transfers, and positioning were conducted for NA #1 and other nursing staff on 8/15/17 and 8/16/17. The inservice staff sign in sheets dated 8/15/17 and 8/16/17 that indicated 18 nursing staff (22 NAs and 15 nurses) attended the inservice were reviewed with the DON. The nursing staff list that indicated there were 37 nursing staff members (22 NAs and 15 nurses) employed at the facility at the time of the incident (8/15/17) was reviewed with the DON. The DON verified all nursing staff were not re-education on the mechanical lift, geri chair, and positioning. She stated the nursing staff members who were in the facility working at the time of the inservices were the ones that were re-educated. She also verified no audits or ongoing monitoring was conducted related to the use of mechanical lifts, geri chairs, transfers, or proper positioning.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider	F 325		10/13/17

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F 325	Continued From page 28 orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to follow the recommendations of speech therapy to change diet to pureed and failed to provide a nutritional supplement as ordered for one of four residents reviewed for nutrition (Resident #73) who experienced weight loss. The findings included: Resident #73 was admitted to the facility on 4/25/17 and readmitted on 8/9/17. Cumulative diagnoses included dysphagia (difficulty swallowing) and gastroesophageal reflux disease. An Admission Minimum Data (MDS) dated 5/2/17 indicated resident #73 was cognitively intact. Supervision was required with eating. Height was documented as 61 inches. Weight was documented as 147 pounds. No weight loss or gain was noted. A Care Area Assessment (CAA) for nutrition dated 5/1/17 stated Resident #73 was alert with some episodes of confusion. She received a regular mechanical soft no added salt diet and thin liquids. A care plan initiated on 5/12/17 last reviewed 8/9/17 included a problem of nutrition due to poor intake and eating less than 25% of meals. Goals stated Resident #73 would maintain adequate nutritional status as evidenced by maintaining weight with no signs or symptoms of malnutrition. Interventions included the following: Weights per facility protocol. Snacks (no specific snacks specified.) Assign seating at meal time. Provide and serve diet (no diet specified).	F 325	1. On 10/2/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure that diet orders and supplement recommendations are provided for residents' who experience weight loss. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director, and Medical Director Through Root Cause Analysis and based on the findings for Resident #73, it was determined that the facility failed to ensure proper communication between nursing and dietary for diet and supplement recommendation from speech therapy and the registered dietitian nutritional recommendations to maintain nutritional status. On 9/14/17, the licensed nurse notified the physician of Resident #73 missed dietary recommendations and an order was obtained to change diet to puree, and restart frozen treats. The orders were communicated and implemented as indicated to maintain nutrition. The Dietary Manager updated the nutrition/hydration care plan on 9/14/17 to accurately reflect the changes. 2. On date 10/4/17, the Director of Clinical	

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F 325	Continued From page 29 A Quarterly MDS dated 7/23/17 indicated Resident #73 was cognitively intact. She required limited assistance with eating. Weight was documented as 130 pounds with no weight loss or gain. A weekly weight history report provided by the Director of Nursing revealed the following weights noted for Resident #73. 5/23/17-136 pounds; 5/30/17-137.5 pounds; 6/2/17-137.5 pounds; 6/6/17-136 pounds; 6/12/17-137 pounds; 6/22/17-137 pounds; 6/26/17-139 pounds; 7/11/17-129 pounds; 7/17/17--135.5 pounds; 7/26/17--132.5 pounds; 8/1/17--129.5 pounds; 8/18/17-134 pounds; 8/22/17--127.6 pounds; 8/30/17--121.2 pounds; 9/5/17--121.2 pounds and 9/13/17-118.8 pounds. 1. a. A nursing note dated 9/5/17 by Nurse #4 stated the Speech Therapist was aware of Resident #73 aspirating (choking) on food and liquids. Nurse #4 called Resident #73 ' s husband and informed him of of resident aspirating and need for diet change to pureed with nectar thick liquids. A Speech Therapy initial evaluation dated 9/6/17 stated Resident #73 was administered a bedside swallow assessment for dysphagia (difficulty swallowing). She had moderate to severe oral pharyngeal dysphagia with anterior pocketing (holding food in her mouth), extended bolus hold, extended oral transit time, reduced anterior posterior transfer, decreased with bolus formation, multiple swallows, throat clearing and coughing after swallowing. Resident #73 was not able to use safe compensatory strategies with no	F 325	Services and Dietary Manager completed a quality assurance monitoring of residents experiencing weight loss from 7/1/17-9/30/17 to ensure accurate diet and supplements as ordered and/or recommended to meet the nutritional needs of the patient per the plan of care. No discrepancies were noted. 3. On 10/2/17, the Regional Director of Clinical Services reeducated the Interdisciplinary Team (IDT)on the policies and procedures of implementing therapy and dietary recommendations to address the nutritional needs of the resident. Education included the monitoring process during daily clinical meetings and weekly weight risk meetings validating the implementation of nutritional orders and recommendations for residents experiencing weight loss. On 10/11/17, the Director of Clinical Services and/or registered nurse designee reeducated all licensed nursing staff, including weekend and PRN, on notifying the physician of therapy and dietary recommendations, obtaining orders and communication of changes to resident plan of care by proper transcription onto the medication administration record and communication to the dietary department by use of the Dietary Communication form. Newly hired licensed nurses will be educated upon hire. The licensed nurse receiving a dietary recommendation for a resident to notify	

