STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF FOREST GLENN	1101 HARTWELL STREET GARNER, NC 27529

(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
F 000	INITIAL COMMENTS On 2/16/18, tag F925 was amended. The 2567 was posted again. On 3/5/18 the author of F 791 deleted the tag before the actual IDR meeting. The 2567 was reposted.	F 000		
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);	F 584		2/13/18

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

Electronically Signed | 02/09/2018

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting 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, staff and resident interviews, the facility failed to provide an odor free environment and in walls, floors, and windows for 2 out of 2 halls (the 100 hall and the 200 hall). Findings include: a.An observation on 1/9/18 at 11:09 pm in room 229 revealed strong ammonia like odor in the room. Both residents were in the room in their beds with their eyes closed and lights off when observation was made. An observation on 1/10/18 at 12:26 am in room 229 revealed strong ammonia like odor room. Both residents were in the room in their beds with their eyes closed and lights off when observation was made. An observation on 1/10/18 at 10:49 am revealed a strong ammonia like odor in room 229. An observation on 1/11/18 at 9:09 am revealed a strong ammonia like odor in room 229. An observation on 1/12/18 at 1:37 pm revealed a	F 584	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is February 13, 2018. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F584 Safe/Clean/Comfortable/Homelike Environment Corrective Action Room 229 and bathroom were deep cleaned (floors stripped and waxed, all linen washed, and everything wiped down with disinfectant) on 01-15-2018. Rooms 112 and 113 have been repaired	

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F 584	Continued From page 2 strong ammonia like odor in room 229. b.An observation on 1/11/18 at 4:25pm of room 112 revealed paint peeling on the wall next to bathroom near the corner of the room. An observation on 1/11/18 at 4:25pm of room 112 revealed black mark on the left wall when entering room. The black mark is approximately 6 inches from floor and measures approximately 2 inches by 24 inches. An observation on 1/12/18 at 1:25pm of room 112 revealed paint peeling on the wall next to bathroom near the corner of the room. An observation on 1/12/18 at 1:25pm of room 112 revealed black mark on the left wall when entering room. The black mark is approximately 6 inches from floor and measures approximately 2 inches by 24 inches. c. An observation on 1/11/18 at 3:55pm of the baseboard to the left outside room 113 revealed the baseboard is loose from the wall. An observation on 1/12/18 at 1:25pm of the baseboard to the left outside room 113 revealed the baseboard is loose from the wall. d. An observation on 1/11/18 at 4:44pm of room 113 revealed paint peeling on the wall to the left of the first bed in the room. An observation on 1/12/18 at 1:29pm of room 113 revealed paint peeling on the wall to the left of the first bed in the room. An observation on 1/11/18 at 4:44pm of room 113 revealed a brown substance on the floor behind	F 584	and painted. The brown substance is a rust stain on the floor that has been cleaned. Black marks on the wall were rubber marks caused by wheelchair wheels, those have been wiped clean on 01-17-2018. Rooms 113 and 115 baseboards have been repaired on 02-05-2018. Room 234's window pane has been cleaned and all web like material has been removed on 02-07-2018. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. The Maintenance Director and Housekeeping Supervisor will fix all alleged deficient practices by 02-13-2018. Routine audits are being done and any alleged deficient practices that are noticed by staff will be shared with the Maintenance Director, Housekeeping Supervisor and /or designee, so they can be fixed in a timely manner. No other issues were identified. Systematic Changes All staff, licensed and certified, fulltime, part time, will be in-serviced by the Housekeeping Director and/or Administrative Nursing on maintaining an odor free environment and clean floors, walls, and windows by 02-13-2018. (staff will be in-serviced before working next	

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F 584	Continued From page 3 the door at the door facing in the corner. An observation on 1/12/18 at 1:29pm of room 113 revealed a brown substance on the floor behind the door at the door facing in the corner. e. An observation on 1/11/18 at 4:00pm of room 234 revealed web like material in between the 2 window panes and outside the window. The web like material extends from one edge of the windows to the other edge of the windows. An observation on 1/12/18 at 12:30pm of room 234 revealed web like material in between the 2 window panes and outside the window. The web like material extends from one edge of the windows to the other edge of the windows. f. During a tour of the facility on 1/12/18 at 1:40pm with the Supervisor of Environmental Services, the following concerns were found: a. Prominent ammonia like odor in room 229. b. Web like material between window panes in room 234 extending from one side of windows to the other side. c. Brown substance on floor behind door in corner at door frame in room 113. g. During a tour of the facility on 1/12/18 at 2:05pm with the Director of Maintenance, the following concerns were found: a. Paint peeling on the wall next to the bathroom near the corner in room 112 b. Black mark on the left wall when entering room 112 c. Paint peeling on the wall to the left of the first bed in room 113 d. Loose baseboard to the left outside the door of room 115	F 584	shift). Monitoring Housekeeping Supervisor, Maintenance Director, and/or designees will conduct room rounds (3) three times per week for (4) four weeks to include weekends. Variances will be corrected at the time of observation. Additional education and/or administrative action will be initiated when indicated. Concerns will be reported to the Administrator weekly for the next (4) four weeks. The Administrator will report results to the Quality Assurance Committee during the monthly meeting. On-going compliance will be monitored by the Administrator and/or through routine room audits and the results will be reported to the facility's Quality Assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 584	Continued From page 4	F 584		

An interview was conducted on 1/11/18 at 9:30 am with NA#11. NA#11 reported Resident #75 in room 229 is incontinent 50% of the time. He stated Resident #36 in room 229 has a catheter but sometimes he will leave the clamp open after he empties the urine from the bag and then urine leaks on the floor or he will run over the bag with his wheelchair.

An interview was conducted on 1/11/18 at 2:44pm with the housekeeper for room 229. Nurse #10 was the interpreter as the housekeeper did not speak English. The housekeeper reported that when urine is found on the floor she cleans with a disinfectant and the smell goes away. The housekeeper reported room 229 frequently smells, but she stated once she used the disinfectant today, the odor was gone. The housekeeper reported the privacy curtains are cleaned every 4 days or sooner if there is an odor in the room.

An interview was conducted on 1/12/18 at 1:40pm with the Supervisor of Environmental Services. The Supervisor reported every room in the facility is cleaned daily which includes mopping, disinfecting sinks and toilets, cleaning all surfaces, emptying trash, and picking up trash from the floors. He reported if the housekeeping staff sees a maintenance issue, then they fill out a maintenance request and gives to the Supervisor to give to the Maintenance Director.

An interview was conducted on 1/12/18 at 2:05pm with the Director of Maintenance. The Director reported he makes rounds in the rooms once a month to make sure there are no maintenance needs in the rooms. The Director reported the staff will verbally let him know of

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F 584	Continued From page 5 maintenance issues or fill out a maintenance request form when a maintenance issue arises. The Director reported he had not been made aware of peeling paint in rooms 112 and 113, the black mark in room 112, or the loose baseboard outside of room 113. The Director produced the maintenance requests for the past 8 months with no request noted for rooms 112, 113, or the baseboard outside room 113. He stated he had not seen the areas of concern before. An interview with the Administrator was conducted on 1/12/18 at 5:30pm. The Administrator reported it is his expectation that all environmental issues including housekeeping services and maintenance repairs should be reported to either Environmental Services or Maintenance by the staff.	F 584		
F 585 SS=C	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.	F 585		2/13/18

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F 585	Continued From page 6 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §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	F 585		

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F 585	Continued From page 7 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident 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 observation, record review, staff interviews and interviews during resident council meeting the facility failed to include in the	F 585	F585 Grievances Corrective Action	

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F 585	Continued From page 8 grievance policy the e-mail address of the Grievance Officer (GO). The facility failed to notify residents individually or post in a prominent place throughout the facility the name of the official GO. Findings included: On 1/10/18 from 12 noon to 12:50 PM a Resident Council Meeting was conducted. During the meeting, all members of the resident council who attended stated they were not aware who was appointed the GO. One resident council member indicated he was not aware of the official GO but when he had issues he just complained to the top person at the facility (referring to the administrator). Review of the Resident Council minutes dated 10/25/17, 11/16/17 and 12/13/17 revealed no evidence that the new grievance policy or GO was discussed. Interview on 1/11/18 at 2:21 PM was held with the Admission Coordinator who indicated that the facility provided the resident or responsible party with contact information about the GO. Review of the admission handbook revealed no information about the business address, phone number or e-mail address of the GO. Interview on 1/11/18 at 2:45 PM with the Administrator reviewed new admission are sent an "app" to the resident or family regarding the email address of the Grievance official. On 1/11/18 at 3 PM the Admission Coordinator was interviewed and inquired about how the person without a smart phone or computer would have access the app to obtain information and the Admission Coordinator lifted her shoulder up and down without a verbal response. At 3:10 PM on	F 585	Resident Council was notified of new grievance policy and that the Grievance Officer is the Administrator of the facility, Jonathan Wade on 02-05-2018 and is reflected in the resident council meeting minutes. Admission Handbook was updated with Grievance Officer's email address on 01-15-2018. Grievance Officer's information has been posted in the front lobby, activities room, both nursing station units, and dining room. Grievance Officer's information is as follows: Jonathan Wade – Grievance Officer, The Laurels of Forest Glenn, 1101 Hartwell Street, Garner, NC 27529, 919-772-8888, jwade@laurelhealth.com on 02-07-2018. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. The Administrator has mailed/delivered a copy of Grievance Officer's information to all responsible parties on 02-07-2018. Social Worker has posted a copy of Grievance Officer's information on all resident's bulletin boards in their room on 02/02/2018. Systematic Changes All staff, licensed and certified, fulltime,	

