STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FISHER PARK HEALTH AND REHABILITATION CENTER	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=D	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have an Emergency Preparedness plan (EP). The EP plan did not include facility and community based risk assessments which includes missing residents, the facilities resident population, a process that includes collaboration with local, regional, state and federal officials. The plan did not have any policy or procedures regarding the emergency plan, the provision of needs for staff and residents, evacuation, sheltering of residents and	E 001	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____	2/23/18

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

Electronically Signed | 02/14/2018

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E 001	Continued From page 1 staff that remain in the facility and the transportation of medical records. The EP plan did not have any documentation regarding arrangements for other facilities to receive patients in the event of evacuation. The communication plan did not address names or contact information for staff, resident's physicians or other facilities. The EP plan did not have a way to share information and medical documents of a resident with another facility. The plan failed to have a training program as well as an emergency and standby power system. Findings included: 1A: A record review of the EP manual revealed that the manual did not include a community or facility based risk assessment and strategies. Further review revealed the manual also did not include missing residents in their EP program. B: A further review of the EP manual revealed that the resident population with in the facility was not addressed as well as the residents who needed special care like oxygen and immobility. The plan did not address the type of services the facility was capable of providing to the residents during an emergency situation. The continuity and succession plan was not included in the EP plan and the risk assessment for the facility was not completed. C: The review of the EP manual revealed that there was not any criteria listed for residents or staff who would be sheltered in the facility during an emergency. The EP manual also did not have any procedure for sheltering residents, staff and others who needed to remain in the facility in the event evacuation could not occur.	E 001	E001 "The plan of correcting the specific deficiency cited: A review of the facility emergency preparedness plan was conducted on 1/26/18 to determine the items which needed updating or additions which should be made to the plan. During the week of 2/12/18 - 2/16/18 the Maintenance Director began the updating of the facility emergency preparedness plan with the required assessments, community contacts, policies and procedures, evacuation arrangements, medical record transportation and communication systems as noted in the survey findings. The Administrator and Maintenance Director prepared and included a) the facility based risk assessment with strategies along with plans for missing residents, b) procedures related to residents with special care needs and how they would be addressed along with a continuity plan, c) procedures for sheltering residents and staff in the facility, d) policies and procedures were added to address maintenance of resident confidentiality and transfer of medical records, e) the communication plan was updated to include name and contact information of staff, resident physicians and any facilities that residents may be evacuated to, f) the procedure for how resident information and medical documents would be shared, g) the procedure for sharing of the facility emergency plan with residents, family	

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E 001	Continued From page 2 D: The EP manual revealed a lack of policies and procedures on how the resident's confidentiality would be maintained, how the resident's medical record information would be protected and how the resident's medical record would be available for continuity of care when evacuated or transferred to another facility during an emergency. E: A record review of the EP manual revealed that the communication plan did not include name and contact information of all the staff working in the facility, name and contact information of the residents physicians and name and contact information of other facilities including but not limited to their sister facility that would be providing care and services to residents during an emergency. F: A review of the communication plan did not include processes or procedures that would indicate how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations during an emergency situation. G: The EP manual revealed that the communication plan did not have any documentation as to how it would share the emergency plan information with the facilities residents, family members and/or the resident's representative. H: A review of the EP manual revealed that there was no training program or testing requirements documented in the plan.	E 001	members or resident representatives, h) the process and plan for training of staff on the emergency plan along with testing, and i) procedure for the availability and utilization of the emergency power system. All identified items noted to be missing from the facility emergency preparedness plan were updated or added by 2/23/18. The review of the facility process for preparing the emergency preparedness plan revealed a breakdown in the areas of ensuring completion and follow-up to ensure a well composed plan. On 2/13/18 the facility QAPI committee began reviewing the concerns noted in tag E001 and will continue to review/monitor the progress of correcting the noted concerns during the regular monthly QAPI meetings. The facility risk assessment which includes a breakdown of the facility population and resident needs, potential hazards rating, plans of operation during an emergency, supply needs, staffing, resident and family communication processes was reviewed and updated. The process that led to the deficiency cited was the facility□s emergency preparedness plans were not updated on Nov. 28, 2017. "The procedure for implementing the plan of correction for the specific deficiency cited: The Administrator and Maintenance Director will compile the necessary elements to complete the facility emergency preparedness plan by utilizing the company templates, policy and procedure resources, established	