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F 325	Continued From page 30 assistance. She was at risk for maximum aspiration and/ or penetration. Recommended diet level was pureed food and thin liquids. On 9/13/17 at 8:00AM, Resident #73 was observed in the dining room sitting in her broad chair being fed by nursing staff. She did not make any attempts to feed herself. The diet slip indicated Resident #73 received a regular mechanical soft diet. The nursing assistant feeding Resident #73 stated Resident #73 ' s appetite varied but she usually did not eat more than 25% of her meals. On 9/14/17 at 8:48 AM, an interview was conducted with the Speech Therapist. She stated she had evaluated Resident #73 on 9/6/17. There was a problem with her insurance so she could not provide services until 9/13/17. The Speech Therapist said she asked nursing to downgrade Resident #73 ' s diet to pureed and continue thin liquids on 9/6/17 following the initial evaluation. The nurse asked her if she wanted thickened liquids and she told the nurse no. She was unsure of the name of the nurse. She said she depended on the nurse to write the order and follow through with the change in diet. She said she was finally able to see Resident #73 yesterday and gave her a trial of the puree diet. The Speech Therapist stated Resident #73 took small bites of the diet and was able to swallow the puree consistency better with less pocketing of food. On 9/14/17 at 9:42 AM, an interview was conducted with Nurse #4. She stated she notified Resident #73 ' s Responsible Party of the dietary recommendations on 9/5/17 and again on 9/6/17. She stated the Speech Therapist requested the	F 325	the physician to obtain orders as indicated and to transcribe onto the Medication Administration Record (MAR)and complete a Dietary Communication form to ensure appropriate communication and implementation of nutritional needs to prevent weight loss and maintain nutrition. The Director of Clinical Services to review dietary recommendations upon receipt from Registered Dietician following their scheduled assessment and during the weekly Weight Risk Meeting to ensure compliance with recommended nutritional changes to prevent weight loss. 4. The Dietary Manager or LPN Supervisor to complete quality assurance monitoring of 5 random residents to ensure appropriate diet, and supplement orders/frozen treats have been implemented to meet the nutritional needs of the resident per the plan of care. Monitoring will also include verification of intake of supplements documented on Medication Administration Record (MAR). Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee to evaluate the	

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downgrade to a pureed diet on 9/5/17. Nurse #4 said she spoke to the Director of Nursing and the Assistant Director of Nursing on 9/5/17 when the Speech Therapist said she could downgrade the diet and they told her to fill out a Speech Therapy referral so Speech Therapy could assess Resident #73 before the diet was changed to pureed. She stated she did not change the diet order.

On 9/14/17 at 11:29 AM, an interview was conducted with the Director of Nursing. She stated she expected Speech Therapy recommendations regarding diets to be followed. She stated nursing staff could downgrade a diet if needed. At that time, the nurse would also notify the physician and Speech Therapy for orders and further evaluation.

1. b. A Registered Dietician (RD) note dated 8/4/17 indicated weights continued to be monitored weekly. The RD recommended to start a frozen nutritional treat with lunch meal due to weight trending downward despite increase of Med Pass 2.0 (supplement) to three times daily on 7/12/17.

A review of Nutritional Therapy Recommendations given to the Director of Nursing for 8/4/2017 included a recommendation for Resident #73 to start frozen nutritional treat with lunch meal due to decline in weight.

An RD note dated 9/5/17 stated Resident #73 ' s weight triggered for 12.81% weight change down over 3 months. Current weight was 121.2 pounds. Weight had continued to trend down over the last 3 months and was being monitored weekly. Weight change could be related to

effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees.