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F 585	Continued From page 9 1/11/18 the Administrator indicated that the information provided was just the handbook and the admission agreement had the necessary contact information about the Grievance official. Review of the admission agreement with the Administrator revealed no email address for the Grievance official. Interview with the Admission Coordinator on 1/11/18 at 3:15 PM who stated it would not matter whether the email address was provided if a resident or responsible party did not have access to a smart phone or computer. Interview and record review of the resident council meeting minutes dated 9/20/17 on 1/11/18 at 3:20 PM with the Activity Director (AD)was done. Review of the minutes revealed a handwritten statement by the AD in a blank space that indicated "informed Residents of location of griev [grievance] forms." Interview and observation of the resident units and hallways with the Administrator on 01/11/18 at 03:29 PM was held. A notice was posted in a glass frame in the front lobby that indicated contact information of the facility's Administrator, Director of Nursing, Social Worker, and Marketing Director. The information did not identify the GO. There was no posting in prominent places identifying the GO or the contact numbers.	F 585	part time, will be in-serviced on new Grievance Policy and postings (all staff will be in-serviced before working next shift) on 02-13-2018. Monitoring Social Worker will conduct rounds (1) once per week for (4) four weeks to ensure postings of Grievance officer are still posted in designated spots in the facility. Administrator will conduct audits (1) once per week for (4) four weeks to ensure all new admissions are receiving Grievance Officer information. Variances will be corrected at the time of observation. Additional education and/or administrative action will be initiated when indicated. Concerns will be reported to the Administrator weekly for the next (4) four weeks. The Administrator will report results to the Quality Assurance Committee during the monthly meeting. On-going compliance will be monitored by the Administrator and/or through routine room audits and the results will be reported to the facility's Quality Assurance program. Additional education and monitoring will be initiated for any identified concerns.	
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,	F 600		2/13/18

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F 600	Continued From page 10 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 resident interviews, staff interviews, resident observations and record review the facility failed to provide incontinent care for 1 of 9 sampled residents (resident #2) who required extensive assistance and who had requested incontinent care on 2 different occasions because she had soiled herself. Findings included: Resident #2 was admitted to the facility on 10-12-10 with multiple diagnoses that included acute upper respiratory infection, muscle weakness, dementia, anxiety and Parkinson. A review of the Minimum Data Set (MDS) dated 1-1-18 revealed that the resident was cognitively intact. Resident #2 was coded as needing extensive assistance with one person for bed mobility, total assistance with 2 people for transfers, total assistance with one person for locomotion on and off the unit, extensive assistance with one person for dressing, toileting and personal hygiene, and supervision with one person for eating.	F 600	F600 Free from Abuse and Neglect Corrective Action Assisted Director of Nursing did 1-on-1 counseling with NA# 2 and Nurse for resident #2 (observation on answering call lights and making sure incontinent care is being provided correctly and in a timely manner) on 01-12-2018. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Education will be provided to all licensed and certified nursing staff regarding abuse and neglect to ensure staff are answering call lights and ensure incontinent care is being provided correctly and in a timely manner. The Director of Nursing, and nurse managers, are conducting audits to ensure call lights are answered and that incontinent care is being provided correctly and timely. No other issues were	

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F 600	Continued From page 11 The care plan dated 1-4-18 revealed a goal that resident #2 would be able to do her bathing/hygiene with extensive assistance. The interventions for this goal included provide choice of scheduling a time for her activities of daily living, provide incontinence care as needed, staff will provide all ADL care that resident cannot complete, provide incontinence care with each episode, An interview with resident #2 occurred on 1-10-18 at 9:45am. The resident stated she was upset because she had a bowel movement in her brief this morning and had not been cleaned yet. Resident #2 went on to state that she had put her call light on 2 times since 7:30am and each time the nursing assistant stated she would be back but did not come back. She stated she felt like she had her bowel movement "a little bit before 7:30 this morning". The resident stated she looked at her clock on the wall to see what time it was. An observation of resident #2's call light on 1-10-18 at 9:55am revealed that the resident put her call light back on at 9:55am. The nurse answered the call light at 9:58am and told the resident "I know you need cleaned. They will be in shortly". The nurse was observed to turn resident #2's call light off and leave the room. The nurse was noted to return to her medication cart without speaking to any of the nursing assistance. The nurse stated that the nursing assistant knew the resident needed cleaned and would be there when she finished with another resident. An observation of resident #2's activities of daily living (ADL) care occurred on 1-10-18 at 10:30am. The nursing assistant stated this was	F 600	identified. Systemic Changes The Director of Nursing and/or Nurse manager will educate all licensed and certified staff, full-time and part-time, and PRN on abuse and neglect policies and procedures including answering call lights and making sure incontinent care is being provided correctly and in a timely manner by 02-13-2018. Monitoring The Director of Nursing, and/or her nurse managers, will perform audits (5) five times weekly for (1) one month and (3) three times weekly for (2) two months, and ongoing random observations on licensed and certified nursing staff to ensure call lights are answered and that incontinent care is being provided correctly and timely. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 600	Continued From page 12	F 600		

the resident's first ADL care since she started her shift that morning at 7:00am. The resident was noted to have dried feces on her groin area as well as her sacral area. No skin breakdown noted.

An interview with resident #2 occurred on 1-11-18 at 2:05pm. Resident #2 stated she had urinated in her brief "a little before 12:00pm" and that she told the nursing assistant at 12:00pm that she needed changed but that the nursing assistant had not been back to change her.

An observation of ADL care for resident #2 occurred on 1-11-18 at 2:30pm. The brief was noted to have a dried yellow ring.

An interview with the nurse (#4) occurred on 1-12-18 at 1:10pm. The nurse stated that resident #2 was total care for ADL's but that she was able to put her call light on when she was needing to be cleaned. She also stated she believed the nursing assistance checked the residents every 2 hours for the need of ADL care. Nurse #4 stated if she answered a resident's call light she would tell the nursing assistant what the resident needed.

An interview with the nursing assistant (NA#2) occurred on 1-12-18 at 1:15pm. NA#2 stated that the resident can help turn herself but that she is total care for ADL's. She also stated that she does try to check on every resident at least every 2 hours. The NA stated sometimes it would take longer if another resident needed extra time.

An interview with the Director of Nursing (DON) and the Administrator occurred on 1-12-18 at 4:00pm. The DON stated she expected the call lights to be answered and care tendered in a

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F 600	Continued From page 13 timely manner.	F 600		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F 636		2/13/18

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F 636	Continued From page 14 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and resident observation the facility failed to complete a comprehensive assessment for the use of bed rails for 1 of 3 residents (resident #63). Findings included: Resident #63 was admitted to the facility on 6-28-13 with multiple diagnoses that included hemiplegia and hemiparesis left side, schizophrenia, conversion disorder and diabetes. The Minimum Data Set (MDS) dated 12-5-17 revealed that resident #63 was severely	F 636	F636 Comprehensive Assessment and Timing Corrective Action Rehab Manager and Director of Nursing assessed Resident #63 for the use of bed rails. Bed Rails were removed 01-12-2018. Corrective Action for those having the potential to be affected All residents have the potential to be	