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E 001	Continued From page 3 I: The EP plan did not have information listed as to an emergency or stand by power system in case of a power failure during an emergency situation. An interview with the Administrator and the head of maintenance occurred on 1-26-18 at 2:30pm. The head of maintenance stated he was given the template by the corporation in a binder but had nothing else to use to prepare the plan. The Administrator stated he thought that the template given to them by the corporation was sufficient. The head of maintenance and the Administrator stated they had not contacted other agencies or completed any drills to test their plan. An interview with the Administrator occurred on 1-26-18 at 2:50pm. The Administrator stated he expected the plan to be done correctly.	E 001	contracted services and community contacts. An emergency preparedness training program was developed and necessary trainings were conducted on 2/23/18. A community and facility risk assessment will be conducted utilizing the Comprehensive Emergency Management Plan template. Contract with other local facilities was completed on 2/23/18. The Administrator and Maintenance Director will contact community emergency resources to provide input into the facility'□s plan by 2/23/18. All necessary required elements will be updated or added to the emergency preparedness plan by 2/23/18. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The Administrator and/or Maintenance Director will conduct monthly reviews of the emergency preparedness plan to ensure the plan is maintained and up to date. Review findings will be presented during QAPI meetings for review of appropriateness and adjustment for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing the plan of correction. The Administrator or Maintenance Director will conduct reviews and monitor for process or system concerns and implement	

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E 001	Continued From page 4	E 001	adjustments to facility processes or systems as necessary. The Administrator or Maintenance Director will report monthly during the facility QAPI meetings of their findings and changes.	
F 584 SS=E	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	F 584		2/20/18

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F 584	Continued From page 5 levels in all areas; §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 maintain ceiling vents, walls, doors, door frames, window sills, floors and privacy curtains clean and in good repair. This was evident in 2 of 2 nursing units. Findings Included: 1. The following observations were made on 1/23/18: a. An observation on 1/23/18 at 11:18 am of room 151 revealed the ceiling vent at the entrance of the room was heavily covered in dust. b. An observation on 1/23/18 at 11:45 am of room 118 revealed the bathroom door frames were heavily scratched and had peeling paint. b. An observation on 1/23/18 at 11:55 am of room 153 revealed the wooden window sill was damaged with pointed, sharp wooden edges and the bathroom vent was covered in dust and rusty. c. An observation on 1/23/18 at 2:45 pm of room 154 revealed the bathroom ceiling vent was covered in dust and rusty. The privacy curtain for bed A had multiple black stained areas, the wall by the light switch at door entrance had a circular dark brown substance and the floor around the toilet had a black substance around the toilet	F 584	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F584 "The plan of correcting the specific deficiency cited: On 1/26/18 the maintenance department and housekeeping department began applying corrections to the noted areas of concern for each of the identified rooms (rooms 151, 118, 153, 154, 159, 131, 156 and 138). Areas identified as being dusty, such as ceiling vents, bathroom vents, dirty privacy curtains and dirty floors were properly cleaned or replaced. Areas identified as needing paint or repairs were addressed. All identified areas of concern were corrected by 2/16/18. A review of	