5. The Executive Director is responsible for the implementation and execution of this plan.

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readmission on 7/6/17 and readmission on 8/9/17. Weight on readmission on 7/7/17 was approximately 125 pounds. Prior to discharge, weight was 139 pounds. Weight prior to readmission on 8/9/17 was approximately 129.5 pounds. Resident #73 was discharged to the hospital prior to the frozen treat starting with the lunch meal and Med Pass 2.0 60 cc (cubic centimeters) three times a day was not restarted on readmission on 8/9/17. Weight change also may have been related to synthroid (thyroid medication) being decreased on 8/14/17 and antibiotics being ordered on 8/24/17. Resident #73 was being fed by staff as of 8/28/17. Her diet was mechanical soft. Monitor weight pattern weekly until stabilized. Recommend restart of Med Pass 2.0 60 cc three times daily and add a frozen treat to the lunch meal daily.

A physician's order dated 9/7/17 revealed an order for Med Pass 2.0 60 cc three times daily. Frozen treat on lunch tray.

A review of the September 2017 Medication Administration Record (MAR) revealed the frozen treat on the lunch tray was signed off by nursing staff for 9/8/17 through 9/13/17. The amount consumed by Resident #73 was not indicated.

A weekly weight history report provided by the Director of Nursing revealed the following weights noted for Resident #73. 5/23/17-136 pounds; 5/30/17-137.5 pounds; 6/2/17-137.5 pounds; 6/6/17-136 pounds; 6/12/17-137 pounds; 6/22/17-137 pounds; 6/26/17-139 pounds; 7/11/17-129 pounds; 7/17/17--135.5 pounds; 7/26/17--132.5 pounds; 8/1/17--129.5 pounds; 8/18/17-134 pounds; 8/22/17--127.6 pounds; 8/30/17--121.2 pounds; 9/5/17--121.2 pounds and

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9/13/17-118.8 pounds.

On 9/13/17 at 8:00 AM, Resident #73 was observed in the dining room sitting in her broad chair being fed by nursing staff. She did not make any attempts to feed herself. The diet slip indicated Resident #73 received a regular mechanical soft diet.

On 9/14/17 at 7:55 AM, an interview was conducted with the Food Service Director. She stated she had not received a dietary communication sheet from nursing regarding a frozen nutritional treat. She said that was how she would know what Resident #73 should receive on her food trays. The Food Service Director stated dietary staff were the ones who provided the frozen treats that were placed on the dietary trays. She added that Resident #73 had not received any frozen treats on her lunch tray.

A review of medical record revealed there was no dietary communication sheet in the record for a frozen treat to be placed on the lunch tray.

On 9/14/17 at 10:00 AM, a telephone interview was conducted with the Family Nurse Practitioner (FNP). He stated he had been aware of the continued weight loss. He said the change in her thyroid medication would not cause weight loss. The FNP said Resident #73 had never expressed to him that she wanted to lose weight and it would not be a goal of his for her to lose weight. He stated a 30 pound weight loss was a significant amount (from 147 on admission on 4/25/17 to 118.6 pounds on 9/13/17) and he expected staff to follow the physician orders.

On 9/14/17 at 11:02 AM, a telephone interview

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was conducted with the Registered Dietician (RD). She stated she wrote her dietary recommendations on the Nutritional Therapy Recommendation sheet and gave a copy of her recommendations to the Director of Nursing. Nursing staff would write the dietary order in the chart, fill out a dietary communication form and send the form to the kitchen. She stated she assented and if there was an order in the medical record, it would be followed. The Registered Dietician stated she expected nursing to follow through with the order and follow the process of communication with dietary.

On 9/14/17 at 11:29 AM, an interview was conducted with the Director of Nursing. She stated her expectation was for doctor orders to be followed. She stated recommendations from the RD were given to her. A copy was given to the nursing staff to follow up on the recommendations and physician orders were written if needed. Nursing would fill out a dietary communication sheet and a copy sent to dietary and a copy would be placed in the medical record. She stated the order for the frozen treat was on the MAR and said nursing staff obtained the frozen treat from dietary, administered the frozen treat to the resident and documented it on the MAR.

