STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and	F 565	The statements included are not an	3/8/18

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

Electronically Signed | 03/02/2018

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F 565	Continued From page 1 resident interviews, the facility failed to resolve grievances that were reported by the Resident Council during meetings for 3 of 3 consecutive months, November 2017, December 2017, and January 2018. Findings included: Review of the Resident Council Minutes for 11/30/17 revealed that 7 of the 7 resident council members present at the Resident Council Meeting reported call lights not being answered timely. The resident's concerns from the 11/30/17 meeting were followed up by the Director of Nursing on 1/16/18 with a call bell education; follow up regarding call light responsiveness, and more frequent rounds by staff. Review of the Resident Council Minutes for 12/26/17 revealed 10 of the 10 resident council member present at the Resident Council Meeting reported call lights not being answered within 20 minutes. There was no follow up found on the Resident Council Minutes. Review of the Resident Council Minutes for 1/30/18 revealed 7 of 7 resident council members present at the Resident Council Meeting reported call lights were not answered with in 20 minutes. Interviews with individual residents: 1. Interview with Resident #30 on 2/5/18 at 3:20 pm revealed she waited 30 minutes for someone to answer her call light. She stated she had wet herself waiting on someone to help her. 2. Interview with Resident #67 o 2/5/18 at 4:07	F 565	admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F565 Resident Council The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. Facility failed to respond to grievances that were reported by the resident council during meetings for 3 of 3 consecutive months. Residents 30 and 40 no longer reside in the facility. Interview on March 2, 2018 with Resident 67, indicates she is pleased with her care and our responses to her call light. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Administrator has asked the resident council to change their monthly meeting schedule to bi-monthly, such schedule to remain in place so long as the council deems necessary, then reverting to a monthly schedule. This will allow center staff to be more responsive to council	

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F 565	Continued From page 2 pm revealed she had to wait 25 minutes for someone to help her when she used her call light. She stated she thought they were short staffed. 3. Interview with NA #1 on 2/8/18 at 12:15 pm revealed they were not staffed well and hadn't been for almost a year. She stated her residents had to wait on her because she had so many residents. Interview with family member: 1. During an interview on 2/5/18 at 1:23 pm with Resident #45's family member, the family member stated there was only one NA for the whole 100 hall side of the facility on Sunday 2/4/18 when she came to visit. She stated the residents were kept in their rooms for supper because they were understaffed. Observation of the Resident Council Meeting on 2/8/18 at 1:36 pm revealed there were 9 residents that attended. They reported it took a long time for help when they put their call light on and they had brought this issue up in Resident Council before with no resolution. During an interview with the Staff Scheduler on 2/8/18 at 2:30 pm she stated the facility was under-staffed at times. She stated on 2/4/18 there were 4.5 NAs scheduled the residents wouldn't get the care that they need. The Staff Scheduler stated from 7:00 pm to 11:00 pm there were 4 NAs for the building. She stated they usually scheduled at least 6 NAs for 3:00 pm to 11:00 pm shift. An interview on 2/8/18 at 2:59 pm with the Director of Nursing revealed she felt that 4 NAs	F 565	requests. 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. No later than next business day after each council meeting, administrator or designee will ensure that staff assignments are made in developing and providing an administrative response to each concern or request raised by the council. These responses will be reviewed by the administrator no later than 1 week following each council meeting for approval. If the council raises a request that cannot be addressed by the facility, the Administrator will request the council□s permission to address the council and will provide to the council a written explanation of same. Grievances presented by the council in two or more consecutive meetings will be brought to the Quality Assurance & Performance Improvement (QAPI) committee for root cause analysis, and further action by committee as required. The specific issue will be presented to completion or revision as needed within the QAPI program. The Administrator is responsible for implementing the acceptable plan of correction by March 8, 2018.	

