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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		1/2/18

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

Electronically Signed | 12/23/2017

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

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews the facility failed to maintain dignity by failing to knock on doors or ask permission to enter resident rooms for 11 of 24 residents observed (Resident #2, Resident #23, Resident #7, Resident #32, Resident #9, Resident #22, Resident #29, Resident #40, Resident #6, Resident #34, Resident #28). Findings included: 1. Resident #2 was admitted to the facility on 3/30/17. Review of Resident #2's most recent quarterly minimum data set assessment dated 7/6/17 revealed she was moderately cognitively impaired. During observation on 11/29/17 at 11:40 AM House Keeper #1 entered Resident #2's room without knocking and swept the floor on the right side of the bed beside Resident #2. During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open. During an interview on 11/29/17 at 12:03 PM Resident #2 stated she wanted staff to knock first before entering her room for privacy. She further stated that she would not want staff entering without her knowing, but some staff did always	F 550	F550 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to maintain dignity by failing to knock on doors or asked permission to enter resident rooms for 11 of 24 residents observed. The identified employees that failed to knock on resident doors was immediately provided education by the Environmental Services Director on 11-29-2017. 2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - On 12-12-17, The Administrator, Director of Nursing, Housekeeping and Laundry Supervisor, began in servicing all FT, PT, and PRN RN's, LPN's, CNA's and Housekeeping and Laundry Staff and	

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F 550	Continued From page 2 knock and some staff did not and she wished they would always knock. She stated that she would like staff to knock if the door was open or closed. During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern. During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He stated that for residents who were cognitively impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room. 2. Resident #23 was admitted to the facility on 9/30/16. Review of Resident #23's most recent minimum data set assessment dated 10/6/17 revealed she was assessed as moderately cognitively impaired. During observation on 11/29/17 at 11:50 AM House Keeper #1 entered Resident #23's room without knocking or asking permission to enter.	F 550	Rehab Staff, Dietary Staff and Department Managers on the following procedures: Honoring Resident Preferences- Respecting resident's private space and property (e.g.,not changing radio or television station without resident's permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting resident's personal possession without permission. Any in-house staff member who did not receive in-service training by 12-31-2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Administrator, Director of Nursing, MDS Coordinator, Central Supply Clerk, Restorative Aid, Environmental Services Director will conduct audits to ensure staff are knocking on doors or asking permission to enter residents rooms, weekly for two weeks and monthly for 3	

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F 550	Continued From page 3 During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open. During an interview on 11/29/17 at 12:04 PM Resident #23 stated she would like staff to knock before entering even if the door is open. She further stated some staff did not always knock before entering. During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern. During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He stated that for residents who were cognitively impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room. 3. Resident #7 was admitted to the facility on 9/22/15.	F 550	months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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Review of Resident #7's most recent minimum data set assessment dated 8/24/17 revealed the resident was assessed as cognitively intact.

During observation on 11/29/17 at 11:51 AM House Keeper #1 entered Resident #7's room without knocking or announcing her presence.

During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern.

During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He stated that for residents who were cognitively impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room.

During an interview on 11/29/17 at 2:25 PM Resident #7 stated she would appreciate staff

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knocking so that she would know who was in her room.

4. Resident #32 was admitted to the facility on 7/22/16.

Review of Resident #32's most recent minimum data assessment dated 10/22/17 revealed she was assessed as severely cognitively impaired.

During observation on 11/29/17 at 11:43 AM House Keeper #1 entered Resident #32's room without knocking or announcing her presence.

During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern.

During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He stated that for residents who were cognitively impaired, his expectation was his staff would

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announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room.

5. Resident #9 was admitted to the facility on 5/29/13.

Review of Resident #9's most recent minimum data set assessment dated 9/5/17 revealed he was assessed as severely cognitively impaired.

During observation on 11/29/17 at 11:49 AM House Keeper #1 entered Resident #9's room without knocking or announcing her presence.

During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern.

During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He stated that for residents who were cognitively

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impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room.

6. Resident #22 was admitted to the facility on 6/30/16.

Review of Resident #22's most recent minimum data set assessment dated 10/7/17 revealed he was assessed as severely cognitively impaired.

During observation on 11/29/17 at 11:51 AM House Keeper #1 entered Resident #22's room without knocking or announcing her presence.

During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern.

During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He

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stated that for residents who were cognitively impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room.

7. Resident #29 was admitted to the facility on 7/7/17.

Review of Resident #29's most recent minimum data set dated 10/14/17 revealed the resident was assessed as severely cognitively impaired.

During observation on 11/29/17 at 11:51 AM House Keeper #1 entered Resident #29's room without knocking or announcing her presence.

During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern.

During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence

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regardless of if the door was open or closed. He stated that for residents who were cognitively impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room.

8. Resident #40 was admitted to the facility on 2/22/11.

Review of Resident #40's most recent minimum data set assessment dated 11/4/17 revealed the resident was assessed as severely cognitively impaired.

During observation on 11/29/17 at 11:51 AM House Keeper #1 entered Resident #40's room without knocking or announcing her presence.

During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern.

During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that

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housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He stated that for residents who were cognitively impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room.

9. Resident #6 was admitted to the facility on 2/13/04.

Review of Resident #6's most recent minimum data set assessment dated 8/23/17 revealed the resident was assessed as moderately cognitively impaired.