On 9/14/17 at 11:42 AM, an interview was conducted with Nurse #4 who usually worked 7:00 AM-3:00 PM and provided care for Resident #73. She stated the frozen treats were put on the lunch trays by dietary and were not given out by nursing. She stated she would go to the dining room and see if the frozen treat was on the tray and sign it off on the MAR. Nurse #4 said she had never personally given Resident #73 a frozen

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F 386 SS=C	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview and staff interviews, the facility failed to ensure that the physician signed and dated orders as required, resulting in the use of a rubber stamp signature by non-physicians for 13 of 13 current resident records reviewed (Resident #'s 52, 39, 88, 31, 25, 13, 73, 30, 14, 11, 9, 2, and 19). The findings included: 1. Resident #88 was admitted on 9/5/17 with diagnoses that included: anemia, heart disease, high blood pressure, benign prostatic hyperplasia, right leg amputation, and generalized weakness. Review of #88's admission physician's orders for 9/5/17 through 9/30/17 revealed a stamped signature in the physician's signature box and no	F 386	1. On 10/2/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents' physician order are signed and dated by the physician as required per Regulation 430.30(b)(1)-(3) regarding physician visits. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Residents #52, 39, 88,	10/13/17

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F 386	Continued From page 36 date. An interview was conducted with the Medical Records Director on 9/13/17 at 12:38 PM. She stated the Physician had stamped the medical records with her signature. She further stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past. She added she had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the signature stamp. On 9/13/17 at 12:40 PM an interview was conducted with the physician whose name was on the stamp. She stated the record was stamped with her stamped signature and was not dated. She revealed she did not stamp the physician orders with her signature stamp. She said she would no longer utilize the stamp and she would make sure the record was dated when signed. The physician stated someone had brought this up to her before and she had informed them, referring to her office staff, not to use the stamp anymore. On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the physician's group, whose physician had used the stamp, was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the rubber stamp. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard	F 386	31, 25, 13, 73, 30, 14, 11, 9, 2 and 19, it was determined that the facility failed to ensure the physician signed and dated physician orders resulting in rubber stamp signatures by non-physicians. On 10/2/17, the Physician signed and dated identified orders for Residents #52, 39, 88, 31, 25, 13, 73, 30, 14, 11, 9, 2 and 19. Identified residents Physician Order Sheets were signed by physician on 10/4/17. 2. On 10/4/17, the Director of Clinical Services (DCS) and Unit Secretary completed a quality assurance monitoring and observation of 57 current residents' physician orders from 7/1/17-9/30/17 to ensure residents' physician order are signed and dated by the physician as required. Multiple residents were affected by this practice, and signatures were obtained from the MD/NP on 10/4/17. All MDs, NPs, and PAs were notified by the Medical Director of the termination of the use of the rubber stamp signature on 10/10/17. The Pharmacy Consultant during their monthly review will monitor to ensure that rubber stamps are not utilized. 3. On 10/13/17, the Director of Clinical Services (DCS) completed reeducation to all licensed nurses, including weekend and PRN, and Unit Secretary on Regulation 483.30(b)(1)-(3) regarding physician visits and requirement of physician orders to be signed and dated by the physician as well as facility policy not permitting use of rubber stamp	

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F 386	Continued From page 37 against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated. On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and the Director of Nursing (DON) regarding the use of the stamped signature being used by the physician to sign orders. They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at the time with the Medical Director. The Administrator said he had not seen the document regarding the use of the physician stamp until 9/13/17 and did not know when it had been originally drafted and signed. The Administrator and the DON stated it was their expectation that the doctor whose name was on the stamp should utilize the stamp only and no other individual utilize his/her signature stamp. 2. Resident #52 was admitted on 6/12/17 with diagnoses that included diabetes, dementia, anxiety, depression, and muscle weakness. Review of #52's monthly physician's orders for 8/1/17 through 8/31/17 revealed a stamped signature in the physician's signature box and no date. An interview was conducted with the Medical Records Director on 9/13/17 at 12:38 PM. She stated the Physician had stamped the medical records with her signature. She further stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past. She added she had questioned the	F 386	signatures. Newly hired licensed nurses will be educated upon hire. The physician will sign and date orders per Regulation 430.30(b)(1)-(3) regarding physician visits. The use of rubber stamp signatures will not be permitted by the facility and a record of physician signatures to be kept on file and maintained by the Executive Director for accuracy. Non-compliance will be reported immediately to the Executive Director for reeducation and/or corrective action as necessary. 4. The Executive Director or Unit Secretary to monitor 5 residents' physician orders for signature and date by the physician per requirements. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members	

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F 386	Continued From page 38 use of the stamped signature but could not remember who she had spoken with about the use of the signature stamp. On 9/13/17 at 12:40 PM an interview was conducted with the physician whose name was on the stamp. She stated the record was stamped with her stamped signature and was not dated. She revealed she did not stamp the physician orders with her signature stamp. She said she would no longer utilize the stamp and she would make sure the record was dated when signed. The physician stated someone had brought up the use of the rubber stamped signature to her before and she had informed them not to use the stamp anymore. On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the physician's group, whose physician had used the stamp, was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the rubber stamp. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated. On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and the Director of Nursing (DON) regarding the use of the stamped signature being used by the physician to	F 386	consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. 5. The Executive Director is responsible for the implementation and execution of this plan.	