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F 565	Continued From page 3 was not optimal for providing care on 3:00 pm to 11:00 pm shift.	F 565		
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 medical record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for 2 of 18 residents. Resident #16 and Resident #39 were both inaccurately coded as having not received antipsychotic medications since the last assessment period. Findings included: 1. Resident #39 was admitted on 8/3/17 whose cumulative diagnoses included: Anxiety disorder, dementia, depression, and psychosis. Review of Resident #39's most recent Minimum Data Set (MDS) assessment revealed a comprehensive significant change assessment with an Assessment Reference Date (ARD) of 1/1/18. The resident was coded as having had received an antipsychotic medication each day of the seven day assessment period. Further review of the MDS assessment revealed the resident was coded as having not received antipsychotic medications since the last assessment. A review of the Medication Administration Record (MAR) for Resident #39 from the assessment period of 12/26/17 through 1/1/18 revealed the	F 641	F641 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. On February 8, 2018, the Minimum Data Set Coordinator (MDSC) modified resident #39□s 1/1/18 Significant Change Minimum Data Set (MDS) and Resident # 16□s 12/8/17 Quarterly MDS to accurately code Question N0450A Antipsychotic Medication Review as the residents received anti-psychotics on a routine basis during the look back period. The MDSC inadvertently coded No instead of Yes to receiving routine anti-psychotics on a daily basis on Question N0450A, Antipsychotic Medication Review. All current residents receiving routine anti-psychotic medication was audited on February 16, 2018 to ensure that Question N0450A, Antipsychotic Medication Review, were coded correctly as receiving an anti-psychotic routinely on a daily basis. The MDSs were modified	3/8/18

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F 641	Continued From page 4 resident was documented as having had received risperidone (an antipsychotic medication) on 12/26/17, 12/27/17, 12/28/17, 12/29/17, 12/30/17, 12/31/17, and 1/1/18. The antipsychotic medication was documented as having an order date of 11/10/17. During an interview with the Director Of Nursing (DON) on 2/8/18 at 2:59 PM she stated her expectations were for the MDS to be completed accurately. During an interview conducted with the Registered Nurse (RN) MDS Coordinator on 2/8/18 at 3:27 PM he stated Resident #39's significant change MDS assessment with an ARD of 1/1/18 had been coded incorrectly. The MDS Coordinator further stated the resident had received an antipsychotic medication during the assessment period and since the last MDS assessment. 2. Resident #16 was admitted on 9/5/17 whose cumulative diagnoses included: Dementia, schizoaffective type disorder, bipolar disorder, and adjustment disorder. Review of Resident #16's most recent Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 12/8/17. The resident was coded as having had received an antipsychotic medication each day of the seven day assessment period. Further review of the MDS assessment revealed the resident was coded as having not received antipsychotic medications since the last assessment. A review of the Medication Administration Record	F 641	by the MDSC for any coding errors identified in the audit, and completed by February 16, 2018. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. On February 16, 2018, the MDSC Consultant provided education to the MDSC based on the Resident Assessment Instrument (RAI) Manual instructions for coding Question N0450A, Antipsychotic Medication Review. This tag will be discussed during weekly Risk Meeting. 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 will audit 5 current residents who are receiving anti-psychotropic medication to ensure Question N0450A, Antipsychotic Medication Review was correctly coded on their MDS. Any issues identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. The issue will be presented to completion or revision as needed within the QAPI program. " 1 week for 4 weeks " Twice a month for 1 month " Monthly for 4 months	

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F 641	Continued From page 5 (MAR) for Resident #16 from the assessment period of 12/2/17 through 12/8/17 revealed the resident was documented as having had received quetiapine fumarate (an antipsychotic medication) on 12/2/17, 12/3/17, 12/4/17, 12/5/17, 12/6/17, 12/7/17, and 12/8/17. The antipsychotic medication was documented as having an order date of 11/10/17. During an interview with the Director Of Nursing (DON) on 2/8/18 at 2:59 PM she stated her expectations were for the MDS to be completed accurately. During an interview conducted with the Registered Nurse (RN) MDS Coordinator on 2/8/18 at 4:16 PM he stated Resident #16's quarterly MDS assessment with an ARD of 12/8/17 had been coded incorrectly. The MDS Coordinator further stated the resident had received an antipsychotic medication since the last MDS assessment.	F 641	The Director of Nursing is responsible for implementing the acceptable plan of correction by March 8, 2018.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility failed to follow physician's order to discontinue an anxiety medication that was ordered on as needed bases for 1 of 5 (Resident #122) residents and; the facility failed to ensure 1 of 18 (Resident # 20) residents observed during observation swallowed medication that was given	F 658	F658 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. 1. Resident #122 is no longer in facility.	3/8/18