During observation on 11/29/17 at 11:52 AM House Keeper #1 entered Resident #6's room without knocking or announcing her presence.

During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern.

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During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He stated that for residents who were cognitively impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room.

10. Resident #34 was admitted to the facility on 12/16/14.

Review of Resident #34's most recent minimum data set assessment dated 10/25/17 revealed the resident was assessed as severely cognitively impaired.

During observation on 11/29/17 at 11:52 AM House Keeper #1 entered Resident #34's room without knocking or announcing her presence.

During an interview on 11/29/17 at 11:52 AM House Keeper #1 stated that she knocked when the doors were closed but she did not have to knock or announce her presence if the doors were open.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing continued stating for residents who were cognitively impaired, staff should still announce

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their presence and that it was a dignity concern.

During an interview on 11/29/17 at 12:51 PM the Environmental Services Director stated that housekeeping staff must knock before entering any room and announce their presence regardless of if the door was open or closed. He stated that for residents who were cognitively impaired, his expectation was his staff would announce their presence. He further stated that this was a dignity concern and House Keeper #1 should have knocked prior to entering each room.

11. Resident #28's was admitted to the facility on 4/5/17.

Review of the Resident #28's most recent minimum data set assessment dated 10/12/17 revealed the resident was assessed as severely cognitively impaired.

During observation on 11/29/17 at 11:17 AM Nurse Aide #1 did not knock or announce herself before she entered Resident #28's room.

During an interview on 11/29/17 at 12:11 PM Nurse Aide #1 stated staff are required to knock or announce their presence before entering a resident's room regardless of if the door is open or closed and get permission to enter.

During an interview on 11/29/17 at 12:15 PM the Director of Nursing stated staff must always knock or announce their presence before entering a resident's room. She further stated it was her expectation was that all staff would knock or announce their presence before entering a resident's room no matter if the door was open or closed. The Director of Nursing

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F 550	Continued From page 13 continued stating for residents who were cognitively impaired, staff should still announce their presence and that it was a dignity concern.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		1/2/18

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F 584	Continued From page 14 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to appropriately store resident care equipment by storing unmarked urinals on bathroom grab bars and floor, and a specimen pan wedged between the grab bar and the wall for 3 of 15 bathrooms reviewed, and failed to change a frayed bed control for 1 of 24 residents reviewed. The findings included: 1. Observations were made on 11/28/2017 at 3:44 PM, 11/29/17 at 2:16 PM and on 11/30/2017 at 11:30 AM of the shared bathroom located between rooms 206 and 208. Two unmarked urinals were observed in the bathroom, one hanging from the grab bar and one laying on it's side on the floor 2. Observations were made on 11/28/2017 at 3:20 PM, 11/29/17 at 2:22 PM and on 11/30/2017 at 11:30 AM of the shared bathroom located between rooms 209 and 211. An uncovered specimen pan was observed wedged between the grab bar and the wall. 3. Observations were made on 11/28/2017 at 3:40 PM, 11/29/17 at 2:25 PM and on 11/30/2017 at 11:30 AM of the shared bathroom located between rooms 214 and 216. Two urinals were	F 584	F584 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to appropriately store resident care equipment by storing unmarked urinals on bathroom grab bars and floor, and specimen pans were wedged between the grab bar and the wall for 3 of 15 bathrooms reviewed and failed to change a frayed bed control for 1 of 24 residents reviewed. a. The unmarked urinals and the specimen pans were discarded immediately on 11-30-17 by the Director Nursing and the Central Supply Clerk.	

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F 584	Continued From page 15 observed in the bathroom, both hanging from the grab bar. One was marked with a resident name and the other was unmarked. 4. Observations were made on 11/29/17 at 8:43 AM, 11/29/17 at 2:20 PM and on 11/30/17 at 11:30 AM of the bed control cord for room 210A. The bed control cord was wrapped around the left hand grip bar and colored wires were visible under the cracked wire covering. An interview with nurse aide (NA) #3 was conducted on 11/30/17 at 11:52 AM. The NA stated urinals and specimen pans were stored in bags and kept in either the bathrooms or in the resident's night stand. The NA stated any equipment that was damaged or needed repair was written up for the maintenance manager. An interview with nurse #3 was conducted on 11/30/17 at 12:57 PM. The nurse stated she regularly cared for the residents on the 200 hall. The nurse stated urinals and specimen pans should be labeled with the resident name. Any exposed wires or equipment not working would be reported to the maintenance director. An interview with NA #4 was conducted on 11/30/17 at 12:57 PM. The NA stated she regularly cared for residents on the 200 hall. The NA stated urinals and specimen pans should be labeled with resident name. Any exposed wires or equipment not working would be reported to the maintenance director. An interview was conducted with the director of nursing (DON) on 11/30/17 at 4:09 PM. The DON stated urinals and specimen pans should be marked with the resident's name and placed in a	F 584	b. The frayed bed control was replaced on 12-11-2017 by the Environmental Services Director. On 12-1-17, the Director of Nursing and Central Supply Clerk conducted an audit of all Resident rooms to include bathrooms to ensure resident care equipment was properly stored. The Environmental Services director conducted an audit of all Resident rooms to ensure bed controls are in good working order. 12-22-2017 2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - On 12-12-17, The Administrator, Director of Nursing, Housekeeping and Laundry Supervisor, began in servicing all FT, PT, and PRN RN's, LPN's, CNA's and Housekeeping and Laundry Staff and Rehab Staff, Dietary Staff and Department Managers on the following procedures: - The resident has a right to a safe clean, comfortable and homelike environment including but not limited to receiving treatment and supports for daily living safely. -The importance of labeling resident care equipment, such as urinals and storing them properly. - The importance of inspecting and reporting any signs of frayed bed controls	