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sign orders. They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at the time with the Medical Director. The Administrator said he had not seen the document regarding the use of the physician stamp until 9/13/17 and did not know when it had been originally drafted and signed. The Administrator and the DON stated it was their expectation that the doctor whose name was on the stamp should utilize the stamp only and no other individual utilize his/her signature stamp.

3. Resident #25 was admitted on 9/9/15 with diagnoses that included: An abnormal heart rate, heart disease, high blood pressure, diabetes, high cholesterol, anxiety, depression, and generalized weakness.

Review of #25's monthly physician's orders for 8/1/17 through 8/31/17 revealed a stamped signature in the physician's signature box and no date.

An interview was conducted with the Medical Records Director on 9/13/17 at 12:38 PM. She stated the Physician had stamped the medical records with her signature. She further stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past. She added she had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the signature stamp.

On 9/13/17 at 12:40 PM an interview was conducted with the physician whose name was on the stamp. She stated the record was

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stamped with her stamped signature and was not dated. She revealed she did not stamp the physician orders with her signature stamp. She said she would no longer utilize the stamp and she would make sure the record was dated when signed. The physician stated someone had brought this up to her before and she had informed them, referring to her office staff, not to use the stamp anymore.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the physician's group, whose physician had used the stamp, was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the rubber stamp. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and the Director of Nursing (DON) regarding the use of the stamped signature being used by the physician to sign orders. They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at the time with the Medical Director. The Administrator said he had not seen the document regarding the use of the physician stamp until

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9/13/17 and did not know when it had been originally drafted and signed. The Administrator and the DON stated it was their expectation that the doctor whose name was on the stamp should utilize the stamp only and no other individual utilize his/her signature stamp.

4. Resident #39 was admitted on 5/2/17 with diagnoses which included: Anemia, heart failure, high blood pressure, peripheral vascular disease, high cholesterol, anxiety, depression, right leg amputation, heart disease, arthritis, and fibromyalgia.

Review of #39's monthly physician's orders for 8/1/17 through 8/31/17 revealed a stamped signature in the physician's signature box and no date.

An interview was conducted with the Medical Records Director on 9/13/17 at 12:38 PM. She stated the Physician had stamped the medical records with her signature. She further stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past. She added she had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the signature stamp.

On 9/13/17 at 12:40 PM an interview was conducted with the physician whose name was on the stamp. She stated the record was stamped with her stamped signature and was not dated. She revealed she did not stamp the physician orders with her signature stamp. She said she would no longer utilize the stamp and she would make sure the record was dated when signed. The physician stated someone had

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brought this up to her before and she had informed them, referring to her office staff, not to use the stamp anymore.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the physician's group, whose physician had used the stamp, was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the rubber stamp. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and the Director of Nursing (DON) regarding the use of the stamped signature being used by the physician to sign orders. They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at the time with the Medical Director. The Administrator said he had not seen the document regarding the use of the physician stamp until 9/13/17 and did not know when it had been originally drafted and signed. The Administrator and the DON stated it was their expectation that the doctor whose name was on the stamp should utilize the stamp only and no other individual utilize his/her signature stamp.

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5. Resident #31 was admitted on 9/25/14 with diagnoses that included: high blood pressure, peripheral vascular disease, diabetes, high cholesterol, arthritis, dementia, anxiety, depression, history of falls, and developmental delay.

Review of #31's monthly physician's orders for 8/1/17 through 8/31/17 revealed a stamped signature in the physician's signature box and no date.

An interview was conducted with the Medical Records Director on 9/13/17 at 12:38 PM. She stated the Physician had stamped the medical records with her signature. She further stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past. She added she had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the signature stamp.

On 9/13/17 at 12:40 PM an interview was conducted with the physician whose name was on the stamp. She stated the record was stamped with her stamped signature and was not dated. She revealed she did not stamp the physician orders with her signature stamp. She said she would no longer utilize the stamp and she would make sure the record was dated when signed. The physician stated someone had brought this up to her before and she had informed them, referring to her office staff, not to use the stamp anymore.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the

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physician's group, whose physician had used the stamp, was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the rubber stamp. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and the Director of Nursing (DON) regarding the use of the stamped signature being used by the physician to sign orders. They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at the time with the Medical Director. The Administrator said he had not seen the document regarding the use of the physician stamp until 9/13/17 and did not know when it had been originally drafted and signed. The Administrator and the DON stated it was their expectation that the doctor whose name was on the stamp should utilize the stamp only and no other individual utilize his/her signature stamp.