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F 584	Continued From page 6 base. d. An observation on 1/23/18 at 3:16 pm of room 159 revealed the floor had food wrappers, food crumbs and leaves present. e. An observation on 1/23/18 at 4:00 pm of room 131 revealed there was a brown substance on the floor behind the door and the bottom section of the bathroom door was scratched. 2. The following observations were made on 1/24/18: a. An observation on 1/24/18 at 8:49 am of room 156 revealed the bathroom vent was covered in dust and rusty. b. An observation on 1/24/18 at 9:01 am of room 138 revealed the bathroom wall had a section of peeling paint and the bathroom door frames had scratches and peeling paint. An interview on 1/26/18 at 3:20 pm with the Maintenance Director revealed he worked full time and he had a 20 hour a week helper. He stated there was not a preventative maintenance program in place right now and he was basically just "putting out fires." He explained most of the repairs completed were based on work orders that were submitted by the staff. The Maintenance Director added he was trying to work on total refurbishment of one room at a time and he was currently re-doing room 110. He stated the bathroom doors were narrow and the wheelchairs were constantly causing scratches and damage to the door frames. The Maintenance Director stated his expectation was to have all the rooms in good physical shape and for them to be clean. An interview on 1/26/18 at 4:17 pm with the	F 584	the facility process for maintaining a safe/clean/comfortable/homelike environment revealed a breakdown in the areas of identification, notification and timely correction of dirty areas or ill-repaired items. The Maintenance Director and Housekeeping Director conducted an inspection of the entire facility during the week of 2/12/18 - 2/16/18 noting all areas which need extra cleaning or repairs completed. The facility noted that the scheduling of housekeeping staff was not providing sufficient coverage to address areas of concern later in the day. The Housekeeping Director adjusted the schedules of the housekeepers on 1/26/18 to better provide services over the course of the day. A review of the facility process revealed that the preventative maintenance program was in need of updates including the development of a touch-up painting schedule. On 2/13/18 the facility QAPI committee began reviewing the concerns noted in tag F584 and will continue to review/monitor the progress of correcting the noted concerns during the regular monthly QAPI meetings. "The procedure for implementing the plan of correction for the specific deficiency cited: All housekeeping staff were educated from 2/12/18 - 2/20/18 regarding the proper procedures for cleaning resident rooms and the general facility. Housekeeping staff were provided with checklists of the areas which must be	

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F 584	Continued From page 7 Housekeeping Manager revealed the ceiling vents were scheduled to be cleaned once a week on Fridays. She stated when she identified an area that needed to be cleaned she would instruct the housekeeping staff to clean that area. An interview on 1/26/18 at 4:20 pm with the Administrator revealed the facility did not currently have a renovation plan in place. He added the Regional Director of Operations was looking into it based on the age of the facility. He stated right now they were addressing environmental concerns as they were identified and refurbishing rooms one at a time. The Administrator added it was his expectation that the resident rooms would be clean and in good repair.	F 584	cleaned on a regular basis. All facility staff were educated from 2/12/18 - 2/20/18 on TELS, the electronic maintenance request system, and to the expectation of submitting maintenance requests into the work order system as soon as they are aware of maintenance issues which includes areas in need of touch-up painting. The Maintenance Director will utilize the Resident Room Inspection Log to conduct monthly inspections. The Maintenance Director will develop and follow a touch-up painting schedule to be implemented by 2/20/18 that will allow for the proper maintenance of all painted areas. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The Maintenance Director and Housekeeping Director or designees will conduct monthly resident room inspections to ensure the maintenance of a safe/clean/comfortable/homelike environment as well as identify areas which need to be addressed. The Administrator will review for completion of necessary cleaning or repairs all areas having been identified during the monthly inspections or scheduled for touch-up painting. Inspection findings and the list of scheduled touch-up painting areas will be presented during QAPI meetings for review of appropriateness and adjustment for 6 months.	

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F 584	Continued From page 8	F 584	"The title of the person responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing and sustaining the plan of correction. As the leaders for their departments, the Housekeeping Manager and Maintenance Director, or their designees with conduct audits, monitor for process or system concerns and implement adjustments to facility processes or systems as necessary. They will report monthly during the facility QAPI meetings of their findings and changes.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		2/20/18

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F 585	Continued From page 9 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident	F 585		

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F 585	Continued From page 10 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to thoroughly investigate a grievance filed by a resident, who stated in the grievance that he did not receive his medications as ordered for 1 of 1 resident reviewed for grievances (resident #332).	F 585	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is	

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F 585	Continued From page 11 Findings included: Resident #332 was admitted to the facility on 12/12/17 with the current diagnoses of respiratory failure, depression and anxiety. Review of the resident's Medication Administration record (MAR) for 12/2017 indicated on 12/12/17 through 12/13/17, there were several medications listed as ordered that had a number 8 in the row, which indicated "other/see progress note". It was unclear if the resident received these medications or not. The resident was not on a leave of absence on 12/12/17 and 12/13/17. There were no progress notes from 12/13/17 to validate if the resident's received his medications or not on that day. The resident was discharged to the hospital on 12/14/17 then readmitted back on 12/18/17. A review of the grievance form dated 12/27/17 revealed Resident #332 reported concerns to the social worker. The resident stated he did not get his medications as prescribed, which made him go to the hospital. The grievance form revealed the resident had a care plan meeting on 12/27/17 and the complaints were discussed with the resident's representative. The form indicated the grievance was resolved but stated that the resident was forgetful and that medications were given. The form indicated the resident was on a leave of absence and this may have played a role in missed medications. The grievance form indicated that medications were available and given as ordered. The date of notification was 12/27/17 and stated that a care plan meeting was	F 585	prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F585 "The plan of correcting the specific deficiency cited: The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. The center has identified the Administrator as the Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances as well as a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. The step that has been alleged to have broken down is the	