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F 636	Continued From page 15 cognitively impaired. The resident had no mood or behaviors coded in the MDS. Resident #63 was coded as needing extensive assistance with 2 people for bed mobility, extensive assistance with one person for transfers, locomotion on and off the unit was extensive assistance with one person, dressing was extensive assistance with 2 people, eating was supervision with one person, toileting and personal hygiene was extensive assistance with 2 people. The resident was also coded as receiving Hospice services. The care plan dated 12-13-17 revealed a goal that resident #63 will be made comfortable with the following interventions; provide activity of daily living care and provide assistance as needed to promote comfort/decrease pain and assist with hygiene activities. An observation of resident #63 occurred on 1-11-18 at 12:00pm. The resident was in the bed laying on her back. She was noted to be able to reach for things on the table over her bed but was unable to reposition herself. An interview with resident #63 occurred on 1-11-18 at 12:00pm. The resident stated she cannot turn over or push herself up in the bed on her own. "They help me" the resident pointed to the nursing assistant standing by her bed. An interview with the nursing assistant (NA #2) occurred on 1-12-18 at 10:10am. NA#2 stated the resident cannot get out of the bed on her own or move herself in the bed. She went on to state that resident #63 was an extensive assist with bed mobility. An interview with the rehab director occurred on	F 636	affected by this alleged deficient practice. The Rehab Director and Director of Nursing have assessed use of bed rails on all residents. Maintenance Director will remove bed rails on the residents that no longer needed bed rails. All Care plans will be updated. Systemic Changes The Assistant Director of Nursing will educate all licensed nurses, full-time, part-time, and on proper assessment of use of bed rails (all staff will be in-serviced before working next shift) by 02-13-2018. Monitoring The Director of Nursing and Administrative nurses will perform a 100% audit of all bedrails in the facility. They will also perform audits bi-weekly for (1) one month and then monthly for (3) three months, to ensure all residents have been properly assessed for use of bed rails. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 636	Continued From page 16 1-12-18 at 12:50pm. She stated that "everyone" who was admitted to the facility was ordered half rails to help with the resident's mobility. The rehab director stated they did not assess the resident's need for the rails when the resident was moved from rehab to skilled nursing. She stated she was aware of the new regulations but that they had not started assessing skilled nursing residents yet "we will probably down the road". An interview with the unit manager (#3) occurred on 1-12-18 at 2:10pm. The unit manager stated that the order for the bed rails for resident #63 was "carried over from the old system" and that the resident no longer needed the side rails. An interview with the Director of Nursing and the Administrator occurred on 1-12-18 at 4:00pm. The Administrator stated that he expected the resident's to be assessed for the need of the side rails.	F 636		
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 record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect Resident #213 received dialysis therapy. This was evident in 1 of 1 resident in the sample reviewed for dialysis therapy. Findings included:	F 641	F641 Accuracy of Assessments Corrective Action MDS Coordinator has corrected identified errors for Resident #213 on 1-12-18 Corrective Action for those having the	2/13/18

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F 641	Continued From page 17 Resident #213 was admitted to the facility on 12/19/17 with cumulative diagnoses which included end stage renal disease. Review of the admission physician orders included in part hemodialysis on Monday, Wednesday and Friday. Review of the 14 -day admission Minimum Data Set (MDS) assessment dated 1/2/18 revealed dialysis was not coded in Section "O." Interview on 1/12/18 at 10:15 AM with MDS coordinator #2 revealed not coding the MDS was "just human error and will fix/correct now." Interview on 1/12/18 at 3:24 PM with the Administrator and the Director of Nurses was held. The Administrator revealed his expectation was MDS assessments be accurate.	F 641	potential to be affected All residents receiving dialysis therapy have the potential to be affected by this alleged deficient practice. An audit of all residents receiving dialysis therapy was completed and compared to the most current Minimum Data Set (MDS) for correct coding. Any corrections were made. Systematic Changes Education will be provided by Regional Clinical Resource Specialist to MDS staff, Director of Nursing (DON) and Assistant Director of Nursing (ADON) on correct Section O coding by 02-13-2018. Monitoring The MDS Coordinator and/or Administrative Nurses will do a 100% audit on coding section o for resident's receiving dialysis therapy. All new admissions and re-admissions will be reviewed for dialysis needs. The MDS and careplans will be reviewed for these guests to ensure accuracy of coding and careplanning. Audits will include 100% for (1) one week, 50% for (2) two weeks, and 25% for (2) two weeks, then once a quarter for (1) one quarter. Results of the audit will be reported to the Regional Clinical Resource Specialist and communicated to the Director of Nursing. The Director of Nursing will report any variances to the Quality Assurance	

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F 641	Continued From page 18	F 641	committee during the monthly meeting. Continued monitoring will occur through routine chart audits by the Regional Clinical resource specialist and communicated to the Director of Nursing.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		2/13/18

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F 657	Continued From page 19 Based on staff interviews and record review the facility failed to update a care plan for 1 of 1 residents (resident # 63) when the resident was no longer receiving anticoagulant therapy. Findings included: Resident #63 was admitted to the facility on 6-28-13 with multiple diagnoses that included hemiplegia and hemiparesis left side, schizophrenia, conversion disorder and diabetes. The Minimum Data Set (MDS) dated 12-5-17 revealed that resident #63 was severely cognitively impaired. The resident had no mood or behaviors coded in the MDS. Resident #63 was coded as needing extensive assistance with 2 people for bed mobility, extensive assistance with one person for transfers, locomotion on and off the unit was extensive assistance with one person, dressing was extensive assistance with 2 people, eating was supervision with one person, toileting and personal hygiene was extensive assistance with 2 people. The resident was also coded as receiving Hospice services. The care plan dated 12-13-17 revealed a goal that the resident will have no signs of active bleeding with the following interventions; encourage use of long sleeves, report abnormal findings to the doctor, observe for abnormal bleeding, caution against bumping or shaving, administer medications as ordered and obtain labs as ordered. A review of the physician orders revealed that resident #63 was ordered Plavix on 3-14-17 but then discontinued on 4-13-17.	F 657	F657 Care Plan Timing and Revision Corrective Action Resident #63's care plan has been updated to reflect no anticoagulant therapy. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. MDS Nurses determined that no other resident was found to need a revised care plan. Systemic Changes The MDS nurses will be re-educated by the regional clinical resource specialist by 02-13-2018, to ensure that resident's care plans are reviewed and revised by licensed nurses and that person-centered care plans are developed for them. Monitoring The Administrative nurses will perform audits twice per week for (1) one month and then monthly for (1) one quarter, to determine if care plans have been updated appropriately. The Administrative nurses will complete a 100% audit of all guests receiving an anticoagulant. After this initial audit, guests who start or stop an anticoagulant will be reviewed. The audit will include a 100% audit for (1) one week, 50% for (2) weeks, then 25% for (2)	

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F 657	Continued From page 20 An interview with the Director of Nursing (DON) occurred on 1-12-18 at 10:15am. The DON stated that resident #63 had not been on an anticoagulant "for a long time". An interview with the MDS/care plan coordinator (#1) occurred on 1-12-18 at 10:20am. The coordinator reviewed the doctor's orders and then reviewed the care plan and stated that the care plan should have reflected that the goal and interventions for anticoagulant therapy had been resolved. An interview with the Administrator and DON occurred on 1-12-18 at 4:00pm. The DON stated her expectations were that the care plans be as accurate as possible.	F 657	weeks, and once a quarter for (1) one quarter. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, resident observations and record reviews the facility failed to provide incontinence care for 1 of 4 sampled residents (resident #2) leaving the resident soiled for 3 hours and failed to provide incontinence care by not cleaning a resident after removing a soiled brief and cleaning a resident from back to front allowing feces to come in contact with the genital area for 2 of 4 sampled residents (resident #63 and #18) who were dependent on staff for their activities of daily living. The facility failed to throughly cleanse	F 677	F677 ADL Care for Dependent Residents Corrective Action The Assistant Director of Nursing did 1-on-1 education with Nurse #4 and NA #2 in regards with Resident #2. They were educated on responsiveness to answering call lights in a timely manner. The Assistant Director of Nursing did 1-on-1 education with NA #2 in regards with Resident #63. She was educated on	2/13/18

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F 677	Continued From page 21 Resident #10's perineal area after a urinary incontience episode. Findings included: 1: Resident #2 was admitted to the facility on 10-12-10 with multiple diagnoses that included acute upper respiratory infection, muscle weakness, dementia, anxiety and Parkinson. A review of the Minimum Data Set (MDS) dated 1-1-18 revealed that the resident was cognitively intact. Resident #2 was coded as needing extensive assistance with one person for bed mobility, total assistance with 2 people for transfers, total assistance with one person for locomotion on and off the unit, extensive assistance with one person for dressing, toileting and personal hygiene, and supervision with one person for eating. The care plan dated 1-4-18 revealed a goal that resident #2 would be able to do her bathing/hygiene with extensive assistance. The interventions for this goal included provide choice of scheduling a time for her activities of daily living, provide incontinence care as needed, staff will provide all ADL care that resident cannot complete, provide incontinence care with each episode, An interview with resident #2 occurred on 1-10-18 at 9:45am. The resident stated she was upset because she had a bowel movement in her brief this morning and had not been cleaned yet. Resident #2 went on to state that she had put her call light on 2 times since 7:30am and each time the nursing assistant stated she would be back to "clean me up" but did not come back. She stated	F 677	appropriate incontinent care of residents. The Assistant Director of Nursing did 1-on-1 education with NA #7 in regards with Resident #18. She was educated on appropriate incontinent care of residents. The Director of Nursing terminated NA #15. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Above mentioned staff have been educated on appropriate incontinent care. Routine observations will be done by the administrative nurses to ensure appropriate incontinent care is being provided as well as call lights are being answered timely. Systemic Changes All Certified Nursing Assistants will be re-educated by the Assistant Director of Nursing on providing appropriate incontinent care and answering call lights timely. (all staff will be in-serviced before working next shift) by 02-13-2018. Monitoring The Administrative Nurses will perform audits (2) twice weekly for (1) one month and then monthly for (3) three months, to ensure that incontinent care is being provided and that call lights are being answered timely. Results of the audits will be reviewed at the monthly Quality	