6. Resident #13 was admitted to the facility 5/4/2012.

A review of physician orders for August 2017 revealed a rubber stamp signature had been used as a physician signature for review of the

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monthly orders. The date was not included with the signature/ stamp.

On 9/13/17 at 12:38 PM, an interview was conducted with Medical Records. She stated the Physician had stamped the medical records with her signature. She stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past and had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the stamp.

On 9/13/17 at 12:40 PM, an interview was conducted with the Physician. She revealed she did not stamp the physician orders with her signature. The Physician acknowledged the record was stamped with her stamped signature and was not dated. She said she would no longer utilize the stamp and she would make sure the record was dated when signed.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician ' s group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stamped signature. The document was reviewed with the Administrator. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

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F 386	Continued From page 46 On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician to sign orders. They stated the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday (09/13/17). The Administrator and the Director of Nursing stated it was their expectation that the doctor whose name was on the stamp utilize the stamp only and no other individual utilize their signature stamp. 7. Resident #14 was readmitted to the facility 11/11/2016. A review of physician orders for August 2017 revealed a rubber stamp signature had been used as a physician signature for review of the monthly orders. On 9/13/17 at 12:38 PM, an interview was conducted with Medical Records. She stated the Physician had stamped the medical records with her signature. She stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past and had questioned the use of the stamped signature	F 386		

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but could not remember who she had spoken with about the use of the stamp.

On 9/13/17 at 12:40 PM, an interview was conducted with the Physician. She revealed she did not stamp the physician orders with her signature. The Physician acknowledged the record was stamped with her stamped signature and was not dated. She said she would no longer utilize the stamp and she would make sure the record was dated when signed.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician ' s group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stamped signature. The document was reviewed with the Administrator. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician to sign orders. They stated the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made

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aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday (09/13/17). The Administrator and the Director of Nursing stated it was their expectation that the doctor whose name was on the stamp utilize the stamp only and no other individual utilize their signature stamp.

8. Resident #73 was admitted to the facility 4/25/17.

A review of physician orders for August 2017 revealed a rubber stamp signature had been used as a physician signature for review of the monthly orders.

On 9/13/17 at 12:38 PM, an interview was conducted with Medical Records. She stated the Physician had stamped the medical records with her signature. She stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past and had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the stamp.

On 9/13/17 at 12:40 PM, an interview was conducted with the Physician. She revealed she did not stamp the physician orders with her signature. The Physician acknowledged the record was stamped with her stamped signature and was not dated. She said she would no longer

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utilize the stamp and she would make sure the record was dated when signed.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician ' s group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stamped signature. The document was reviewed with the Administrator. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician to sign orders. They stated the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday (09/13/17). The Administrator and the Director of

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Nursing stated it was their expectation that the doctor whose name was on the stamp utilize the stamp only and no other individual utilize their signature stamp.

9. Resident #30 was readmitted to the facility 5/2/2011.

A review of physician orders for August 2017 revealed a rubber stamp signature had been used as a physician signature for review of the monthly orders.

On 9/13/17 at 12:38 PM, an interview was conducted with Medical Records. She stated the Physician had stamped the medical records with her signature. She stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past and had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the stamp.

On 9/13/17 at 12:40 PM, an interview was conducted with the Physician. She revealed she did not stamp the physician orders with her signature. The Physician acknowledged the record was stamped with her stamped signature and was not dated. She said she would no longer utilize the stamp and she would make sure the record was dated when signed.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician ' s group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use

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of the stamped signature. The document was reviewed with the Administrator. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician to sign orders. They stated the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday (09/13/17). The Administrator and the Director of Nursing stated it was their expectation that the doctor whose name was on the stamp utilize the stamp only and no other individual utilize their signature stamp.

10. Resident #9 was initially admitted to the facility on 8/22/08 and most recently readmitted on 2/7/15.

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A review of Resident #9 ' s physician orders for August 2017 revealed a rubber stamp signature had been used as a physician signature for review of the monthly orders.

On 9/13/17 at 12:38 PM, an interview was conducted with Medical Records. She stated the Physician had stamped the medical records with her signature. She stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past and had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the stamp.

On 9/13/17 at 12:40 PM, an interview was conducted with the Physician. She revealed she did not stamp the physician orders with her signature. The Physician acknowledged the record was stamped with her stamped signature and was not dated. She said she would no longer utilize the stamp and she would make sure the record was dated when signed.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician ' s group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stamped signature. The document was reviewed with the Administrator. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document

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was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician to sign orders. They stated the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday (09/13/17). The Administrator and the Director of Nursing stated it was their expectation that the doctor whose name was on the stamp utilized the stamp only and no other individual utilize their signature stamp.