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F 584	Continued From page 16 plastic bag and not unmarked on the floor or hanging on the grab bars. The DON stated it was her expectation of staff to properly mark and store urinals and specimen pans. The DON stated it was her expectation of staff to report any damaged bed controls to maintenance for repair.	F 584	Any in-house staff member who did not receive in-service training by 12-31-2017, will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Administrator, Director of Nursing, MDS Coordinator, Central Supply Clerk and Restorative Aid, Environmental Services Director will conduct audits on: Resident rooms and bathrooms to ensure resident care equipment is properly stored and the resident bed controls are in good working order. These audits will be completed weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for	

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F 584	Continued From page 17	F 584	implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff, family, and physician interviews, and record review the facility failed to identify a pressure ulcer and initiate pressure ulcer wound care until five days after admission to the facility for 1 of 2 residents reviewed for pressure ulcer care. (Resident #57) Findings included: Review of wound care instructions for Resident #57 from the discharging medical center dated 11/2/17 and faxed to the facility on 11/14/17 revealed Resident #57 had an unstageable	F 600	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	1/2/18

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F 600	Continued From page 18 wound to her right lateral ankle. The wound measured 1 centimeter long 1.5 centimeters wide, and no depth. The order was to cleanse the wound with normal saline, pat dry, and cover with foam dressing Monday, Wednesday, Friday, and as needed. Resident #57 was admitted to the facility on 11/15/17. Her active diagnoses included atrial fibrillation, hyperlipidemia, aphasia, and hemiplegia. Review of Resident #57's admission nursing assessment dated 11/15/17 revealed the resident was assessed as at risk to develop pressure ulcers. Resident #57's skin was assessed to be "good" with normal skin care required, including a diabetic skin assessment. Wound care was not identified to be required. Review of Resident #57's care plan dated 11/15/17 revealed the resident was care planned for pressure ulcer development. The interventions included to observe the resident ' s skin for redness or open areas and inform nurse if any areas were noted and perform weekly full body skin assessments. Review of Resident #57's dietitian nutritional assessment dated 11/16/17 revealed Resident #57 was assessed to have no wounds. Review of skilled nursing reviews dated 11/16/17, 11/17/17, 11/18/17, and 11/19/17 revealed Resident #57 was not identified to have any wounds. Review of a weekly pressure ulcer assessment dated 11/20/17 revealed that an initial pressure	F 600	deficiencies cited have been or will be corrected by the dates indicated. F 600 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to identify pressure ulcer and initiate pressure ulcer wound care until five days after admission to the facility for 1 of 2 residents reviewed for pressure ulcer care. A full body assessment was completed on 100% of in house residents on 11-30-2017. DON, MDS Coordinator, and licensed nurses assessed for any pressure ulcers/skin concerns and to ensure MD orders for wound care. 100% of resident charts were reviewed for current treatment orders on identified skin conditions on 11-30-2017 by MDS Coordinator. Pressure and nonpressure wound UDA completed on residents that had pressure ulcers/skin concerns identified on 11-30-2017 by MDS Coordinator. On 11-30-17 the Director of Nursing audited 100% of the following: All current residents had a full body skin assessment completed all areas noted	

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F 600	Continued From page 19 ulcer assessment was performed 11/20/17 for Resident #57. The onset dated for the wound was documented to be 11/15/17 and was identified to be community acquired. Resident #57 was assessed to have one wound to the right outer ankle. The wound was identified as an unstageable pressure ulcer. The wound measurements were 0.9 centimeters long, 1.4 centimeters wide, and had no depth. The tissue was 100% slough. The note stated resident had an unstagable, slough covered wound to her right outer ankle. The area around wound was reddened and slightly edematous. No drainage was noted at that time. The wound edges were well defined. A dressing was applied and was to be changed every 2 days. The physician and family was notified on 11/20/17. Review of Resident #57's treatment record revealed that treatment for the right outer ankle pressure wound was not ordered or started until 11/20/17. Review of Resident #57's most recent Minimum Data Set (MDS) assessment dated 11/22/17 revealed she was assessed as rarely or never understood with modified independence. She required limited assistance with bed mobility and transfers. Resident #57 required physical help in part with bathing. She was assessed to have one unstageable pressure ulcer which was present upon admission and measured 0.9 centimeters long, 1.4 centimeters wide, and no depth. During an interview on 11/28/17 at 11:27 AM Resident #57's family stated Resident #57 had a pressure ulcer on her right ankle which developed before arrival in the facility. The family stated that the resident left the medical center on 11/14/17	F 600	were reviewed for a current treatment order on current resident Pressure wound UDA/non pressure UDA completed on current residents This audit was completed on 12-1-2017 with the following findings of two residents without treatment orders for newly identified areas. These two were immediately corrected with orders in place for wound care, UDA completed and RP notified. This was completed on 12-1-2017 by MDS Coordinator and staff nurse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 12-12-2017 the Director of Nursing began in servicing all FT, PT, and PRN RN's, LPN's, Med Tech's, and Supply Clerk on the following procedures: Importance of clinical documentation to assure that all potential risks related to resident safety care are met, UDA's musts be fully and accurately completed. All UDAs must be completed within scheduled time frames. (i.e. Admission, quarterly, annually, readmission, and with significant change in status) Completion of weekly skin/ wound assessment and the proper way to conduct skin UDA (head to toe looking at resident unclothed.)	