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held on 12/27/17 and discussed above complaints with the resident's representative. The grievance revealed it was completed by the Director of Nursing (It did not indicate the form of communication) and stated that the grievance was resolved. The resident's MAR was attached to the grievance. The resident was discharged from the facility on 12/28/17. There was no documentation of interviews/statements from the staff for this grievance.

The resident's admission Minimum Data Set dated 12/29/17 revealed that Resident # 332 was cognitively intact, had no mood disorder and was receiving an antianxiety and antidepressant medications for 7 days.

The DON was interviewed on 1/25/18 at 4:00 PM. She stated the nurse that was working with the resident on the day of 12/13/18, no longer worked at the facility. The DON stated that she didn't see the "8" (that indicated other/see progress note) on the MAR and thought the medications were given to the resident. She also added that she had the follow up to the complaint with the resident during the care plan meeting and they reviewed the MAR.
The Social Worker was interviewed on 1/25/18 at 1:44 PM. She stated that the Resident's speech was impaired but the resident was alert and oriented. There was a grievance for this resident. The resident came to her office and stated that he didn't get his medications, which caused him to go to the hospital. She stated she filled out a grievance form and gave to the DON. The DON investigated the concern. The resident wanted to discharge as soon as possible due to multiple concerns.

necessary investigation. The Administrator has educated the Director of Nursing regarding how to thoroughly investigate a grievance and to attach documentation reviewed to the Grievance Form.

"The procedure for implementing the plan of correction for the specific deficiency cited:
Resident #332 discharged from the center on 12/28/17. The center did not resolve the grievance prior to the resident discharging from the center. The procedure to implement an acceptable plan of correction is to have the Administrator or Staff Development Coordinator educate staff when a resident has grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. The center has identified the Administrator as the Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with

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F 585	Continued From page 13 The DON was interviewed again on 1/25/18 at 5:25 PM. She stated she just now looked into the issue and did not know if the resident got his medications or not for that night/day. She stated that she could not find any more documentation about it and could not get in contact with the nurse that worked that night because the nurse did not work here anymore. The nurse that worked on 12/13/17 was not available for an interview after several attempts. The DON was interviewed on 1/26/18 at 2:48 PM. She stated there was no more documentation for the grievance filed. She stated that she was given the grievance in the afternoon. It was after the care plan meeting and the grievance was filled out by the social worker. Then the grievance was given to her after the Care Plan meeting. She stated she was responsible for filling out the rest of the grievance. She stated that she reviewed the MAR with the family. She did not realize at that time that the documentation on the MAR did not confirm if the resident received his medications or not. She stated the family also stated that the resident was not getting breathing treatment or tracheostomy care. She stated that tracheostomy care was documented on the MAR as completed. She stated that she talked to the nurse, but she could not remember which nurse, about medications being offered to the resident in regards to his breathing treatments (There was no documentation of interviews conducted). She stated that she would not be surprised if the resident did not received his medication right after he was admitted because he was admitted in the late evening. She stated that she did not feel that if the resident missed his breathing treatment that would be the reason he was admitted to the	F 585	grievances as well as a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. The Administrator or Staff Development Coordinator will educate the Department Managers 2/6/18 - 2/16/18 regarding how to thoroughly investigate a grievance and to attach documentation reviewed to the Grievance Form. All staff were educated on the grievance procedure 2/6/18 - 2/16/18. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The monitoring procedure to ensure effectiveness will include weekly audits by the Administrator for three months to include reviewing timelines of concerns, thorough investigation was completed, resolution was identified and whether action plan was needed and implemented. The Grievance Process will be reviewed by the QAPI (Quality Assurance and Performance Improvement) Committee monthly for three months. The QAPI Committee will make recommendations, as needed, to assure compliance is sustained ongoing. "The title of the person responsible for implementing the acceptable plan of correction: The Administrator is ultimately responsible for the plan of correction.	