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F 677	Continued From page 22 she felt like she had her bowel movement "a little bit before 7:30 this morning". An observation of resident #2's call light on 1-10-18 at 9:55am revealed that the resident put her call light back on at 9:55am. The nurse answered the call light at 9:58am and told the resident "I know you need cleaned. They will be in shortly". The nurse was observed to turn resident #2's call light off and leave the room. The nurse was noted to return to her medication cart without speaking to any of the nursing assistance. An observation of resident #2's activities of daily living (ADL) care occurred on 1-10-18 at 10:30am. The resident was noted to have dried feces on her groin area as well as her sacral area. No skin breakdown noted. An interview with resident #2 occurred on 1-11-18 at 2:05pm. Resident #2 stated she had urinated in her brief "a little before 12:00pm" and that she told the nursing assistant at 12:00pm that she needed changed but that the nursing assistant had not been back to change her. An observation of ADL care for resident #2 occurred on 1-11-18 at 2:30pm. The brief was noted to have a dried yellow ring. An interview with the nurse (#4) occurred on 1-12-18 at 1:10pm. The nurse stated that resident #2 was total care for ADL's but that she was able to put her call light on when she needed to be cleaned. An interview with the nursing assistant (NA#2) occurred on 1-12-18 at 1:15pm. NA#2 stated that the resident can help turn herself but that she is	F 677	Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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total care for ADL's.

An interview with the Director of Nursing (DON) and the Administrator occurred on 1-12-18 at 4:00pm. The DON stated she expected the call lights to be answered and care tendered in a timely manner.

2: Resident #63 was admitted to the facility on 6-28-13 with multiple diagnoses that included hemiplegia and hemiparesis left side, schizophrenia, conversion disorder and diabetes.

The Minimum Data Set (MDS) dated 12-5-17 revealed that resident #63 was severely cognitively impaired. The resident had no mood or behaviors coded in the MDS. Resident #63 was coded as needing extensive assistance with 2 people for bed mobility, extensive assistance with one person for transfers, locomotion on and off the unit was extensive assistance with one person, dressing was extensive assistance with 2 people, eating was supervision with one person, toileting and personal hygiene was extensive assistance with 2 people. The resident was also coded as receiving Hospice services.

The care plan dated 12-13-17 revealed a goal that resident #63 will be made comfortable with the following interventions; provide activity of daily living care and provide assistance as needed to promote comfort/decrease pain and assist with hygiene activities.

An observation of resident #63 occurred on 1-11-18 at 9:00am. The resident was noted to be sitting up in her wheelchair watching TV.

An interview with resident #63 occurred on

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1-11-18 at 11:00am. The resident stated she had been in her wheelchair all morning. She also stated that no staff had been in to check her for incontinence since she had been in her wheelchair. Resident #63 stated she had urinated in her brief and needed cleaned. The resident was unable to state if she had told a staff member that she needed cleaned.

An observation of activities of daily living (ADL) care occurred on 1-11-18 at 12:15pm. The brief was noted to be wet with urine. Once the nursing assistant removed the soiled brief she promptly put a clean brief on the resident without cleaning the resident's genital area first.

An interview with the nursing assistant (NA#2) occurred on 11-11-18 at 12:25pm. NA#2 thought about the steps she just performed on resident #63 and stated she did not know what she had forgotten to do. Once the NA was prompted she stated "I should have washed her before I put on the clean brief".

An interview with the Director of Nursing (DON) and the Administrator occurred on 1-12-18 at 4:00pm. The DON stated that she expected staff to give appropriate genital and anal care.

3: Resident #18 was admitted to the facility on 4-21-16 with multiple diagnoses which included adult failure to thrive, dementia, Alzheimer and diabetes.

The Minimum Data Set (MDS) dated 10-13-17 revealed that resident #18 had memory deficits and her cognitive skills were severely impaired. Resident #18 was coded as needing extensive assistance with one person for bed mobility,

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extensive assistance with 2 people for dressing, limited assistance with one person for eating, extensive assistance with one person for toileting and extensive assistance with 2 people for personal hygiene.

The care plan dated 12-29-17 had a goal that resident #18 would be made comfortable with the following interventions; assist with hygiene activities and encourage and assist with turning and repositioning to promote comfort/decrease pain.

An observation of activities of daily living (ADL) occurred on 1-11-18 at 2:15pm. The nursing assistant (NA) was noted to explain to resident #18 what she was going to do and had all appropriate supplies ready. The NA requested assistance from another NA. Both NA's were noted to position the resident appropriately for ADL care however neither of them closed the blind to provide the resident with privacy as resident #18's bed was in view of the window. Resident #18's brief noted to have urine and feces present. The NA was noted to clean resident #18's buttocks appropriately and changed wash towels to clean resident's genital area however the NA was noted to wipe the resident from back to front spreading feces to resident #18's genital area.

An interview with the nursing assistant (NA#7) occurred on 1-11-18 at 2:40pm. NA#7 stated she did forget to close the blind but then went on to state "I don't ever close the blinds because the windows are so dirty I don't think anyone can see in anyway". The NA also stated that the resident should be washed from front to back and that she was in a hurry to pick up her nephew from school

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and did not realize she washed from back to front at the time.

Attempted to interview resident #18 but she was not able to answer any questions due to her cognitive state.

An interview with resident #18's representative occurred on 1-12-18 at 3:30pm. She stated that she was pleased with the care her mother is receiving and that she did not have any complaints.

An interview with the Director of Nursing (DON) and the Administrator occurred on 1-12-18 at 4:00pm. The DON stated she expected her staff to provide appropriate incontinent care.

4. Resident #10 was readmitted to the facility on 12/29/17 with cumulative diagnoses which included dementia and status post urinary tract infection.

Review of the quarterly Minimum Data Set (MDS) assessment dated 9/30/17 revealed Resident #10 was severely cognitively impaired, totally dependent on staff for toileting and always incontinent of bowel and bladder.

Reviewed the care plan dated 1/1/18 regarding actual UTI that included good pericare with each incontinent episode.

Observation of incontinence care on 01/12/18 at 10:54 AM performed by Nursing Assistant #15 (NA) was conducted. Nurse #12 assisted with the transfer of the resident to the bed from the wheelchair. Then Nurse #12 assessed the resident's skin and left the room. NA #15 filled

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F 677	Continued From page 27 water in 2 (two) basins. One basin had skin and hair cleanser added. Both sides of the groin were cleansed with the soapy water in a downward motion and rinsed off with plain water. NA #15 did not open Resident #10's legs to expose the perineal area for cleaning. A clean brief was then applied. Interview on 01/12/18 at 11:16 AM with NA #15 stated she was nervous and realized she had not exposed the perineal area for cleaning but she should have. Interview on 01/12/18 at 11:30 AM with Unit Manager #12 indicated she expected staff to cleanse the perineal area when doing incontinent care. An interview with the Director of Nursing (DON) and the Administrator occurred on 1-12-18 at 4:00pm. The DON stated she expected her staff to provide appropriate incontinent care.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview, complainant interview, record review and observation the facility staff while repositioning a	F 689	F689 Free of Accident Hazards/Supervision/Devices	2/13/18

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F 689	Continued From page 28 resident that required extensive assistance for repositioning in bed caused the resident to have a black eye for 1 of 3 residents (resident #63). Findings included: Resident #63 was admitted to the facility on 6-28-13 with multiple diagnoses that included hemiplegia and hemiparesis left side, schizophrenia, conversion disorder and diabetes. The Minimum Data Set (MDS) dated 12-5-17 revealed that resident #63 was severely cognitively impaired. The resident had no mood or behaviors coded in the MDS. Resident #63 was coded as needing extensive assistance with 2 people for bed mobility, extensive assistance with one person for transfers, locomotion on and off the unit was extensive assistance with one person, dressing was extensive assistance with 2 people, eating was supervision with one person, toileting and personal hygiene was extensive assistance with 2 people. The resident was also coded as receiving Hospice services. The care plan dated 1-4-18 revealed a goal that resident #2 would be able to do her bathing/hygiene with extensive assistance. The interventions for this goal included encouraging the resident to comb her own hair, encourage independence, and provide choice of scheduling a time for her activities of daily living and set up for her morning bath. The resident will have no signs of active bleeding with the following interventions; encourage use of long sleeves, report abnormal findings to the doctor, observe for abnormal bleeding, caution against bumping or shaving, administer medications as ordered and obtain labs as ordered.	F 689	Corrective Action Resident #63's black eye resulted from resident making contact with the bed rails. The resident was assessed and bed rails were padded at that time. Since then, the Director of Nursing and Rehab Director have assessed resident #63 for usage of bed rails, determined that they were not needed, and they have been removed from the bed. No residents including (resident #63) have had further injury related to bedrails. CNA was counseled on providing extensive assistance while repositioning resident #63 in bed. The Director of Nursing did 1-on-1 counseling with NA #5 in regards with Resident #63. They were counseled on providing extensive assistance while repositioning resident in bed. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Above mentioned staff have been educated on providing extensive assistance for repositioning. Routine observations will be done by the administrative nurses to ensure staff are providing proper level of assistance for repositioning residents in bed, and that bedrail assessments are being completed timely and accurately and that placement or removal of bedrails occurs timely to match correctly completed assessments.	