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F 600	Continued From page 20	F 600		

and arrived on 11/15/17 at the facility. She further stated the facility did not notice the pressure ulcer for six days until she brought it to MDS Nurse #1's attention on 11/20/17 and the wound still had the bandage from the prior medical center present when staff looked at the wound on 11/20/17. The family continued to state she was unsure if the wound had actually gotten worse but it did appear to have more redness on 11/20/17, however the wound was healing now and currently looked much better than it ever had.

During an interview on 11/30/17 at 11:14 AM Nurse Aide #2 stated that she was the nurse aide who was working when Resident #57 was admitted. She further stated Resident #57 needed some assistance with bathing and that the nurse aides bathed her legs and feet and her back. She further stated she did not see any skin concerns on Resident #57 on 11/15/17 or 11/16/17 during care. She stated she did not work again until the next Monday, 11/20/17 when the wound was discovered.

During an interview on 11/30/17 at 11:29 AM MDS Nurse #1 stated that Resident #57's family came to him on 11/20/17 and asked him what the facility was doing for Resident' #57's wound. He stated he went to the room and assessed the wound. MDS Nurse #1 further stated the dressing that was on Resident #57's right outer ankle at that time was not a dressing the facility had in house. He concluded the dressing that was on Resident #57's right outer ankle must have been from 11/14/17 or before. He stated he called the wound doctor and described the wound and the wound doctor ordered dressings to be applied to the wound every two days. The wound doctor then came to the facility on the 11/22/17 and

Review of facility protocol on documentation of wounds and the inclusion of measurements, location, drainage amount, signs of infection for UDA completion.

Review with nursing staff importance of promptly reporting changes to skin or wounds, notification of physician, residents RP notification.

Any in-house staff member who did not receive in-service training by 12/31/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

The Director of Nursing or MDS Coordinator will audit UDA weekly for two weeks then monthly for three months for completion of the skin wound UDAs. This monitoring will continue until resolved by QOL/QA committee.¿ Reports will be

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F 600	Continued From page 21 assessed the wound. He further stated that he was unable to identify any documentation of the wound prior to 11/20/17 and stated due to this, he did not believe the wound had been identified by the facility before 11/20/17. He further stated that on the day the resident was admitted Nurse #1 was the nurse who admitted the resident and he audited her admission assessment. He stated he did not identify the pressure ulcer when he finished the admission assessment audit for the nurse. During an interview on 11/30/17 at 11:42 AM the Director of Nursing stated that it was her expectation that all residents would have a full head to toe assessments upon entry. She further stated that staff should have identified the pressure ulcer on Resident #57 upon admission through record review as well as a full head to toe assessment, it was not done, and the wound was not identified until the family member brought it to MDS Nurse #1's attention on 11/20/17. During a phone interview on 11/30/17 at 1:33 PM Nurse #1 stated she did not identify the pressure ulcer on Resident #57's right outer ankle because it was her second day of training and she was told by her trainer that on the rehab section of the nursing home, nurses did not have to complete a full body assessment and she only needed to perform a focused assessment on Resident #57's feeding tube site. She stated her trainer was Nurse #2 and she was with her that day when she admitted Resident #57. During an interview on 11/30/17 at 1:41 PM the Director of Nursing stated that Nurse #2 did train Nurse #1 but Nurse #2 was not in the facility on 11/15/17 and Nurse #1 had completed her	F 600	presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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F 600	Continued From page 22 training and was working independently on 11/15/17. She further stated that no staff had ever been told to not perform a full head to toe assessment on a resident on admission in any unit of the facility. During a phone interview on 11/30/17 at 1:45 PM Nurse #2 stated that she trained Nurse #1 but did not work on 11/15/17. She further stated that at no time during the training of Nurse #1 did she tell her that full head to toe assessments were not required on the rehab unit of the nursing home. During a phone interview on 11/30/17 2:28 PM the Wound Care Physician stated when she first saw the wound it was an unstageable pressure ulcer with necrotic tissue covering most of the wound bed. She stated having not seen the wound before 11/22/17 she could not say for sure if the wound had deteriorated but from what she saw on her initial assessment on 11/22/17 she felt the lack of dressing changes had not negatively impacted the status of the pressure ulcer at that point. She further stated not changing the dressing on pressure wounds had the potential to cause a decline in the wound, however Resident #57's wound did not have any indications or signs of deteriorating tissue.	F 600		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs	F 622		1/2/18

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cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this

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THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

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F 622	Continued From page 24	F 622		

section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:

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F 622	Continued From page 25 Based on interviews with the Responsible Party (RP) and facility staff and record reviews the facility failed to allow a resident with exit seeking behaviors to remain in the facility by issuing a discharge notice which stated the facility could not meet the resident's needs for 1 (Resident # 108) of 3 residents reviewed for discharge. The findings included: A review of the Adult Care Home FL2 form dated 8/291/17 revealed Resident #108 had diagnoses which included dementia, syncope, seizure disorder and cerebral infarct with hemiparesis of the right dominant side. Resident #108 was admitted to the nursing home on 8/30/17. A review of the Initial Risk Assessment dated 8/30/17 revealed the resident did not exhibit wandering, had no wandering in the last 7 days and was chair fast and not able to walk. A nursing note dated 8/31/17 at 3:37 AM revealed the resident was new admission and did not appear to be adjusting well. The note stated Resident #108 did not sleep and had been up once every hour. He had been offered a snack, hydration and had been toileted. Another nursing note written on 8/31/17 at 11:56 by the Director of Nursing (DON) revealed a telephone call was made to the resident's doctor to "discuss other options for resident care." The note also stated the exit seeking behavior and facility inability to accommodate his needs was discussed and the doctor was agreeable with a plan to find another placement for the resident.	F 622	F622 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to allow a resident with exit seeking behaviors to remain in the facility by issuing a discharge notice which stated the facility could not meet the resident's needs. Resident #108 was admitted on 8-30-2017. FL-2 and medical records were shared with facility prior to 8-30-2017, and resident was admitted on 8-30-2017. A Pre-admission medical records did not disclose that resident was an active frequent exit seeker and capable of working through exit seeking barriers, such as a wanderguard system.	

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F 622	Continued From page 26 During an interview with the Director of Nursing on 12/1/17 at 10:37 AM she stated Resident #108 had exit seeking behaviors and even went onto the service hall looking for an exit. She added that he had syncope and was at increased risk for falls. She said the facility contacted the doctor to inform him they were afraid for Resident #108's safety. The DON stated the doctor said they should do what was best for the resident. She said Resident 108 was wearing a Wander Guard which alarmed when he got near the front door. An interview was conducted with the Administrator on 12/1/17 at 1:36 PM. She stated Resident #108 was "very busy and wandering around." She stated she told the resident's RP "He was more than we could handle and not appropriate for our facility." She added Resident #108 was more appropriate for a locked unit. The Administrator also said she felt he needed a dementia unit because he was an exit seeker and that she gave the RP a discharge notice. A review of the Nursing Home Notice of Transfer/Discharge revealed it was dated 8/31/17 and the date of discharge was "as soon as facility finds placement." The reason for transfer/discharge was "It is necessary for your welfare and your needs cannot be met in this facility." The form also stated the plans to transfer or discharge was to another named nursing home facility and the form had the address and phone number of that facility. The form contained the appeal rights and long term care ombudsman's contact information. The form was signed by the administrator and dated 8/31/17. During a telephone interview with Resident #108's	F 622	Resident was admitted on 8-30-2017. Assessments were completed to identify any risk and resident scored as a low risk. Within twenty four hours, resident became very active and was repetitively exit seeking and the wanderguard system was not effective for resident. Communication with RP and MD to discuss appropriate level of care and specialty units that may accommodate residents need. A 30 day DC was issued to allow and support time needed to address resident's exit seeking behaviors and/or specialty unit. RP made the decision to take resident back to his previous facility on 8-31-2017. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - The facility will include the following components of reviewing with residents/RP discharge planning processes: The facility will offer Resident #108 to return back into the facility. During the admissions process, Social	

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F 622	Continued From page 27 RP on 12/5/17 at 1:30 pm she stated she had visited the facility during a weekend prior to admission. Resident 108's RP said she received a telephone call from the facility stating there was a bed available. She stated she drove Resident #108 from the adult care home to the nursing home in her car. The RP also stated she was not able to complete the admission paperwork on 8/30/17 because the social services/admission coordinator was not available. Resident #108's RP added that as she was driving back to the facility on 8/31/17 to complete the admission paperwork, she received a telephone call from the Administrator who told her the facility was not able to care for her father because he was a liability due to his wandering behaviors. The RP did say she had provided the facility with medical information for her father on 8/30/17. Resident # 108 was discharged on 8/31/17.	F 622	Worker, Social Services assistant and or Activities Director will conduct Resident Interviews to obtain information about Residents preferences regarding activities, leisure time and going outside. Involve the IDT, resident and/or resident representative in developing a discharge plan that reflects the resident's current discharge needs, goals, and treatment preferences while considering caregiver support; Document that the resident was asked about their interest in receiving information about returning to the community; Assist the resident and/or resident representatives in selecting a post-acute care provider if the resident went to another SNF (skilled nursing facility), NH (nursing home), HHA (home health agency), IRF (inpatient rehab facility), or LTCH (LTC hospital). Education for the Interdisciplinary Team (including Social Worker, Admissions, Nursing, MDS Coordinator) was conducted by the Administrator, to	

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F 622	Continued From page 28	F 622	include: Discharge processing and assessment, including documentation requirements Processes of issuing 30 day Dc notices and communication to Resident/RP Any in-house staff member who did not receive in-service training by 12-31-2017, will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.	

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The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

Discharge Audits will be conducted by Admissions, Social Services Assistant, MDS Coordinator, Health Information Manager or Director of Nursing on Residents discharged from the facility. These audits will be conducted to ensure the discharge has the appropriate discharge and discharge documentation.