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F 658	Continued From page 6 to her during a medication pass. The medication was found at Resident #20's bedside still in the medication cup. 1. Resident #122 was admitted to the facility on 9/8/17 with diagnoses of stroke, anxiety, hypertension and diabetes. A Pharmacy Consult dated 11/23/17 and signed by the physician on 12/8/17, recommended Resident #122's Lorazepam 0.5mg give 1 tablet by mouth every 8 hours as needed for anxiety be discontinued. Review of Resident #122's Medication Administration Records for December 2017 and January 2018 revealed she received 20 doses (12/11/17 for two doses, 12/13/17, 12/14/17, 12/18/17, 12/20/17, 12/21/17, 12/22/17, 12/25/17, 12/27/17, 12/28/17, 12/29/17, 1/1/18, 1/3/18, 1/6/18, 1/7/18, 1/8/18, 1/10/18, 1/11/18, and 1/12/18) of Lorazepam 0.5 mg after it was discontinued on 12/8/17. Interview with the Director of Nursing on 2/8/17 at 5:15 pm revealed her expectation was that orders be transcribed when they are given. Interview with the Physician on 2/8/17 at 5:30 pm revealed there would have been no harm to Resident #122 for continuing the Lorazepam 0.5 mg until 1/12/18 when the last dose was given. 2. Resident #20 was admitted to the facility on 3/28/17 with diagnoses which included: Dementia, diabetes, anemia, high cholesterol, and depression.	F 658	Pharmacy recommendation was received from pharmacy rep 11/27/17. Given to Nurse Practitioner (NP) on 12/4/17. She took them home and signed them on 12/8/17, but did not return them to facility until 12/18/17, orders were implemented 12/19/17. January pharmacy recommendations were reviewed for completeness by the Director of Nursing. 2. Pills were left at the bedside of resident #20. Resident #20 is no longer in the facility. No other residents were affected. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. 1. Director of Nursing and designees are to be educated by regional nurse consultant regarding follow through on pharmacy recommendations. 2. Education provided to nurse #2 and all other licensed nurses regarding proper Medication Administration. 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. 1. The Director of Nursing will monitor/audit pharmacy recommendations monthly to ensure that all have been addressed by NP/physician and new orders were implemented x6 months. 2. The Staff development Coordinator will complete medication pass audits with 3 nurses weekly x4 weeks, 2 nurses weekly	

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F 658	Continued From page 7 Review of Resident #20's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 12/15/17. The resident was coded as having had moderate cognitive impairment. An observation of and resident interview conducted with Resident #20 on 2/5/18 at 10:40 AM revealed the resident lying in her bed in the resident's room. The resident's breakfast tray was observed on the resident's over the bed table to the resident's left. During the observation a clear medicine cup with pills in it was observed on the resident's breakfast tray. Closer inspection of the medicine cup revealed the following: One white tablet, one and a half pink tablets, one green tablet, another pink tablet, and another white tablet. The total of the observed medications was 5.5 tablets. The resident stated she did not remember when the medications were left on her breakfast tray. Review of Resident #20's February Medication Administration Record completed on 2/7/18 revealed the following medications as having been documented as having been administered on 2/5/18 at 8:00 AM: Citalopram Hydrobromide 1.5 Tablets 10 milligram (mg), Ferrous Sulfate 1 Tablet 325 mg, Furosemide 20 mg 1 Tablet, Lisinopril 20 mg 1 Tablet, and Potassium 10 mg 1 Tablet. The total of documented administered medications was 5.5 tablets. An interview conducted with Nurse #2on 2/8/17 at 10:52 AM revealed he was the nurse who had signed off as administering the medications to Resident #20 on 2/5/18. He stated he had given the medications to Resident #20 during his 8:00 AM medication pass. He stated the resident had	F 658	x4 weeks, then 1 nurse weekly x4 weeks. Results of these audits (#1 and #2) will be reviewed at Weekly Risk Quality Assurance Meeting for three months and at Quarterly Quality Assurance meeting for two meetings for further resolution if needed. The Director of Nursing is responsible for implementing the acceptable plan of correction by March 8, 2018.	