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F 689	Continued From page 29 A review of the incident report dated 10-20-17 revealed "CNA hit her face on the bed rail". A review of the employee disciplinary record dated 10-24-17 stated that "during care resident being turned grasped at side rail and corner of eye bumped rail". The report also revealed that the nursing assistant was educated on resident safety when rendering activities of daily living and at the request of the family the nursing assistant was removed from caring for resident #63. A review of the nursing notes dated 10-20-17 at 11:32pm revealed that the resident received a hematoma to the left side of her face by the eye. The note revealed that resident #63 told the nurse that the nursing assistants pushed her against the bed rail. An interview with the complainant occurred on 1-10-18 at 2:17pm. The complainant stated she felt that the facility was short staffed and that the nursing assistant was trying to hurry, not paying attention to what she was doing. She went on to state that being short staffed is not a reason to not provide safe good care to her grandmother. An interview with resident #63 occurred on 1-11-18 at 12:00pm. The resident stated she remembered having a black eye and stated the area is still sore but denied knowing how she received the black eye. An interview with the nursing assistant (NA#5) occurred on 1-11-18 at 3:50pm. NA#5 stated she was the one rendering care to resident #63 the night of the incident. She stated she was providing ADL care around 10:00pm to resident	F 689	Systemic Changes All licensed and certified, fulltime, part time, and PRN staff will be in serviced by the Director of Nursing and/or administrative nurses on providing the proper level of assistance while repositioning residents in bed, and correct and timely completion of bedrail assessments by 02-13-2018. Monitoring The Director of Nursing and/or Administrative Nurses will perform audits (5) five times weekly for (1) one month and then (3) three times weekly for (3) three months, to ensure that staff are providing proper level of assistance while repositioning residents in bed. The Director of nursing and/or administrative nurses will perform audits (5) times weekly for (1) one month and then (3) three times weekly for (3) three months to ensure correct and timely completion of bedrail assessments is occurring and that placement or removal of bedrails occurs timely to match correctly completed assessments. All accidents will continue to be reported timely per policy. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 689	Continued From page 30 #63 and when she went to role the resident onto her side, the resident reached for the side rail and pulled herself into the side rail hitting her left eye on the side rail. NA#5 stated she finished providing ADL care then went and told the nurse. She stated she has not worked with resident #63 since then per the family's request. A phone interview with the nurse (#6) occurred on 1-11-18 at 4:15pm. The nurse stated he was the one working the night of the incident. He stated the nursing assistant came to him and told him resident #63 had a black eye from hitting her face on the side rail. The nurse stated the nursing assistant told him that resident #63 pulled herself into the rail when she was trying to turn the resident. He stated he did not believe the nursing assistant because resident #63 "does not have enough strength to pull herself that hard". The nurse stated he went and assessed the resident and asked her what happened. He stated resident #63 told him the nursing assistant pushed her into the side rail. The nurse stated he called the representative and the physician about the incident. An interview with the Director of Nursing (DON) and the Administrator occurred on 1-12-18 at 4:00pm. The DON stated she expected her staff to ensure that the resident is far enough away from the rail before turning or to put the side rail down. She also stated if the nursing assistant is having difficulty to ask for help.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		2/13/18

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F 757	Continued From page 31 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain lipid panel as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident #106). Findings included: The resident was admitted on 6/15/12 with the current diagnosis of Anxiety, depression, and Chronic Obstructive Pulmonary Disease. Resident's #106's Minimum Data Set assessment dated 1/1/18 revealed that the resident was moderately cognitively impaired. The resident had received an antipsychotic, antianxiety, antidepressant and diuretic medication. Physician's orders dated 2/1/17 through 2/31/17	F 757	F757 Drug Regimen is Free from Unnecessary Drugs Resident #106 had a lipid panel done on 2/5/18. A lipid panel was not done in February 2017 as ordered. Corrective Action The Director of Nursing did 1-on-1 education with UM #12 in regards with Resident #106's lipid panel. Education will be provided by Director of Nursing to administrative nurses on following Pharmacy recommendations by 02-13-2018.	

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F 757	Continued From page 32 revealed to draw a lipids panel annually due in February (order start date was 9/27/16). Review of the resident's Medications Administrator Record dated 2/1/17 through 2/27/17 revealed the resident was on Pravastatin daily, a statin medication for high cholesterol. The resident received the medication through 1/12/18 Review of nursing notes from 2/1/17 through 2/27/17 revealed no notes that mentioned a lipid panel or laboratory (lab) work being performed. Review of the resident's lab work revealed the last lipid panel was last drawn on 2/1/16. A pharmacy recommendation sheet dated 2/24/17 stated that a lipid panel lab work was past due and to please check on these results. Another pharmacy recommendation sheet dated 9/26/17 stated that a lipid panel was past due and there was no previous labs charted. The Unit Manager was interviewed on 1/12/18 at 3:27 PM. She stated that she could not find a lipid panel for the resident for last year. It is ordered in February, 2017 and she thought it had been overlooked. She stated that she called the doctor and he stated to just get the lipid panel on Monday. The labs are usually printed and in the computer now. She stated that all she could find was a lipid panel from February, 2016. The contract was signed for the new lab company to take over in February, 2017. The administrator stated on 1/12/18 at 3:43 PM that the facility's new lab company was effective 02/01/17. The administrator explained that 2/20/17 would have been the "go live" date with	F 757	Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Administrative staff will be educated on following pharmacy recommendations. All pharmacy recommendations will be reviewed and shared with the appropriate doctor. Any variances will be corrected. Systemic Changes All Administrative nurses will be in-serviced on following pharmacy recommendations. Monitoring The Director of Nursing and administrative nurses will perform audits (1) once monthly for (3) three months, to ensure pharmacy recommendations are being reviewed by the doctor and implemented as ordered. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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the new lab system. He stated they had to put the labs in both lab systems and the old lab company was still doing all of their labs until 2/20/17 when the other lab company took over.

The pharmacist was interviewed on 1/12/18 at 4:06 PM. He stated that he had noticed some labs were not being completed in February, 2017. He stated that if labs were not completed then he would create a recommendation sheet that was sent to the Director of Nursing and was given to the nursing staff. Then when the recommendation was completed then it was placed in the resident's chart. He stated that he would also go to the head nurse on each unit and let them know if there was a pattern of inconsistency with labs and he had noticed this around thanksgiving this year.

The pharmacist was interviewed again on 1/12/18 at 4:39 PM. He stated that he does not remember anything specific about Resident #106's labs and why they were not drawn. He stated that he made recommendations in 2/2017 and 9/2017 about obtaining the lab.

The Nurse Practitioner was interviewed on 1/16/18 at 9:35 AM. He stated that they have standing orders for Complete Blood Counts, lipid panels and Basic Metabolic Panels to be performed on a routine basis. He stated that if he wanted to order a lab then he would see the patient, would write an order for it and tell the nurse that he wanted the lab to be drawn. He stated that the provider would usually pick up on it if a lab was not drawn as ordered. He stated that a routine level of lipids needed to be drawn or the resident should be taken off the "statin" medications. He stated that she hasn't had any problems with her medication and doesn't think it

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F 757	Continued From page 34 had been years since she had the lipid level drawn. The Lab Supervisor for the previous lab company was contacted on 1/16/18 at 10:05 AM. He stated that he did not see anything in their system for this resident more recent than May, 2016. He stated that the most recent lab order was May, 2, 2016 and nothing else was in their system. The facility currently did not have an active account with this lab company. The current lab providing services to the facility was contacted several times on 1/16/18 at 10:42 AM but attempts were unsuccessful to conduct an interview. The Director of Nursing was interviewed on 1/12/18 at 7:03 PM. She stated that labs should be completed as ordered. She stated that she made copies of Resident #106's most recent lipid panel that she could find (The copy was a lipid panel dated 2/1/16).	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		2/13/18