These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.

The title of the person responsible for implementing the plan of correction.

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F 622	Continued From page 30	F 622	The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review the facility failed to correctly code a resident's toilet use and eating abilities on a quarterly minimum data set assessment (Resident #30) and a resident's toilet use on a quarterly minimum data set assessment (Resident #24) for 2 of 7 residents reviewed for resident assessments. Findings included: 1. Resident #30 was admitted to the facility on 8/17/17. His active diagnoses included vascular dementia, gout, and atrial fibrillation. Review of Resident #30's most recent quarterly minimum data set (MDS) assessment dated 10/14/17 revealed in section G toilet use was marked as activity only occurred once or twice. Also in section G eating was marked as activity occurred only once or twice. During observation on 11/28/17 at 12:20 PM Resident #30 was observed to be eating in his room. Set up assistance only was required.	F 641	F641 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to correctly code a resident's toilet use and eating abilities on a quarterly minimum data set assessment(Resident #30) and a resident's toilet use on a quarterly minimum data set assessment(Resident #24) for 2 of 7 residents reviewed.	1/2/18

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F 641	Continued From page 31 During an interview on 11/30/17 at 4:00 PM Nurse Aide #1 stated that Resident #30 required limited assistance with meals and needed extensive assistance for toilet use. She further stated that Resident #30 had never had a feeding tube. The nurse aide continued to state that Resident #30 had not gone a day without voiding. During an interview on 11/30/17 at 5:03 PM MDS Nurse #1 stated that they were having documentation issues with the nurse aides. He stated the nurse aide that provided care for the resident during that look back period of 7 days and documented that the resident's eating and toilet use were an activity that only occurred once or twice no longer worked at the facility and because of this they could not change this documentation. He further stated this was the reason the minimum data set assessment dated 10/14/17 did not accurately reflect Resident #30's status. During an interview on 12/1/17 at 9:02 AM the Director of Nursing stated it was her expectation that MDS Nurse #1 would ensure that the minimum data set assessments were correct and if inaccurate documentation was identified by MDS Nurse #1 then it should be corrected. She further stated the minimum data set assessment for Resident #30 was incorrect and the documentation should have been corrected. 2. Resident #24 was admitted to the facility on 2/13/12. Her active diagnoses included heart failure, muscle weakness, and arthritis. Review of Resident #24's most recent quarterly minimum data set assessment dated 10/7/17	F 641	The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: The MDS consultant in-serviced the MDS Coordinator and Director of Nursing on the following procedures: How to accurately code Section G0110H and G0110I (Toilet Use and Eating) on the MDS assessment. The two resident MDS' were corrected electronically by the MDS Coordinator. This information has been integrated into the standard orientation training for MDS Coordinator and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The MDS Consultant, Director of Nursing, MDS Coordinator, will conduct audits to ensure accurate coding of Section G (G0110H and G0110I) of MDS assessments, weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and	

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F 641	Continued From page 32 revealed in section G toilet use was marked as activity only occurred once or twice. During an interview on 11/30/17 at 4:00 PM Nurse Aide #1 stated that Resident #24 required extensive assistance with toilet use. The nurse aide continued to state that Resident #24 had not gone multiple days without voiding. During an interview on 11/30/17 at 5:03 PM MDS Nurse #1 stated that they were having documentation issues with the nurse aides. He stated the nurse aide that provided care for the resident during that look back period of 7 days and documented that the resident's toilet use was an activity that only occurred once or twice no longer worked at the facility and because of this they could not change this documentation. He further stated this was the reason the minimum data set assessment dated 10/7/17 did not accurately reflect Resident #24's status. During an interview on 12/1/17 at 9:02 AM the Director of Nursing stated it was her expectation that MDS Nurse #1 would ensure that the minimum data set assessments were correct and if inaccurate documentation was identified by MDS Nurse #1 then it should be corrected. She further stated the minimum data set assessment for Resident #24 was incorrect and the documentation should have been corrected.	F 641	ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		1/2/18

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F 686	Continued From page 33 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff, family, and physician interviews, and record review the facility failed to identify a pressure ulcer and initiate pressure ulcer wound care until five days after admission to the facility for 1 of 2 residents reviewed for pressure ulcer care. (Resident #57) Findings included: Review of wound care instructions for Resident #57 from the discharging medical center dated 11/2/17 and faxed to the facility on 11/14/17 revealed Resident #57 had an unstageable wound to her right lateral ankle. The wound measured 1 centimeter long 1.5 centimeters wide, and no depth. The order was to cleanse the wound with normal saline, pat dry, and cover with foam dressing Monday, Wednesday, Friday, and as needed. Resident #57 was admitted to the facility on 11/15/17. Her active diagnoses included atrial fibrillation, hyperlipidemia, aphasia, and hemiplegia. Review of Resident #57's admission nursing assessment dated 11/15/17 revealed the resident	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 686 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to identify a pressure ulcer and initiate pressure ulcer wound care until five days after admission to the facility for 1 of 2 residents reviewed for	