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F 585	Continued From page 14 hospital. She stated she talked with the resident about these concerns later in the day, and on the morning on 12/28/18. She stated she would expected the medications would be delivered to the resident. She also added that she would talk with the medical director about what had happened and in-service the nurses on MAR documentation. The Administrator was interviewed on 1/26/18 at 3:31 PM. He stated that a grievance was completed for any issue that needed to be addressed. Any person involved in the grievance should be spoken with. A follow up with the resident should also be completed as quickly and thoroughly as possible in a way that was satisfactory.	F 585		
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 staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) to reflect a resident's opioid medications for 1 of 5 residents reviewed for unnecessary medications (Resident #74). The facility failed to accurately code the weight status on the MDS for 1 of 5 residents reviewed for nutrition. (Resident #36). The facility failed to accurately code the MDS for falls involving 1 of 1 resident. (Resident #52) reviewed for accidents. The facility also failed to accurately code the MDS for the use of oxygen in 1 of 1 residents (Resident #48) reviewed for respiratory care.	F 641	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F641	2/20/18

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F 641	Continued From page 15 Findings included: 1.Resident #74 was admitted on 1/13/17 with the diagnosis of constipation, dementia, Cerebral Palsy and anxiety. The resident's Annual MDS dated 1/1/18 revealed the resident was severely cognitively impaired and had received an antipsychotic medication, antianxiety medication, and antidepressant medication for 7 days. The MDS did not reflect that the resident had received an opioid medication. Physician's orders for December, 2017 revealed the resident had 5 milligrams of Oxycodone (an opioid medication for pain) initially ordered on 10/12/17 by mouth before meals and before bedtime. The resident's Medications Administration Record (MAR) for December, 2017 revealed that resident #74 received Oxycodone from 12/26/17 through 12/31/17. The resident's MAR for January, 2018 revealed the resident received Oxycodone on 1/1/18. Nurse #3 was interviewed on 1/26/18 at 9:50 AM. She stated the resident was getting scheduled oxycodone for as long as she had been here, which had been since October, 2017. MDS nurse #1 was interviewed on 1/26/18 at 1:00 PM. She stated she looked at the MAR to determine what medications the resident was taking in order to code the MDS. She stated that she coded the medication section of this MDS. She stated the resident was receiving oxycodone	F 641	"The plan of correcting the specific deficiency cited: The Resident Care Management Director (RCMD) or designee will complete an audit of current residents receiving an Omnibus Budget Reconciliation Act Assessment during the last 14 days to verify accurate coding of Sections N, J, K and O of the Minimum Data Set (MDS) per the Resident Assessment Instrument (RAI) Manual guidelines. Residents numbers 73 required corrections for Annual Assessment Reference Date 1/1/18 (resident #73) and was completed on 1/26/18 to reflect accurate coding of opiate medication. A Quarterly Assessment Reference Date 11/15/17 (resident #36) required corrections and was completed o 2/14/18 for accurate coding of weight. Resident number 52 had a modification of Quarterly Assessment Reference Date 12/12/17 on 1/26/18 to reflect accurate coding of fall status. Resident number 48 had a modification of Significant Change Assessment Reference Date 12/1/17 on 1/25/18 to reflect accurate coding of Oxygen. A Modification will be completed by the RCMD and or MDS Designee per the RAI Manual guidelines. The process breakdown occurred when the coding of the Minimum Data Assessments did not correspond with the Resident Assessment Instrument Manual. "The procedure for implementing the plan of correction for the specific deficiency	