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F 812	Continued From page 35 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove food in 2 out of 2 nourishment rooms 100 unit and 200 unit) that was past the use by date (200 unit) and did not have opened food dated and labeled (100 and 200 units). Findings include: A. An observation was made on 1/9/18 at 11:55pm of the nourishment room on the 200 unit. The refrigerator revealed Hydrolyte Nectar dated as opened on 12/25/17 and Honey thickened liquid was opened with no date noted on bottle. Another observation was made on 1/11/18 at 12:41pm of the nourishment room on the 200 unit. Three milk cartons in the refrigerator were past the best use by date. Two of the milk cartons were dated best use by 1/9/18 and one milk carton was best used by 1/10/18. The refrigerator revealed Nectar dated as opened on 12/25/17 and Honey thickened liquid was opened with no date noted on bottle. An observation was made on 1/12/18 at 11:40am of the nourishment room on the 200 unit. Two milk cartons were out of date with best use by dates of 1/9/18 on one carton and 1/10/18 on the other carton, Nectar dated as opened on 12/25/17 and Honey thickened liquid was opened with no date noted on bottle.	F 812	F812 Food Procurement, Store/Prepare/Serve Sanitary Corrective Action All items that were identified as expired in the 100 and 200 hall nourishment refrigerator were discarded on 1/12/2018. The Director of Nursing will do 1-on-1 education with all staff on labeling and dating items when stored in the nourishment refrigerators. Documentation on food storage will be posted at nourishment refrigerators in regards to not storing food or liquid without being labeled or dated. If items were found in the refrigerator not labeled or dated, those items would be discarded. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. All licensed and certified staff will be in-serviced on the facility's food storage and proper labeling and dating policy. Systemic Changes The Assistant Director of Nursing and/or	

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F 812	Continued From page 36 B. An observation was made on 1/11/18 at 11:00am of the nourishment room on the 100 unit. The counter in the nourishment room revealed an opened Wellness probiotics with blueberry lemonade water opened with no date or name noted and a Styrofoam cup half full of brown liquid with no date or name noted on the cup. The nourishment room refrigerator revealed a cup with liquid in it with no date or name noted and a white Styrofoam cup, uncovered, with unidentified lumpy white material in it with no name or date on the cup. An observation was made on 1/11/18 at 12:25pm of the nourishment room on the 100 unit. The opened, undated Wellness probiotics with blueberry lemonade water and the undated, unlabeled Styrofoam cup half full of brown liquid remained on the counter. The undated, unlabeled cup with liquid in it remained in the refrigerator along with an uncovered white Styrofoam cup with white lumpy material in it that is not labeled or dated. An observation made on 1/11/18 at 12:35pm revealed Unit Manager #12 throwing the opened and unlabeled cup, 2 Styrofoam cups and probiotic water in the trashcan in nourishment room on the 100 unit. An interview was conducted with the dietary manager on 1/11/18 at 11:30 am. The dietary manager reported that the dietary staff and the nursing staff monitor the foods kept in the nourishment rooms. The dietary manager reported the dietary staff brings the bedtime snacks to the units with dinner and each snack is labeled and stored in nourishment room. The dietary manager reported it is her expectation that the dietary aides will check the dates and remove any outdated food in the nourishment rooms every night. The dietary manager reported any	F 812	administrative nurses will educate all licensed nurses, full-time and part-time, on the facility's food storage and proper labeling and dating policy. (all staff will be in-serviced before working next shift) by 02-13-2018. Monitoring The Director of Nursing and/or administrative nurse managers, will perform audits (5) five times weekly for (1) one month, and then (3) three times weekly for 2 months to ensure the facility is adhering to the food storage and proper labeling and dating policy. Variance will be reported to the Quality Assurance Committee for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 812	Continued From page 37 food brought in by families will be labeled with the resident's name and dated. An interview was conducted with Unit Manager #12 on 1/11/18 at 12:35am. Unit Manager #12 reported dietary is responsible for the nourishment rooms but because the nursing staff is in and out of the nourishment rooms every day, the unit managers and ADON are also responsible for checking the nourishment room for unlabeled or out of date food. Unit Manager #12 reported opened thickened liquids are only kept for two days then are disposed. Unit Manager #12 threw out unlabeled, undated items from the nourishment room on unit 100. An interview was conducted on 1/12/18 at 10:30 am with the administrator. The administrator reported the nourishment rooms are monitored by the dietary department and the nursing department. The administrator reported the bedtime snacks are labeled and dated. The administrator reported all food brought in by family members are to be dated and labeled with the resident's name. The administrator reported it is his expectation that the nourishment rooms are checked daily for unlabeled, undated, and expired items and those items are removed immediately.	F 812		
F 865 SS=D	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;	F 865		2/13/18

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F 865	Continued From page 38 §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. §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, observations and staff interviews, the facility's Quality Assessment and Assurance Committee (QA) failed to maintain procedures and monitor the interventions that the committee put into place in December 2016. This was for recited deficiencies, which were originally cited in December 2016 on a recertification survey, on a complaint survey in June 2017 and on the current recertification survey. The deficiencies were in the areas of Minimum Data Set (MDS) accuracy, Infection control and QA. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Finding Included: This tag is cross referenced to F641: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect Resident #213 received dialysis therapy. This was evident in 1 of 1 resident in the sample reviewed for	F 865	F865 QAPI Program/Plan, Disclosure/Good Faith Attempt Corrective Action MDS Coordinator has corrected the identified errors for Resident #213. Resident #81 has the proper trash can in place for disposing linens, gowns and gloves on 1/13/2018. Corrective Action for those having the potential to be affected At the time of the survey, an audit of all residents receiving dialysis therapy was completed and compared to the most current Minimum Data Set (MDS) for correct coding for the past 6 months to determine if there were any residents that required any additional modifications of assessments. No other resident was found requiring modifications. An extra trash can have been placed in resident's	

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F 865	Continued From page 39 dialysis therapy. This deficiency (F 278) was originally cited in 12/9/16 during a recertification survey for failing to code a resident's dental status on the MDS for 1 of 3 residents. This deficiency (F 278) was also cited on a complaint survey on 6/21/17 for failing to code falls and the active diagnosis on the MDS. F880: Based on observations, record review, and staff interviews, the facility staff failed to follow contact precautions when providing care to one of one resident (Resident #81), this included cans for disposal of linens, gowns and gloves. This deficiency (F441) was originally cited on 12/9/16 during a recertification survey for failing to gown and glove before entering a room on isolation precautions and for failing to properly sanitize a glucometer. F865: Based on observations and staff interviews, the facility's Quality Assessment and Assurance Committee (QA) failed to maintain procedures and monitor the interventions that the committee put into place in December 2016. This deficiency (F 520) was cited on 12/9/16 during the recertification survey for repeat deficiencies in the areas of MDS accuracy and medication error rate greater than 5%. This deficiency (F520) was cited again on 6/21/17 during a complaint survey for MDS accuracy. The Administrator was interviewed on stated 1/12/18 at 7:03 PM. He stated that they had identified in QA that wound care and falls had	F 865	room. Administrative nurses will do audits to ensure all isolated rooms had an extra trash can beside door. Systemic changes The QAPI committee will be in-serviced by the Administrator on the procedure for developing and implementing appropriate plans of action to correct identified quality concerns. Education will include determining the root cause of the identified concern, identifying, implementing and monitoring the corrective action plan and recognizing when an action plan may need to be revised. The MDS/Care Plan Nurse and administrative nurses will be re-educated by our Clinical Resource Specialist regarding accuracy of the MDS. Monitoring The MDS coordinator will do a 100% audit (1) once weekly for (4) four weeks on resident's receiving dialysis therapy. These findings will be compared to the most recent MDS. The Unit Managers and ADON, utilizing the QA audit, will complete a 100% audit of all residents currently on isolation to ensure there is an extra trash can have been placed by the door, so the staff can throw away gown and gloves before exiting the room. The Administrative nurses will complete rounds weekly for (4) four weeks, then monthly for (2) two months to ensure there is an extra trash can have been	

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F 865	Continued From page 40 increased and they had tracked the trends and made sure that the issues were addressed. He stated that they have a specific policy and procedure that they go by for QA. The Director of Nursing stated on 1/12/18 at 7:03 PM that her expectation was to look at what they can do differently in QA and what areas need to be addressed so they could be addressed.	F 865	placed by the door, so the staff can throw away gown and gloves before exiting the room. Staff are wearing gloves and isolation gowns prior to entering an isolated room. Administrative nurses will also conduct staff interviews on what to do when entering and exiting an isolated room. Administrative nurses will conduct interviews with (5) five staff members (3) times weekly on different shifts including weekends for (1) month, then (10) ten staff members (1) monthly for (2) two months. Any variances will be corrected upon observation and continued education provided. The results will be reported by the DON, to the monthly QAPI meeting for any further recommendations or need for root cause analysis. The DON will be responsible to follow-up on any recommendation from the committee and additional training as indicated.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		2/13/18

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F 880	Continued From page 41 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 42 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility staff failed to follow contact precautions when providing care to one of one resident (Resident #81), this including cans for disposal of linens and gowns and gloves. Findings include: A review of the facility's inservice records revealed the nursing staff including nursing assistants were inserviced on proper personal protective equipment use on 11/14/17, on isolation precaution/infection control on 9/27/17, and on infection control and use of personal protective equipment on 6/22/17. Resident #81 was admitted to the facility on 11/15/17. Resident #81's diagnoses include enterocolitis due to clostridium, urinary tract infection, acute kidney failure, major depressive disorder, hypertension, and diabetes. Resident #81's MDS (Minimum Data Set) dated 11/29/17 was coded as an admission	F 880	F880 Infection Prevention& Control Corrective Action Resident #81 has an extra trash can have been placed by the door for disposing linens, gowns and/ or gloves on 1/13/2018. Corrective Action for those having the potential to be affected Assisted Director of Nursing will do 1-on-1 counseling with NA#8 on proper de-gowning and de-gloving before leaving a resident's room. An extra trash can was placed by the door in Resident #81's room. Administrative nurses will complete audits to ensure all isolated rooms have an extra trash can beside the door. Administrative nurses will conduct staff interviews on proper procedures when entering and exiting isolated rooms.	