11. Resident #11 was admitted to the facility on 1/5/15.

A review of Resident #11 ' s physician orders for August 2017 revealed a rubber stamp signature had been used as a physician signature for review of the monthly orders.

On 9/13/17 at 12:38 PM, an interview was conducted with Medical Records. She stated the Physician had stamped the medical records with her signature. She stated she did not have the

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stamp and indicated she had noticed that a stamped signature had been used in the past and had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the stamp.

On 9/13/17 at 12:40 PM, an interview was conducted with the Physician. She revealed she did not stamp the physician orders with her signature. The Physician acknowledged the record was stamped with her stamped signature and was not dated. She said she would no longer utilize the stamp and she would make sure the record was dated when signed.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician ' s group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stamped signature. The document was reviewed with the Administrator. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician to sign orders. They stated the physician had signed the monthly orders for September yesterday

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(09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday (09/13/17). The Administrator and the Director of Nursing stated it was their expectation that the doctor whose name was on the stamp utilized the stamp only and no other individual utilize their signature stamp.

12. Resident #19 was admitted to the facility on 2/22/10.

A review of Resident #19 ' s physician orders for August 2017 revealed a rubber stamp signature had been used as a physician signature for review of the monthly orders.

On 9/13/17 at 12:38 PM, an interview was conducted with Medical Records. She stated the Physician had stamped the medical records with her signature. She stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past and had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the stamp.

On 9/13/17 at 12:40 PM, an interview was conducted with the Physician. She revealed she did not stamp the physician orders with her

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signature. The Physician acknowledged the record was stamped with her stamped signature and was not dated. She said she would no longer utilize the stamp and she would make sure the record was dated when signed.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician ' s group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stamped signature. The document was reviewed with the Administrator. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated.

On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician to sign orders. They stated the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being

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used as a signature, the Administrator said he had not seen the document until yesterday (09/13/17). The Administrator and the Director of Nursing stated it was their expectation that the doctor whose name was on the stamp utilized the stamp only and no other individual utilize their signature stamp.

13. Resident #2 was initially admitted to the facility on 9/27/10 and most recently readmitted on 7/31/17.

A review of Resident #2 ' s readmission physician orders for 7/31/17 revealed a rubber stamp signature had been used as a physician signature for review of the orders.

On 9/13/17 at 12:38 PM, an interview was conducted with Medical Records. She stated the Physician had stamped the medical records with her signature. She stated she did not have the stamp and indicated she had noticed that a stamped signature had been used in the past and had questioned the use of the stamped signature but could not remember who she had spoken with about the use of the stamp.

On 9/13/17 at 12:40 PM, an interview was conducted with the Physician. She revealed she did not stamp the physician orders with her signature. The Physician acknowledged the record was stamped with her stamped signature and was not dated. She said she would no longer utilize the stamp and she would make sure the record was dated when signed.

On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician ' s group was asked about the stamp a

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F 386	Continued From page 58 while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stamped signature. The document was reviewed with the Administrator. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one in possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated. On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician to sign orders. They stated the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday (09/13/17). The Administrator and the Director of Nursing stated it was their expectation that the doctor whose name was on the stamp utilized the stamp only and no other individual utilize their signature stamp.	F 386		
F 412	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY	F 412		10/13/17

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F 412 SS=D	Continued From page 59 DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow the dental provider ' s recommendation for immediate follow up care for 1 of 2 residents (Resident #9) reviewed for dental services. The findings included: Resident #9 was initially admitted to the facility on 8/22/08 and most recently readmitted on 2/7/15 with multiple diagnoses that included dementia,	F 412	1. On 10/2/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents' receive dental services as recommended to meet the dental health needs of the resident. QAPI committee members in attendance	