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F 641	Continued From page 16 during the MDS 7 day look back period. She stated she was not sure why it was missed on the MDS. She stated she might have not scrolled down all the way on the MAR and just didn't see it. The Director of Nursing was interviewed on 1/26/18 at 2:47 PM. She stated she would expect if a resident was receiving a medication that it would be coded on the MDS. If it was not coded on the MDS, then a modification should be completed. The administrator stated on 1/26/18 at 3:33 PM that the MDS should be coded accurately. 2. Resident #36 was admitted to the facility on 9/2/16 and diagnoses included dementia, cerebral vascular accident and hemiparesis. A quarterly minimum data set (MDS) dated 11/18/17 for Resident #36 identified her weight as 131 pounds (lbs.) and as having a significant weight loss that was no physician prescribed. A review of the weight record for Resident #36 revealed her weight on 11/8/17 of 130.8 lbs. had been crossed out on 1/23/18 by the Registered Dietitian (RD). Her weight on 10/5/17 was documented as 165.1 lbs. Review of a quarterly nutrition progress note dated 10/23/17 identified Resident #36' s weight as 165.1 lbs. on 10/5/17. An interview on 1/26/18 at 9:44 am with the RD revealed when she reviewed the November weight of 130.8 lbs. for Resident #36 she had requested a re-weight because she suspected it was an error. She stated the resident ' s weights	F 641	cited: District Director Care Management will provide education related to accurate coding of MDS assessments according to the RAI Manual on February 12, 2018. The Resident Care Management Director will re-educate the Interdisciplinary Team and MDS Staff on accurate coding related to opioid coding, weight and weight loss, fall status and oxygen use on 2/15/18. The RCMD will randomly review 5 completed MDSs weekly for 12 weeks to verify accurate coding of Sections N,J,K and O of the MDS. Opportunities will be corrected as identified as a result of these audits. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The results of these audits will be presented by the Resident Care Management Director monthly for 3 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. "The title of the person responsible for implementing the acceptable plan of correction: The Administrator is ultimately responsible for implementing and sustaining the plan of correction.	

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had been stable in the 160 ' s and the resident hadn ' t had a change in condition to support such a big weight loss. The RD added the resident had refused the re-weight. She stated when the resident ' s December weight was obtained it was 170 lbs. and confirmed the November weight was an error. The RD explained the Dietary Manger had completed Section K of the MDS dated 11/18/17 using the weight of 131 lbs. which resulted in her coding it as a significant weight loss. She stated this was a coding error for Section K.

An interview on 1/26/18 at 12:28 pm with the MDS nurse revealed the Dietary Manager had completed Section K for the quarterly MDS dated 11/18/17. She stated this section was coded incorrectly for a significant weight loss because the weight of 130.8 lbs. was determined to be in error.

3. Resident #52 was admitted to the facility on 7-3-17 with multiple diagnoses including Alzheimer's, muscle weakness, malnutrition and repeated falls.

The Minimum Data Set (MDS) dated 12-12-17 revealed that there was no cognitive staff assessment completed. Resident #52 was coded as needing extensive assistance with one person for bed mobility and transfers, limited assistance with one person for walking in her room, extensive assistance with one person for locomotion on and off the unit as well as dressing, toileting and personal hygiene. The MDS revealed that the resident was coded as having no falls since last assessment of 10-10-17.

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The care plan dated 1-24-18 revealed resident #52 had a goal of observation for safety with the following interventions; ensure proper footwear, provide extensive assistance with transfers. Resident #52 had another goal of being free of injury from falling with the following interventions; offer toileting before and after meals, encourage the resident to ask for assistance, interdisciplinary referral and place frequent items within reach.

A review of the incident reports for resident #52 revealed that the resident had 2 falls on 11-12-17. One fall occurred at 6:30am with no injuries listed and the second fall on 11-12-17 occurred at 7:30am with no injuries listed. The incident reports also revealed that resident #52 had a fall on 11-26-17 at 8:00pm with a bruise noted to the left side of her forehead.

An interview with the MDS coordinator (MDS nurse #1) occurred on 1-26-18 at 11:45am. The MDS nurse #1 stated "I just hit the wrong button. It was just a mistake".

An interview with the Administrator occurred on 1-26-18 at 2:00pm. The Administrator stated he expected the MDS nurse to assure accuracy of what she is coding and talking with staff to ensure that accuracy.

4. Resident #48 was admitted to the facility on 8-19-17 with multiple diagnoses that included diabetes, fracture of the left clavicle, muscle weakness and chronic obstructive pulmonary disease.