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F 880	Continued From page 43 assessment. The active diagnoses included enterocolitis due to clostridium, diabetes, left below the knee amputation, and hypertension. The MDS coded Resident #81 as cognitively intact. The MDS revealed Resident #81 needs extensive assistance with ADLs (Activities of Daily Living). The MDS coded Resident #81 as frequently incontinent of bladder and bowel. A review of Resident #81's care plan dated 11/20/17 revealed the resident has clostridium with goal that resident will have no diarrhea and will not develop dehydration within 90 days. The interventions included the resident is on contact isolation per policy. Resident #81 was placed on contact precautions on 11/15/17. The contact precaution sign was noted to be on the wall beside the door to Resident #81's room. An observation of Resident #81's room on 1/10/18 at 2:01pm revealed PPE (Personal Protective Equipment) available outside Resident #81's door in closed cart and precaution sign above the door number. An observation in Resident #81's room revealed no specified trash receptacle for contaminated trash or a container for contaminated linens. An observation on 1/11/18 at 8:56am revealed NA #8 entering Resident #81's room without gowning or gloving. The ADON (Assistant Director of Nursing) went over to the door and called the NA to the door and instructed NA #8 in contact precautions. The NA then gowned and gloved and reentered the room. Observed NA #8 leave the room with the gown balled up in her hands and go into the shower room and dispose of the gown.	F 880	Systemic Change The ADON will educate all employees on the facility's infection prevention and control program. (part-time/weekend staff will be in-serviced before working next shift). New hire employees will be educated upon hire during orientation process. Monitoring The Administrative nursing staff, will complete a 100% audit of all residents currently on isolation to ensure there is an extra trash can placed by the door, so the staff can throw away gowns and gloves before exiting the room. The Administrative nurses will complete rounds (1) daily for (4) four weeks, then (1) weekly for (4) four weeks to ensure there is an extra trash can placed by the door, so the staff can throw away gowns and gloves before exiting the room. Staff are wearing gloves and isolation gowns prior to entering an isolated room. Administrative nurses will also conduct staff interviews on what to do when entering and exiting an isolated room. Administrative nurses will conduct interviews with (5) five staff members (3) times weekly on different shifts including weekend for (1) month, then (10) ten staff members monthly for (2) two months. Any variances will be corrected upon observation and continued education provided. The results of the audits will be reported to the DON. The DON will report results to the Quality Assurance	

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F 880	Continued From page 44 An observation on 1/11/18 at 9:45am revealed the wound care physician enter Resident #81's room without gowning up or putting on gloves. An observation was made on 1/11/18 at 12:20pm revealed NA #2 entering Resident #81's room gowned and gloved. The observation revealed NA #2 removing the gown and gloves prior to leaving Resident #81's room and disposing of the materials in trash can at the door. The observation revealed NA #2 then go into the nourishment room next to Resident #81's room to wash her hands. An interview was conducted on 1/11/18 at 10:30am with Nurse #9. Nurse #9 reported that when someone is on contact precautions there should be a sign outside the room and there should be a cart with PPE equipment outside the room. Nurse #9 reported there should be a biohazard bag for trash and laundry in the resident on precautions room. An interview was conducted with the wound care physician on 1/11/18 at 10:50am. The physician reported he keeps gloves in his pocket and applied gloves prior to performing wound care on Resident #81. He reported he did not don a gown as he was only examining the wound on Resident #81's foot. The physician reported he did remove his gloves and wash his hands prior to leaving Resident #81's room. An interview was conducted on 1/11/18 at 2:35pm with Nurse #10. Nurse #10 reported Resident #81 has been on contact precautions since he arrived in November 2017. Nurse #10 reported Resident #81 will be on precautions until his bowel movements test negative for clostridium difficile. She reported Resident #10 finished treatment for	F 880	Committee. Continued compliance will be monitored through daily rounding by unit managers, ADON, DON and department heads. Any variances identified will be corrected and continued education provided. The DON will report findings to the Quality Assurance Committee to ensure performance improvement.	

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F 880	Continued From page 45	F 880		

clostridium difficile 1/10/18 and will have a stool sample obtained on 1/18/18.

An interview was conducted on 1/12/18 at 12:51pm with the supervisor of Environmental Services. The supervisor reported when a resident is on contact precautions, the clothes and linen are bagged separately in a labeled bag in Resident #10's room and are washed separately in the laundry. He reported the linens are washed using a commercial grade detergent. He reported all trash from an isolation room is double bagged and put in the trash bins. The nursing staff notifies the environmental staff of any resident on isolation. The supervisor reported that there is a precaution sign posted outside of the room of a resident on isolation along with a PPE cart. He reported that when a resident is removed from isolation, the room is deep cleaned by housekeeping.
An interview with the DON (Director of Nursing) was conducted on 1/12/18 at 4:55pm. The DON reported that it is her expectation when a resident is on contact precautions, the staff will place a precaution sign on the door and have a PPE cart outside the resident's room. The DON reported it is her expectation that all staff will glove and gown if providing care to the resident prior to entering the room. She reported it is her expectation that when the staff is finished providing care that they will remove the gown and gloves and dispose in bag in room and wash hands with soap and water prior to leaving the room. The DON reported it is her expectation that a labeled bag is left in the room for soiled linen to be put in then that bag is put in the linen cart for the laundry. The DON reported it is her expectation that the staff follow any precautions that residents have. The DON reported all the

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F 880	Continued From page 46 staff are inserviced on infection control and precautions during orientation and yearly. An interview with the administrator was conducted on 1/12/18 at 5:30pm. The administrator reported it is his expectation that if a resident is on infection precautions, the staff will follow those precautions.	F 880		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident, family, and staff interviews, the facility failed to promote an insect free environment throughout the kitchen area, the supply room area and 2 of 30 resident rooms (Room # 208 A and #206 A). Findings included: Resident # 102 in room 208 A was admitted with the diagnosis of hypertension, anemia and kidney disease. Resident #102 Minimum Data Set dated 1/1/18 revealed the resident was cognitively intact and did not have any behaviors of refusal of care. A pest control invoice dated 6/22/17 revealed that the interior of room 208 was treated with cockroach gel bait for the target pest of roaches. Pest control invoices were also reviewed for the following dates of 10/12/17, 10/17/17, 10/27/17,	F 925	F925 Mains Effective Pest Control Program Corrective Action Kitchen area, supply room area, 208 A and 206 A are free of insects. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. The kitchen area, supply room area, 208a and 206a have been thoroughly cleaned and the pest company has completed treatments of all alleged specific areas on 1/31/18. Routine audits are being done and any alleged deficient practices that are noticed by staff will be shared with the Maintenance Director and written in the Pest log, so they can be fixed in a timely	2/13/18

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F 925	Continued From page 47 11/9/17, 11/17/17, 11/24/17, and 12/29/17. No concerns with room 208 was noted. Review of the pest control sheet revealed that a new pest company had a service agreement with the facility dated 12/8/17. The pest company had come to the facility on 1/8/17 and 1/10/17 and serviced the building. The facility's pest log dated 1/8/18 stated that rooms 208, 212, 100, 101, 109 and 207 rooms were treated. The pest log dated 1/9/18 reveled that room 212 A had a large roach. There were no other pest log sheets available. A behavior contract provided by the Administrator dated 1/12/18 was made with the resident regarding keeping opened food in his room and the potential for bugs. A family member was interviewed on 1/11/18 at 11:30 AM. She stated that there were cockroaches in the facility and in her family member's room (room 206 A). She stated that the facility was not doing anything about the bugs. She also stated that the bugs were coming in from this man's room that is to the left of her family members (room 208). She stated that she only noticed the bugs on the floor. Floor technician #1 was interviewed on 1/12/18 at 10:17 AM. He stated that there had been many times that he saw bugs at the facility. He stated that he cleans/strips and waxes the floors and deep cleans the rooms. He stated that when he saw the bugs, he kills them. He stated that he also reports any bugs seen to housekeeping. He stated that room 208 A had bugs and the resident keeps open food in his room. Resident # 102 gave permission for his bedside	F 925	manner. No other issues were identified. Systematic Changes All staff, licensed and certified, fulltime, part time, PRN, have been in-serviced by the Maintenance Director on Pest Control policy by 02-05-2018. (prn/weekend staff will be in-serviced before working next shift). Monitoring Maintenance Director and/or designees will conduct rounds (3) three times per week for (4) four weeks to include weekends to ensure facility is a pest free environment. Variances will be corrected at the time of observation. Additional education and/or administrative action will be initiated when indicated. Concerns will be reported to the Administrator weekly for the next (4) four weeks. The Administrator will report results to the Quality Assurance Committee during the monthly meeting. On-going compliance will be monitored by the Administrator and/or through routine room audits and the results will be reported to the facility's Quality Assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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table to be looked in on 1/12/18 at 10:38 AM. The Floor Technician was present.