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F 686	Continued From page 34 was assessed as at risk to develop pressure ulcers. Resident #57's skin was assessed to be "good" with normal skin care required, including a diabetic skin assessment. Wound care was not identified to be required. Review of Resident #57's care plan dated 11/15/17 revealed the resident was care planned for pressure ulcer development. The interventions included to observe the resident's skin for redness or open areas and inform nurse if any areas were noted and perform weekly full body skin assessments. Review of Resident #57's dietitian nutritional assessment dated 11/16/17 revealed Resident #57 was assessed to have no wounds. Review of skilled nursing reviews dated 11/16/17, 11/17/17, 11/18/17, and 11/19/17 revealed Resident #57 was not identified to have any wounds. Review of a weekly pressure ulcer assessment dated 11/20/17 revealed that an initial pressure ulcer assessment was performed 11/20/17 for Resident #57. The onset dated for the wound was documented to be 11/15/17 and was identified to be community acquired. Resident #57 was assessed to have one wound to the right outer ankle. The wound was identified as an unstageable pressure ulcer. The wound measurements were 0.9 centimeters long, 1.4 centimeters wide, and had no depth. The tissue was 100% slough. The note stated resident had an unstagable, slough covered wound to her right outer ankle. The area around wound was reddened and slightly edematous. No drainage was noted at that time. The wound edges were	F 686	pressure ulcer care. A 100 % audit was completed on all newly admitted resident charts for full body assessment, wound care orders and completion in the EMR on 11/30/2017 by DON and MDS Coordinator. On 11-30-17 the Director of Nursing audited 100% of the following: 100% of newly admitted residents charts were audited for wound care orders and compared with EMR for accuracy and completion 100% audit completed on newly admitted residents for Pressure wound UDA/non pressure UDA completion. This audit was completed on 12-1-2017 by DON and MDS Coordinator with no incident of missing orders. All newly admitted residents with wound care orders upon admission had been accurately transcribed. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 12-12-2017 the Director of Nursing began in servicing all FT, PT, and PRN RN's, LPN's, Med Tech's, and Supply Clerk on the following procedures:	

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F 686	Continued From page 35 well defined. A dressing was applied and was to be changed every 2 days. The physician and family was notified on 11/20/17. Review of Resident #57's treatment record revealed that treatment for the right outer ankle pressure wound was not ordered or started until 11/20/17. Review of Resident #57's most recent Minimum Data Set (MDS) assessment dated 11/22/17 revealed she was assessed as rarely or never understood with modified independence. She required limited assistance with bed mobility and transfers. Resident #57 required physical help in part with bathing. She was assessed to have one unstageable pressure ulcer which was present upon admission and measured 0.9 centimeters long, 1.4 centimeters wide, and no depth. During an interview on 11/28/17 at 11:27 AM Resident #57's family stated Resident #57 had a pressures ulcer on her right ankle which developed before arrival in the facility. The family stated that the resident left the medical center on 11/14/17 and arrived on 11/15/17 at the facility. She further stated the facility did not notice the pressure ulcer for six days until she brought it to MDS Nurse #1's attention on 11/20/17 and the wound still had the bandage from the prior medical center present when staff looked at the wound on 11/20/17. The family continued to state she was unsure if the wound had actually gotten worse but it did appear to have more redness on 11/20/17, however the wound was healing now and currently looked much better than it ever had. During an interview on 11/30/17 at 11:14 AM Nurse Aide #2 stated that she was the nurse aide	F 686	Proper way to conduct a skin UDA looking at resident from head to toe unclothed. Completion of weekly skin/ wound assessment and the proper way to conduct skin UDA (head to toe looking at resident unclothed.) Importance of clinical documentation to assure that all potential risks related to resident safety care are met, UDA's musts be fully and accurately completed. Review of facility protocol on documentation of wounds and the inclusion of measurements, location, drainage amount, signs of infection for UDA completion. Review with nursing staff importance of promptly reporting changes to skin or wounds, notification of physician, residents RP notification. Any in-house staff member who did not receive in-service training by 12/31/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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	345404	A. BUILDING _____ B. WING _____	C 12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

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F 686	Continued From page 36 who was working when Resident #57 was admitted. She further stated Resident #57 needed some assistance with bathing and that the nurse aides bathed her legs and feet and her back. She further stated she did not see any skin concerns on Resident #57 on 11/15/17 or 11/16/17 during care. She stated she did not work again until the next Monday, 11/20/17 when the wound was discovered. During an interview on 11/30/17 at 11:29 AM MDS Nurse #1 stated that Resident #57's family came to him on 11/20/17 and asked him what the facility was doing for Resident' #57's wound. He stated he went to the room and assessed the wound. MDS Nurse #1 further stated the dressing that was on Resident #57's right outer ankle at that time was not a dressing the facility had in house. He concluded the dressing that was on Resident #57's right outer ankle must have been from 11/14/17 or before. He stated he called the wound doctor and described the wound and the wound doctor ordered dressings to be applied to the wound every two days. The wound doctor then came to the facility on the 11/22/17 and assessed the wound. He further stated that he was unable to identify any documentation of the wound prior to 11/20/17 and stated due to this, he did not believe the wound had been identified by the facility before 11/20/17. He further stated that on the day the resident was admitted Nurse #1 was the nurse who admitted the resident and he audited her admission assessment. He stated he did not identify the pressure ulcer when he finished the admission assessment audit for the nurse. During an interview on 11/30/17 at 11:42 AM the Director of Nursing stated that it was her	F 686	requirements: The Director of Nursing or MDS Coordinator will audit UDA weekly for two weeks then monthly for three months for completion of the skin wound UDAs. This monitoring will continue until resolved by QOL/QA committee.¿ Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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F 686	Continued From page 37	F 686		

expectation that all residents would have a full head to toe assessments upon entry. She further stated that staff should have identified the pressure ulcer on Resident #57 upon admission through record review as well as a full head to toe assessment, it was not done, and the wound was not identified until the family member brought it to MDS Nurse #1's attention on 11/20/17.