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F 658	Continued From page 8 a history of at times appearing to have taken her medications by holding the medication cup up to her mouth but would not take the medications. The nurse stated he went back to the resident's room after 10:40 AM on 2/5/18 to check on the resident and she had not taken her medication and she had not. The nurse stated the resident took the medications in his presence when he returned to her room. The nurse stated not making sure the resident had taken their medications was not how he would usually administer medications to residents. The nurse further stated the resident was not care planned to self-administer medications. During an interview conducted on 2/8/18 at 2:57 PM with the Director of Nursing (DON) she stated it was her expectation for a nurse to make sure a resident consumes their medication when it was administered. The DON further stated it was her expectation if the resident did not consume the medication, the nurse would remove the medication out of the resident's room.	F 658		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693		3/8/18

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F 693	Continued From page 9 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to store the piston and the syringe, separated, for one of one residents reviewed for tube feeding (Resident #53). Findings included: Resident #53 was admitted to the facility on 10/21/14. The resident's cumulative diagnoses included: Diabetes, aphasia (difficulty speaking), hemiplegia (paralysis of one side of the body), dysphagia (difficulty swallowing), and presence of feeding tube. Review of Resident #53's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 12/22/17. The resident was coded as having had a feeding tube and received 51% or more of her total calories through tube feeding. In addition the resident was coded as having received 501 cubic centimeters (ccs) or more of fluid intake through tube feeding. An observation was conducted of the tube feeding equipment of Resident #53 on 2/5/18 at 11:54 AM. The observation revealed a 2 ounce	F 693	F693 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The tube feeding syringe was stored with the piston in place instead of separately. The facility has ensured that the feeding syringe for resident 53 is stored properly. There are currently no other residents receiving peg tube feedings. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The Staff Development Coordinator will provide education to all licensed nurses on proper storage of feeding syringes. 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 Unit Coordinator will monitor the storage of	

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F 693	Continued From page 10 syringe stored with the piston inside the syringe in a clear plastic bag hanging on an intravenous (IV) pole. The syringe had visible liquid inside the tip of the syringe. An observation was conducted of the tube feeding equipment of Resident #53 on 2/8/18 at 11:02 AM. The observation revealed a 2 ounce syringe stored with the piston inside the syringe in a clear plastic bag hanging on an IV pole. The syringe had visible liquid inside the tip of the syringe. An interview conducted on 2/8/18 with Nurse #3 in the room of Resident #53 revealed she was the nurse assigned to care for Resident #53. The nurse stated she had flushed the feeding tube that morning for Resident #53 after the nightly tube feeding was completed. The nurse stated she had used the 2 ounce syringe to flush the feeding tube. The nurse further stated she had utilized the 2 ounce syringe to administer the resident's medications. The nurse stated upon completion of the administration of the medications and flushes of the feeding tube she rinsed the piston and the syringe out, put the piston and the syringe back together, and then placed them in the bag. The nurse further stated she had not been instructed to store the piston and the syringe separated in the bag and storing the piston and the syringe separated was not their standard practice. During an interview conducted on 2/8/18 at 2:59 PM with the Director of Nursing (DON) she stated it was her expectation for a nurse to follow the policy for the storage of the syringe and piston when not in use from a feeding tube.	F 693	tube feeding syringes 5x□s a week for 4 weeks, 3x□s a week for 4 weeks, and 2x□s a week for 4 weeks. This will be reviewed at the quarterly QAPI meeting. The Director of Nursing is responsible for implementing the acceptable plan of correction by March 8, 2018.	

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	345419	A. BUILDING _____ B. WING _____	C 02/08/2018

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F 732	Continued From page 11	F 732		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever	F 732		3/8/18