Room 208 A (resident's #102 room) was observed on 10:40 AM. The resident was noted to have a fly swatter laying on his bed. The bedside table drawers were opened by the Floor technician #1. When the 3rd drawer was opened by the floor Technician #1, bugs scattered on the floor and crawled up the cabinet. There was noted to be 10 live bugs crawling under, in and around the drawer. The bugs had a brown body with a black stomach. 3 of the bugs were medium in size and 7 of the bugs were small. In addition, there was 1 spider and spider web inside the resident's bedside table that was alive and medium in size. There were also 22 dead bugs (brown bodies with black stomachs) observed throughout the resident's bedside table. The resident was noted to have many papers, food crumbs and opened packaged food items in the 3rd drawer. The floor technician killed one of the 10 bugs on the floor as it was crawling towards him. 1 medium size dead bug (brown body with black stomach) was noted in between 208 A bed and 208 B bed.

Resident #102 was interviewed on 1/12/18 at 10:48 AM. He stated that he had bugs in his room sometimes. He stated that he had seen bugs in his drawer before and near the bathroom sometimes. He stated the bugs have never gotten on him before. He stated that he had not told them about the bugs and they never clean his cabinet area.

The Housekeeping Supervisor was interviewed on 1/12/18 at 10:55 AM. He stated that the pest control company came 2-3 times a week and

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were aware of the bugs. He stated that they cleaned resident #102 room a week ago and the resident had a lot of food in the room. He stated they would also round on the rooms every other week. He stated that he had only gotten reports of bugs but had not seen any. This was the only room with concerns in regard to food and bugs. He stated that a possible entry point could be the air conditioning unit for this room.

The storage room for toilet tissue and lights was observed on 1/12/18 at 11:19 AM. There was 7 large dead bugs with brown bodies and black stomachs noted on the ground and 1 large dead bug with a brown bodies and black stomach was noted on the window seal in the room. The floor was noted to have a hole in it and a metal piece was covering the hole. The swishing of the sound of water could be heard in the room, which seemed to be coming from under the metal piece on the floor. The concrete floor was noted to be chipped in several places around the metal piece covering the hole. The metal piece covering the hole was unable to be removed.

The Administrator was interviewed on 1/12/18 at 11:36 AM. He stated that they had a pest company in 2017 but had just went with a new pest company in 2018. He stated that if anyone reported that there were pest, he would called the pest company and they would treat the building. He stated that they switched to the new pest company on 1/8/17. He stated that resident #102 feeds the pets outside the cat food that was in his room. This resident would not report to them that there was bugs because he does not want them to find the cat food and food stored in his room.

The Maintenance Man was interviewed on

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1/12/18 at 11:55 AM. He stated that pest control come twice a month and as needed. He stated that they will service the trouble areas and check the fly lights. There had been a little bit of an issue with the previous pest company and they switched companies. The problems throughout was with water bugs and spiders but not so much cockroaches. The pest control company would come out and would spray the baseboards and put traps out. He stated they don't spray the resident's drawers. He stated that resident # 102 hoards food in his room. There was constantly people in and out of the building and lots of points of entry for bugs. On 12/15/17 and 12/28/17, the pest control company came out for a routine visit. There was no other pest concerns in December, 2017. Today was the first time that he was alerted about pest.

The Housekeeper Manager was interviewed on 1/12/18 at 4:25 PM. He stated that housekeeping was in the rooms every day and that this resident would refuse to have his room cleaned initially sometimes but this resident would eventually let them come and clean his room 9 out of 10 times now. The resident would accumulated food in his room and some of the items needed to be refrigerated. He stated that they do a specific log of pest in the rooms. He stated that he has seen bugs in the hall way and has killed them and reported them so the pest control company could come out. He stated that today he was shocked at the amount of bugs in room 208 A and usually just sees the water bugs. He stated that a garbage bag was filled with the resident's food from his drawers today.

The Maintenance Man was interviewed again on 1/12/18 at 4:41 PM. He stated that if a resident

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had concerns about pest control then he would write it in the pest control log and the pest control would check the book and initial it that the area was checked. He stated that he could not find any of these log except for the one from Monday (1/8/18) but would make a copy of Monday's log for me. He stated that he had never known this resident to have pest in his room. He stated that usually the pest control company would just come out on the next scheduled visit unless there was a big problem with bugs. He stated that the pest control company treated the outside the building every time they came and would also treat the spots that were in the pest book, as well as the kitchen and dining room. He stated there was also nothing about pest concerns in his maintenance work orders.

Housekeeper #2 was interviewed on 1/12/18 at 4:45 PM. She stated that she works in the kitchen every other weekend and on occasion. She stated that about 2 weeks in resident #102 room, she noticed that there was old food and juices in the resident's bedside drawer. She and the Floor Technician #1 deep cleaned resident's 102 room and the Nursing Assistant that day told her that they had already cleaned the resident's drawers. She stated that there was an orange spill that she cleaned up in the room. She stated she had to pull out the dresser and bedside table from the wall and noticed a lot of bugs that were alive as well as some dead ones and some droppings. She stated this was just 2 weeks ago. She stated that she wiped down the dresser, the bed and cleaned the inside of the drawers. She stated that she just cleaned the room and told her supervisor (housekeeping manager). She stated that he stated that pest control were coming that next day. Pest control came the next day and sprayed.

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She stated that resident #102 brought in a lot of food. The resident had a nasty attitude sometimes but would let the housekeeping supervisor come in to clean his room. She stated she wasn't sure where the bugs were coming from. The bugs in that room were coming from the under the dresser.

The Housekeeping Manager was interviewed again on 1/12/18 at 5:15 PM. He stated there was no documentation of room 208 A being deep cleaned. He stated that pest control came within a week after the room was deep cleaned and the resident was reloading his drawers with food again.

Nursing Assistant #3 was interviewed on 1/12/18 at 5:18 PM. She stated she hasn't seen bugs in residents' rooms but has seen bugs in the hallway sometimes. She stated that if she sees a bug she would kill it, pick it up and would tell the environmental staff about it. She stated she had never noticed bugs in resident's 102 room before.

Nurse #5 was interviewed on 1/12/18 at 5:31 PM. She stated that she usually worked 200 hall and has seen bugs in the hallways. She stated that she would kill the bugs in the hall way and usually sees the big one. She stated that she would also fill out a work order form to have the inspector come. She stated that she had never seen bugs in 208 room and that resident #102 was alert and oriented and could tell you what he needs.

The administrator was interviewed on 1/12/18 at 6:46 PM. He stated that they have to have the air conditioning units on the wall. He stated that the residents have the right to have food to eat in their room. There was a lot of potential risk for

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them to have pests and having a pest company to call and treat their pest in a timely manner would be what he would expect. He stated that he did not know of pest in that room (208A) prior to today. He added that when he called the pest control company, they will come out. When they see pest, they identify the issue and try to address it. The Pest control company would go around and treat the baseboard or the barriers in the rooms and pest become more of issue when it becomes cold outside. They did a behaviors contract with the resident that was completed today and also deep cleaned the resident's room and contacted the resident's family. He stated that the resident was alert and oriented.

The Social Worker was interviewed at 1/12/18 at 6:54 PM. She stated that the Minimum Data Set indicated that the resident was cognitively intact and the resident was alert and oriented.

The pest control inspector was called on 1/16/18 at 9:04 AM. He stated if anything comes in then the facility would alert him and they would come out. He stated that he was the initial inspector to come out to the facility and that the facility just switched to their company. He stated they are making sure that the roaches don't start to build up. He stated that they treat the outside of the building. They also inspect the exterior and interior of the building, the kitchen and any other places of concern that they are alerted to. He stated that they would also check the resident's rooms but it's up to the technician on how they want to check the rooms. The technician may check all the rooms or just the one they are alerted to. If there is a specific room with a concerns, then they would go check that room and educate the patients and staff on the issues.

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F 925	Continued From page 54 He stated there was a room last Friday with a concern and a complaint and it was addressed on the 200 hall. They just have to make sure the bugs do not have access to moisture at the facility. He stated that they come twice a month and check for flies and rodents and come as needed. They were scheduled to start providing services to the facility in the middle of the month but there was complaints of roaches so they started a little earlier and the technician came out and treated the building. They would do a follow up on the treatments if the facility communicated to them that it was needed. He stated that they treat for everything (rodent wise)at the facility. Lights could also attract insects and they can come in many different ways but as soon as they cross the threshold from the outside of the building that had been treated, the pest would die. He stated that he could only remember that there was maybe 1 or 2 bugs that were spotted in the kitchen but that was it.	F 925		