During a phone interview on 11/30/17 at 1:33 PM Nurse #1 stated she did not identify the pressure ulcer on Resident #57's right outer ankle because it was her second day of training and she was told by her trainer that on the rehab section of the nursing home, nurses did not have to complete a full body assessment and she only needed to perform a focused assessment on Resident #57's feeding tube site. She stated her trainer was Nurse #2 and she was with her that day when she admitted Resident #57.

During an interview on 11/30/17 at 1:41 PM the Director of Nursing stated that Nurse #2 did train Nurse #1 but Nurse #2 was not in the facility on 11/15/17 and Nurse #1 had completed her training and was working independently on 11/15/17. She further stated that no staff had ever been told to not perform a full head to toe assessment on a resident on admission in any unit of the facility.

During a phone interview on 11/30/17 at 1:45 PM Nurse #2 stated that she trained Nurse #1 but did not work on 11/15/17. She further stated that at no time during the training of Nurse #1 did she tell her that full head to toe assessments were not required on the rehab unit of the nursing home.

During a phone interview on 11/30/17 at 2:28 PM

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F 686	Continued From page 38 the Wound Care Physician stated when she first saw the wound it was an unstageable pressure ulcer with necrotic tissue covering most of the wound bed. She stated having not seen the wound before 11/22/17 she could not say for sure if the wound had deteriorated but from what she saw on her initial assessment on 11/22/17 she felt the lack of dressing changes had not negatively impacted the status of the pressure ulcer at that point. She further stated not changing the dressing on pressure wounds had the potential to cause a decline in the wound, however Resident #57's wound did not have any indications or signs of deteriorating tissue.	F 686		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(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; §483.55(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;	F 791		1/2/18

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F 791	Continued From page 39 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(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 observations, staff interviews, and record review, the facility failed to offer routine dental services for 1 of 2 residents reviewed for dental status and services (Resident #20). Findings included: Resident #20 was admitted to the facility on 12/5/13. Her active diagnoses included anemia, hypertension, and arthritis. Review of the dental records revealed Resident #20 had last seen a dentist on 11/17/16. Review of Resident #20's most recent minimum data set assessment dated 10/2/17 revealed the resident was assessed as severely cognitively	F 791	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Plan for correcting specific deficiency.	

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F 791	Continued From page 40 impaired. She was assessed to have an obvious or likely cavity or broken natural teeth. Review of Resident #20's care plan last updated 11/28/17 revealed Resident #20 was care planned for oral and dental health problems with risk for further decline. The interventions included to coordinate arrangements for dental care and transportation as needed or as ordered. During observation on 11/28/17 at 2:42 PM Resident #20 was observed to have broken lower front teeth and missing teeth. During an interview on 12/01/17 at 10:56 AM Health Information Manager #1 stated she was the individual who scheduled dental appointments. She further stated that the residents had their own local dentists in the area and they are scheduled yearly through them for routine dental care. She further stated that Resident #20 saw the dentist in November of 2016. She further stated that Resident #20's Responsible Party had signed a consent for care upon admission which included dental care and had not declined routine dental services for Resident #20. She further stated Resident #20 was not currently scheduled for any dental appointments. She further stated there was no reason that the facility had not arranged for the resident to have a routine dental exam and Resident #20's routine dental exam was missed and had not been seen by a dentist in over a year. During an interview on 12/1/17 at 11:31 AM the Administrator stated that residents are seen by either a consultant dentist or a dentist of choice. Local dentists are called in the event of an	F 791	The process that led to deficiency cited. The facility failed to offer routine dental services for 1 of 2 residents reviewed for dental status. The Resident identified during the survey was discharged from the facility on 12-20-2017. Resident interviews will be conducted to offer each Resident dental services. All Residents that agree will have a dental appointment made and then annual appointments made thereafter. Any Resident that decline dental services will have responses documented in the medical record. 12-31-2017 2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - On 12-12-17,The Administrator, Director of Nursing, began in servicing all FT, PT, and PRN RN's, LPN's, and Department Managers on the following procedures: The staff will be in-serviced on F tag 791 and to include the facility must provide or obtain from an outside resource routine dental services and emergency dental services to the meet the needs of each resident	

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F 791	Continued From page 41 emergency and as needed. She further stated it was only offered on an as needed based and routine annual dental care was not offered. During an interview on 12/1/17 at 11:34 AM Nurse Consultant #1 stated that the facility did not offer all residents annual routine dental services because nursing staff provided the quarterly and annual inspections of the resident's oral health.	F 791	Any in-house staff member who did not receive in-service training by 12-31-2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing, MDS Coordinator, Admission Coordinator, Social Services Assistant and or Health Information Manager will conduct audits to ensure Residents are being provided routine dental services. The audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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F 791	Continued From page 42	F 791	The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	