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F 732	Continued From page 12 is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview, observation and review of required nurse staffing posted during survey 2/5/17 to 2/8/17, the facility failed to post staffing information for one day and post correct staffing totals as compared to the nursing staff schedule for the facility for two days. The facility failed to post nurse staffing on 2/5/18, and failed to provide correct nurse staffing totals on 2/3/18 and 2/4/18. Review of the Daily Nursing Staff Schedule for 2/3/18 revealed there were 5 NAs on the 3:00 pm to 11:00 pm shift and 5 NAs on the 11:00 pm to 7:00 am shift for entire skilled nursing facility population. The Daily Nursing Staffing Summary for 2/3/18 revealed the facility had posted there were 6 NAs on the 3:00 pm to 11:00 pm shift and 6 NAs on the 11:00 to 7:00 am shift for the entire skilled nursing facility population. Review of the Daily Nursing Staff Schedule for 2/4/18 revealed there were 4 Nurses and 6 NAs on the 7:00 am to 3:00 pm shift; 4.5 NAs on the 3:00 pm to 11:00 pm shift; and 4 NAs on the 11:00 pm to 7:00 am shift for the entire skilled nursing facility population. The Daily Nursing Staffing Summary for 2/4/18 revealed the facility posted there were 5 nurses and 7 NAs on the 7:00 am to 3:00 pm shift; 6.5 NAs on the 3:00 pm to 11:00 pm shift; and 6 NAs on the 11:00 pm to 7:00 am shift for the entire skilled nursing facility population.	F 732	F732 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The staff posting was not changed over the weekend and the posting for 2/2/18 was still in place on 2/5/18 despite the others being placed behind it for the weekend staff to change. No specific resident was affected by deficient practice. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Administrator, Director of Nursing and designees are to be educated by regional nurse consultant on posted nurse staffing and census. 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. Administrator and/or Director of Nursing will conduct audit of daily nurse staffing summary for completeness weekly for 4 weeks; once every two weeks for 4 weeks and monthly for one month. Results of these audits will be reviewed at Weekly Risk Quality Assurance Meeting for three months and at Quarterly Quality Assurance meeting for two meetings for further resolution if needed.	

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F 732	Continued From page 13 An observation of Daily Staffing Summary on 2/5/18 at 10:20 am revealed it was dated for 2/2/18. Interview on 2/8/18 at 2:30 pm with the Staff Scheduler revealed she fills out the Daily Nursing Staffing Summary for each day from the Daily Nursing Staff Schedule but does not correct the staff reflected on the Daily Nursing Staffing Summary when staff call out. She stated she didn't know who was responsible for correcting the Nursing Staffing Summary when someone calls out. Interview with the Director of Nursing on 2/8/18 at 2:59 pm revealed her expectation was the Staff Scheduler would put the Daily Nursing Staffing Summary up and the Nursing Supervisors would be responsible for switching the staffing sheets to the appropriate day and they would make sure the actual amount of staff that worked would be recorded.	F 732	The Director of Nursing is responsible for implementing the acceptable plan of correction by March 8, 2018.	
F 865 SS=C	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		3/8/18

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F 865	Continued From page 14 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Performance Improvement committee (QAPI) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 2/18/2018 to achieve and sustain compliance. The facility had a repeat deficiency on Posted Nurse Staffing Information for the recertification survey dated 2/8/2018. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to 483.35: Based on staff interview, observation and review of required nurse staffing posted during survey 2/5/17 to 2/8/17, the facility failed to post staffing information for one day and post correct staffing totals as compared to the nursing staff schedule for the facility for two days. The facility failed to post nurse staffing on 2/5/18, and failed to provide correct nurse staffing totals on 2/3/18 and 2/4/18. During the previous recertification survey of 3/9/2017, the facility was cited for a deficiency 483.35: Based on staff interview and record review the facility failed to accurately report the resident census and staffing figures on the Staff Posting	F 865	F865 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. In reference to 483.35 the facility had a repeat deficiency on Posted Nurse Staffing Information for the recertification survey dated 2/8/18 No residents were affected by deficient practice. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Administrator, Director of Nursing and designees are to be educated by regional nurse consultant on posted nurse staffing and census. 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. Administrator and/or Director of Nursing will conduct audit of daily nurse staffing summary for completeness weekly for 4 weeks; once every two weeks for 4 weeks and monthly for one month. Results of the audits will be reviewed at Weekly Risk Quality Assurance Meeting	

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F 865	Continued From page 15 for 4 of 4 survey days on all 3 shifts, failed to exclude the residents residing in non-Skilled Nursing Facility level of care beds from the census total, and failed to exclude the staff time allocated to those residents from the staff posting figures for the designated Skilled Nursing Facility level of care beds. An interview with the Administrator was conducted on 02/08/18 at 05:10 PM. The Administrator reported the QAPI committee meets quarterly with the Administrator, Director of Nursing, department heads, and the facility physician. The Administrator further reported the committee uses a root cause analysis and will form a subcommittee when there is a problem, and he was uncertain why the system failed for a repeat deficiency.	F 865	for three months and at Quarterly Quality Assurance meeting for two meetings for further resolution if needed. The Director of Nursing is responsible for implementing the acceptable plan of correction by March 8, 2018.	