The Minimum Data Set (MDS) dated 12-1-17 revealed that resident #48 was cognitively intact. The MDS coded the resident as needing

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F 641	Continued From page 19 extensive assistance with one person for bed mobility, extensive assistance with 2 people for transfers, extensive assistance with one person for locomotion on and off the unit as well as dressing, toileting and personal hygiene. The MDS revealed that resident #48 was not coded for oxygen use but receives oxygen at 2 liters. The care plan dated 1-2-18 revealed resident #48 had a goal of no signs or symptoms pf poor oxygen absorption with the following interventions; give medication as ordered, observe for signs and symptoms of respiratory distress, oxygen setting at 2 liters and position the resident to facilitate ventilation. A review of the physician orders revealed that resident #48 was ordered oxygen on 11-8-17. An interview with the MDS coordinator (MDS nurse #1) occurred on 1-25-18 at 4:35pm. The MDS coordinator stated "it must have just been a typo" but that the resident should have been coded as using oxygen. An interview with the Administrator occurred on 1-26-18 at 2:00pm. The Administrator stated he expected the MDS nurse to assure accuracy of what she is coding and talking with staff to ensure that accuracy.	F 641		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of	F 867		2/20/18

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F 867	Continued From page 20 action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 2-1-17 annual recertification survey. This was for two recited deficiencies in the areas of: Accuracy of assessments (Was F278 and now F641) and QAPI/QAA improvement activities (Was F520 and now F867). These deficiencies were cited again on the current Recertification investigation survey of 1-23-18. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to: 1: F641 (was F278) Accuracy of assessments - Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for falls involving 1 of 1 residents (resident #52) reviewed for accidents. The facility also failed to accurately code the MDS for the use of oxygen in 1 of 1 residents (resident #48) reviewed for respiratory care. During the recertification survey dated 2-1-17, the facility was cited for F278 for failing to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (Resident #19) reflecting hearing, speech and vision. During the current annual recertification survey dated 1-23-18 the facility failed to accurately code the MDS for falls	F 867	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F 867 "The plan of correcting the specific deficiency cited: Facility Administrator conducted a Quality Assurance and Improvement (QAPI) Committee meeting on 2/19/18 to discuss the current survey citations from survey exit. The QAPI Committee determined the alleged process breakdown occurred when the center achieved substantial compliance the audits were discontinued per the plan of correction and that further random auditing needed to have occurred throughout the year at the QAPI Committee□s discretion. "The procedure for implementing the plan of correction for the specific deficiency cited: The QAPI Committee determined random audits from the plan of correction should be conducted throughout the year to validate sustained compliance ongoing.	

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F 867	Continued From page 21 involving 1 of 1 residents (resident #52) and for oxygen use for 1 of 1 residents (resident #48). 2: F867 (was F520) QAPI/QAA improvement activities - Based on staff interview, and record review the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 2-1-17 annual recertification survey. During the recertification survey dated 2-1-17 the facility was cited for F520- failing to sustain an effective QAA program. During the current annual recertification survey dated 1-23-18 the facility failed to maintain implemented procedures and monitor interventions that the committee put into place following the 2-1-17 annual recertification survey. An interview with the Administrator occurred on 1-26-18 at 2:50pm. The Administrator stated the committee meets monthly and that the committee consists of 8 members including the medical director, Administrator, Director of Nursing, Assistant Director of Nursing, Dietary manager, Medical records, Social Services and the Minimum Data Set nurse. He stated their last meeting was 1-19-18 and that their next meeting is scheduled 2-13-18. The Administrator stated that they will have "ad-hoc" meetings when the need arises to work through improvement plans. The Administrator stated he was new to that facility and could not speak to past surveys but that he expected that when the team meets in February they will discuss how to improve their assessment accuracy.	F 867	"The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The Administrator will educate the Interdisciplinary team and members of the Quality Assurance and Improvement Committee by 2/19/18 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to assure state and federal compliance in the facility. The QAPI Committee determined random audits from the plan of correction will be conducted throughout the year to validate sustained compliance ongoing. The QAPI Committee will meet at least monthly to conduct the facility□s Quality Assurance and Performance Improvement Meeting. Should any interdisciplinary team member find that the facility may need an Ad Hoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any Ad Hoc meetings held. This monitoring tool will be signed off by the responsible Interdisciplinary team member after each meeting accepting and acknowledging all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 22	F 867	monitoring and revisions set forth by the Quality Assurance and Performance Improvement Committee. The Vice President of Operations or designee will review the facility QAPI meeting minutes at least monthly x 3 months. "The title of the person responsible for implementing the acceptable plan of correction: The Administrator is ultimately responsible for implementing the plan of correction and to ensure the plan of correction is sustained ongoing.	