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	345442	A. BUILDING _____ B. WING _____	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 412	Continued From page 60 depression, anxiety, and delusional disorder. The annual Minimum Data Set (MDS) assessment dated 10/17/16 indicated Resident #9 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #9 required the extensive assistance of one staff for eating and personal hygiene. She was on a mechanically altered diet and had no significant weight loss. Resident #9 ' s Oral/Dental Status was assessed as obvious or likely cavity or broken natural teeth. The Care Area Assessment (CAA) related to dental for the 10/17/16 annual MDS indicated Resident #9 had her own natural teeth which were in poor condition with several broken teeth. She denied needing to see a dentist and denied any current mouth pain or difficulty with eating. Staff continued to assist Resident #9 with her oral care. It was indicated this area was not going to be included in the plan of care for Resident #9 due to her denying the need to see a dentist. A dental consultation dated 1/19/17 indicated Resident #9 was seen for a periodic oral exam. The consultation indicated Resident #9 needed immediate care due to Resident #9 ' s left root tips hurting. The form indicated, "very uncomfortable ...need extractions". The quarterly MDS assessment dated 8/4/17 indicated Resident #9 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #9 required the extensive assistance of one staff for eating and personal hygiene. She was on a mechanically altered diet and had no significant weight loss.	F 412	included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #9, it was determined that the facility was unable to obtain a dental provider that could complete the dental services onsite and due to the two-person assistance requirements for transfer of an immobile resident via mechanical lift, an alternate approach would need to be arranged. On date 10/2/17, the Unit Manager and Social Worker scheduled dental services for Resident #9 on 10/5/17 and coordinated transportation with a contracted transport provider. The facility to send two nursing assistants and a mechanical lift to residents' dental appointment to aide in the safe transfer of resident into dental providers' service chair for dental care as indicated. All dental recommendations will be reviewed by the Interdisciplinary team (IDT), including the Director of Clinical Services, LPN Supervisor, and Social Worker, to ensure dental services are provided as indicated. Upon completion of Section L (Dental), the MDS Coordinator will review dental recommendations to ensure dental services are provided as indicated. 2. On 10/4/17, the Director of Clinical Services(DCS), MDS Coordinator, and	

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F 412	Continued From page 61 A review of the medical record revealed no additional notes, consultations, or appointments related to Resident #9 ' s dental care. An interview was conducted with the Social Worker (SW) on 9/14/17 at 9:10 AM. She indicated she was responsible for scheduling routine dental visits for the residents. She stated if a dentist recommended a follow up appointment after a routine visit the nursing staff was responsible for coordinating the follow up appointment. The dental consultation dated 1/19/17 for Resident #9 that indicated she needed immediate care was reviewed with the SW. The medical record that contained no additional notes, consultations, or appointments related to Resident #9 ' s dental care following the 1/19/17 dental appointment was reviewed with the SW. She stated she was going to review the medical record to see if anything was missing from Resident #9 ' s chart. A follow up interview was conducted with the SW on 9/14/17 at 9:28 AM. She stated she was unable to locate any additional documentation related to Resident #9 ' s dental care. She revealed the dental recommendation from 1/19/17 for immediate care for Resident #9 had not been followed. The SW stated she contacted a dental provider and scheduled an appointment for Resident #9 on 9/21/17 at 9:00 AM. An interview was conducted with the Director of Nursing (DON) on 9/14/17 at 10:35 AM. She indicated the SW was responsible for scheduling routine dental visits for the residents. She stated	F 412	Social Worker completed a quality assurance monitoring and observation of 57 current residents' dental status and of dental care recommendations and/or orders from 7/1/17-9/30/17 to ensure dental services are provided as indicated. No further discrepancies were identified. 3. On 10/13/17, the Director of Clinical Services completed reeducation to licensed nurses and the Social Worker on following physicians' orders and the coordination of dental services for residents to meet their dental care needs. Education included the expectation of the licensed nurse to communicate emergent dental care needs to the Social Worker via a copy of physician order for coordination and scheduling of dental services as ordered by the physician. Newly hired licensed nurses and Social Workers to be educated upon hire. The licensed nurse to communicate emergent dental care needs to the Social Worker for coordination and scheduling of dental services as ordered by the physician to meet the residents' dental care needs. The Social Worker to coordinate routine onsite contracted dental services to residents at a minimum of bi-annually. 4. The Minimum Data Set (MDS) nurse or LPN Supervisor to complete quality assurance monitoring of 5 random residents by review of dental recommendation and/or orders for compliance and by physical observation of	

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F 412	Continued From page 62 if a dentist recommended a follow up appointment after a routine visit the nursing staff was responsible for coordinating the follow up appointment. The dental consultation dated 1/19/17 for Resident #9 that indicated she needed immediate care was reviewed with the DON. The medical record that contained no additional notes, consultations, or appointments related Resident #9 ' s dental care following the 1/19/17 dental appointment was reviewed with the DON. The DON verified the dental recommendation from 1/19/17 for immediate care for Resident #9 had not been followed. She explained that the charge nurse who worked on 1/19/17 should have coordinated the follow up dental appointment. She indicated the charge nurse on 1/19/17 was no longer employed at the facility. She stated her expectation was for dental recommendations to be followed.	F 412	residents dental status to ensure proper dental care of the resident as necessary. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. 5. The Executive Director is responsible for the implementation and execution of this plan.	